DEVELOPMENT FOCUS

Reference Manual on Sexual Reproductive Health Rights and Child Marriage for Program Co-ordinators

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Sexual Reproductive Health Rights and Child Marriage for Program Coordinators

Clusters: DAHAR, Western Orissa Child Marriage Prevention (WOCMP), Shiksha Chetna.

Acknowledgement

Development Focus expresses heartfelt thanks to the youth in 400 villages and 2400 Change agents – Yuva Mitra in the states of Jharkhand and Orissa of Child Marriage Program for their energy and openness throughout the Program. The enthusiasm of the youth to learn about Sexual Reproductive Health and Rights (SRHR) and also addressing the issue of Child Marriage in their communities.

Development Focus appreciates team SHRISTY for the meticulous work in developing the material contained in this Reference Manual with a special mention of Mr. Pankaj Gupta and Ms. Nasreen Jamal for the concept, designing, technical content, illustrations, pilot testing and evaluation.

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Development Focus remembers with endless gratitude all the people worked really hard for the accomplishment of the program.

Foreword

The Child Marriage program in 12 districts of Jharkhand and Orissa, is an important initiative that addresses the need for holistic education and development of youth. The carefully designed activities have galvanized the youth to be well informed of their physical and overall growth and development to help them and their parents to make wise and informed choices on their marriages and future lives.

The Reference Manual is developed for the use of Program Coordinators under the Child Marriage Program working in 20 Partner Organisations in 3 clusters of two states, Jharkhand and Orissa. The 3 clusters include Dahar with 10 Partner Organisations in Jharkhand, and the other two are in Orissa, namely Western Orissa Child Marriage Prevention cluster and Shiksha Chetna cluster with 5 Partner Organisations.

Program Coordinators, Yuva Mitras (Youth Facilitators) and Youth Groups have undergone specific subject related and management trainings. This reference manual is meant to further help the program coordinators and the youth groups in their continued endeavour, especially beyond the project. Updated knowledge about Sexual Reproductive Health and Rights (SRHR) and ways of resisting child marriage will enable program coordinators to adopt a nuanced approach in handling interactive learning sessions with the youth including those from communities' in the neighboured. Imparting SRHR education through simple and meaningful activities enables individuals to translate knowledge, attitudes, and values into actual abilities. The methods used in teaching are built upon how young people learn from their own experiences and from people around them. The comprehensive range of sessions on SRHR and child marriage in the reference manual will provide the youth with awareness and confidence to grow into strong, confident, and wise young women and men who can take informed decisions on SRHR issues.

The sessions and activities are intended to spread awareness among youth and adolescents. This curriculum takes an interactive approach, using various games, role-plays, small group activities, and discussions to enhance the participants' learning and skill-building.

We are confident that this reference manual will serve as an important tool in that endeavour.

Development Focus wishes the youth success in their life journey, and the parental community and the handholding 'Yuva Mithras' and Program Coordinators the very best in their endeavours.

Development Focus

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
ARSH	Adolescent Reproductive & Sexual Health
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
BSY	Balika Samridhi Yojana
CBO	Community Based Organization
CDPO	Child Development Projector Officer
CM	Child Marriage
CMPO	Child Marriage Prohibition Officer
CRC	Convention of Child Rights
DIG	Deputy Inspector General
DLHS	District Level Household Survey
HIV	Human Immuno Deficiency Virus
IAHTU	Integrated Anti Human Trafficking Units
ICDS	Integrated Child Development Services
IEC	Information Education Communication
IFA	Iron Folic Acid
IG	Inspector General
KGBV	Kasturba Gandhi Balika Vidayalaya
KSY	Kishori Shakti Yojana
NFHS	National Family Health Survey
NGO	Non-Government Organization
NHE	Nutrition & Health Education
PCMA	Prohibition of Child Marriage Act
RTI	Reproductive Tract Infection

SC	Schedule Caste
SP	Superintendent of Police
ST	Schedule Tribe
STD	Sexually Transmitted Disease
SSA	Sarv Siksha Abhiyan
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UN	United Nations
VHND	Village Health Nutrition Day
WIFS	Weekly Iron Folic Acid Supplementation

Module I: Introductory Module

Learning Objectives	**By the end of the session, participants will be able to:**
	Know each other
	Understand the objective of the two day program
	List out their expectations

Movie chits, Flip Chart, Marker, Flash card

45 min

Session	Topic	Methodology	Time
1	Ice Breaking: Welcome & Introduction	Game	15 min
2	Expectation of the workshop	Group activity	10 min
3	Setting ground rules	Group discussion	10 min
4	Pre test	Pre-test questionnaire	10 min

Session 1: Ice Breaking: Welcome & Introduction

Step I:

The facilitator will welcome participants to the training, acknowledge, and introduce before them. Inform participants that we are going to conduct an exercise by which we all will get to know each other more than just our names.

Step II:

Make pairs of participants using chits on which the names of movies are written. Ensure that the chits should always be in pairs and should be sufficient for all those in the training room.

Step III:

Facilitator should also join the introductory round. Ask each pair to discuss amongst each other regarding the following:

- Name
- Qualification
- Designation & Name of Organization
- Place of Work
- Any memorable incident during adolescent period

Step IV:

Ask each pair to come forward and share the pair name and then introduce the partner. Once each pair is through with their introduction, thank them for the active part they took.

Session 2: Expectation from the workshop

Step I:

Facilitator will ask the participants to list down their expectations of what they want to learn from the training on the flash card.

Step II:

The cards are then collected and displayed on the wall and their expectations are addressed. The expectations of the participants are matched with the training curriculum.

Step III:

Facilitator will identify expectations that are not relevant for this training and which may be outside the scope of the training and specify that why it will not be addressed.

Session 3: Setting ground rules

Step I:

Facilitator will discuss some rules for the conduct of the training from the participants themselves.

Step II:

The rules will be listed down in a chart paper and displayed on the wall of the training hall. Some of the rules could be:

- Try to maintain the time
- Raise hands for asking queries or sharing your opinion
- In case of urgent call kindly attend it outside the workshop hall
- Sit in straight posture
- Do not talk to each other or gossip
- Participation by all is compulsory

Session 4: Pre test

Step I:

Facilitator will hand over the pre-test questionnaire to the participants and mention that ten minutes has been allotted to complete the questionnaire.

Step II:

Participants are to be informed that they are not to write their names on the questionnaire.

Module II: Who is a child? Concept of child right and child abuse

Learning Objectives	**By the end of the session, participants will be able to:**
	Define National and International definition of child
	Learn about the child rights in global and national context

Flip Chart, Marker, Laptop, Projector, Chart paper, Flash card

60 min

Session	Topic	Methodology	Time
1	Who is a child	Brain Storming & Group Work	30 min
2	Child Rights	Lecture & Presentation	30 min

Session 1: Who is a Child?

Step I

First ask the participants:

"What is the age definition of a child", or

"Who is called child"

Followed by from where they got idea about the age of child. The discussion points need to be noted down in a chart paper.

Step II

The facilitator would discuss with the participants to describe the community common view on child, i.e. what is the community's perception about the age of a child. All common view needs to be noted down in a flip chart.

Step III

The trainer will explain the UN definition of child as well as define the different legal definition as per Indian Constitution. (Ref. Trainer Guide)

Tips for the Facilitator:

Facilitator must ensure that every participant should take part equally in the discussion

- Should not impose his/her view on participants during discussion.
- Should identify the "know all" category participants.
- Will explain properly the different definition of child as per Indian law.

Session 2: Child Rights?

Step I

Facilitator writes down all the child rights in a flash card separately. Then distribute it to the participants.

Step II

Facilitator would then ask one of the participants to volunteer to draw a sketch of a child on the chart paper and paste different colour chart paper along the four side of the sketched child.

Step III

The facilitator will then explain every child has four basic rights.

- Right to survival
- Right to development
- Right to protection
- Right to participation.

The four rights will be the heading of four different coloured chart paper which has already been pasted around the sketch of child.

Step IV

Then the facilitator will explain the participants to think that which right will be come under which basic right. And ask them to paste in the chart paper accordingly. Ask the volunteer to explain the chart paper.

Step V

Then the facilitator will explain the child rights as per UNCRC and constitutional rights

Trainer Guide

Some commonly held views

Children

- Are the 'property' of parents who have the right to decide and direct them as they see fit;
- Are adults in the making and as yet cannot contribute to society; (though in rural society children are often like young adults and contribute a lot);
- Do not vote and hence do not have political and economic power and therefore no 'say' in any matter.
- Are too young to take decisions, therefore they must not be allowed to decide for themselves. (This concept extends to lack of choices in marriage, career, job, etc., even after they have reached maturity.)
- Do not have voices, especially girls – they are not to be heard.
- Can be given corporal punishment (it is fine to physically abuse and punish them in the interests of discipline which often really means that they must defer to the adult no matter what)

Definition of Child

- In society, children are defined differently in different context, viz. for parents, their children always remain children. Even when their children get married and have children of their own, parents continue to see them as their offspring and their property. They treat their children as less experienced and therefore always in need for guidance, advice and support.
- The definition of "**child** "is changing with the changing socio cultural scenario of the world. Earlier any person in the age of 14 years was treated as a child. The definition amended in the UN Declaration of the Rights of the Child, 1959, defined a child as an individual up to 16 years of age. The UN convention adopted in 1989 in UN redefined a child as every human being below the age of 18 years
- **Internationally,** a child is any individual below 18 years of age. This is based on the definition of the UNCRC, which has been accepted and ratified (become law in that country) by most countries including India. In accordance with the CRC (since 1992), for most purposes (especially development programmes), therefore, the age of a child is taken to be 0-18 years, even if the child is married and has children of his/her own. Sometimes 16-18 year olds are covered under a separate category of 'Youth' (Kishore).Such variations must be kept in mind while considering the statistical profile presented here.

In India there is a variation in the definition and age criteria under different laws and institutions

- Census of India defines child as any person below the age of 14.
- In the Indian Penal Code, i.e., under criminal law, any offence committed by a child less than 7 years is not considered as a crime and this extends up to 12 years in special circumstances.
- Under the Juvenile Justice Act, 1986, a new amendment was passed in 2001 whereby a juvenile is a child who has not completed 16 in case of a boy, and 18 in case of a girl.
- Age of sexual consent for a girl is 16 years, and 15 years if married.

- Under the Child Marriage Prohibition Act, legal age of marriage for girls is 18 and for boys 21.
- The minimum age of recruitment for the army is 16 years.
- For voting purposes and to get a driving license the benchmark is18 years.
- The Factories Act, 1948: under 14 years
- The Mines Act, 1952: 18 years
- The Apprentices Act, 1961: 14 years
- The Child Labour (Prohibition and Regulation) Act, 1966: 14 years

Categorization of rights

- Right to Survival includes rights to:
  - Life
  - Identity
  - Highest attainable standard of health
  - Nutrition
  - Adequate standard of living
  - Name and nationality (identity)
- Right to Development includes rights to:
  - Education
  - Support for early childhood care and development
  - Social security
  - Leisure and recreation
  - Cultural activities
- Right to Protection includes protection against:
  - All forms of exploitation
  - Abuse (physical, mental, sexual)
  - Inhuman or degrading treatment
  - Neglect
  - Special protection in special cases is for instance, emergencies, war, disasters, Conflict, Disability, etc.
- Right to Participation includes:
  - Respect for child's views
  - Freedom of expression
  - Right to information
  - Right to identity
  - Right to participate in community programmes

Children's Rights under the Indian Constitution:

Children have the same rights as other citizens under the Indian Constitution

Article 14: Guarantees equality before law and equal protection of laws to every citizen

Article 15: Provides the right against discrimination on grounds of race, caste, sex, place of birth or residence.

Articles 21: Ensure all citizens rights to personal liberty & due process of law.

Article 23: Provides protection from trafficking and bonded labour
Article 46: Deals with rights of weaker sections to be protected from social injustice and all forms of exploitation. (SC, ST, OBC, gender, lower economic strata, minorities)

Some Special Rights for Children

Recognizing that children are especially vulnerable and need urgent attention and protection in childhood which is time-bound, (as children outgrow childhood), the Constitution includes some special provisions and laws for children:

Article 21A: Right to free and compulsory elementary education for all children-6-14 years
Article 24: Protection from any hazardous employment up to age 14.
Article 39(e): Protection from abuse and being forced by economic necessity to enter any occupation unsuited to their age or strength.
Article 39(f): Right to equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity & guaranteed protection of childhood & youth against moral and material abandonment.

State Responsibilities

Article 15(3): Special provisions for girl children
Article 29: Interest of minorities
Article 46: Promotion of educational interests of weaker sections
Article 47: Raising level of nutrition and standard of living of its people and the improvement of public health.

International

The UNCRC signed in 1989 and ratified by 2nd September 1990, is the most significant and most widely ratified/accepted of international laws for children.
It is a comprehensive document, and covers all rights: civil, political, economic, social and cultural. It gives in detail what a child needs for a safe, happy and fulfilled childhood.

Some Important Features of CRC

- CRC applies equally to boys and girls up to 18 years whether married or single or having children of their own
- Guided by the principle of Best Interest of Child, non-discrimination and respect for child's views
- Importance of family and need to create environment conducive to healthy growth and development of children in the family
- Obligation on State to ensure children get fair and equitable deal
- Emphasis on four sets of civil, political, social, economic and cultural rights:
- Survival
- Development
- Protection
- Participation

Module III: Concept and overview of Child marriage

Learning Objectives	**By the end of the session, participants will be able to:**
	Understand the concept and legal aspects of Child marriage
	Understand the scenario of Child Marriage
	To categorize and prioritise the cause & effect of child marriage

Flip Chart, Marker, Laptop, projector, Chart paper

60 min

Session	Topic	Methodology	Time
1	Concepts, Legal aspects and community Perspective on Early Marriage	Brainstorming	15 min
2	Scenario of Child Marriage	Presentation	15 min
3	Cause and Effect of Child Marriage	Group Work	30 min

Session 1: Concepts, Legal aspects and community Perspective on Early Marriage

Step I:

This session will be conducted through brain storming exercise. Participants will be asked to describe what marriage is and community perspectives on early marriage. Try to understand what kind of practice exists in the community. The points will be noted down in a chart paper.

Step II:

The facilitator will explain some common view on Early Marriage:

- Girls are considered as burden
- Have to pay high dowry if the brides are getting older
- Safety of the girl child from sexual violence which the parents are unable to guarantee.
- Ensure girl's future socially and economically
- Insecurity of finding a proper match for an older girl.
- Society will take in negative aspect
- Ultimately she has to get married, then why to delay the same?
- She has to take care of household chores so there is no need for further study
- It's her growing age so need to give proper direction otherwise she will be go in wrong way

Step III:

In this step facilitator will recap the whole discussion and then explain the legal aspect of early marriage:

- What is the definition of child marriage as per Child Marriage Prohibition act, 2006?

- What is the legal age for marriage for Boys and for Girls?

The facilitator will finally explain the UN definition of Child Marriage

Session 2: Scenario of Child Marriage

Step I

The Session will start with recapitulation of previous session. Then the participants will be asked to describe what they faced in ground realities? In which age girls and boys getting married in their community. The points will be noted down in a chart paper.

Step II

The facilitator will explain the status of Child Marriage in India and Jharkhand, through presentation with the data available from different survey. (Ref Trainer Guide)

Session 3: Cause and Effect of Child Marriage

Step I

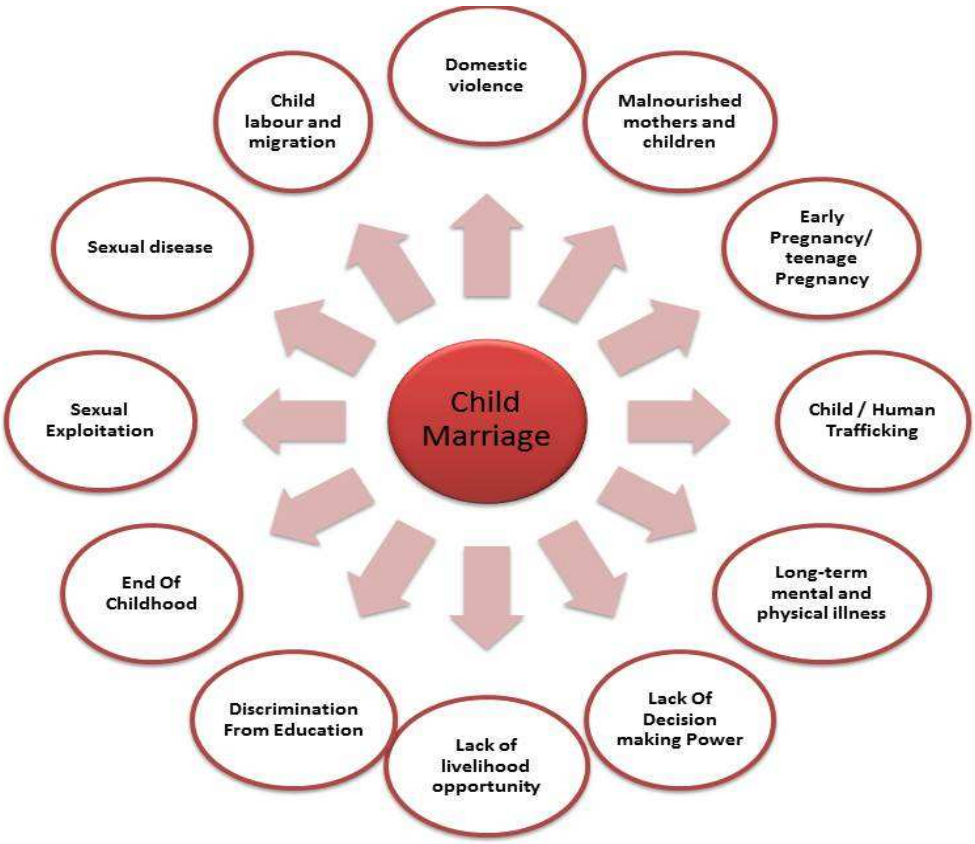
In this session the facilitator will start with the discussion on reason of child marriage. The facilitator will divide the participants in 4-5 groups and ask the participants to state five big reasons of child marriage. After that each group will do presentation.

Step II

In this step the facilitator with participants' consensus will filter out the important cause and note down in the chart paper. The facilitator might add on explaining the causes if anything is left out or not identified by the group members, and must also establish linkage with the traditional view and practice.

Step III

In this session the facilitator will discuss the effect of child Marriage with the help of the following model.



Step IV

Finally the facilitator will summarize the effect of the child marriage with the help of data from different sources. (Ref Trainer Guide)

Trainer's Guide

THE PROHIBITION OF CHILD MARRIAGE ACT, 2006

What is a Child Marriage?

It is a marriage to which either of the contracting party is a child. {S2 (b) of the Prohibition of Child Marriage Act, 2006}

Whom does it apply to?

- It applies to all citizens of India irrespective of religion, without and beyond India.
- It however, does not apply to the State of Jammu and Kashmir.
- It excludes the Reno cants of the Union Territory of Pondicherry from its application.

What does the law provide for?

The basic premise of the law is:

- To make a child go through a marriage is an offence.
- Child or minor is a person up to 18 years in the case of girls and 21 years in the case of boys.
- The provisions of this law can be classified into three broad categories:
    A. Prevention
    B. Protection
    C. Prosecution of Offenders

The authorities identified for prohibiting child marriage under the present law are:

- Child Marriage Prohibition Officer
- District Magistrate
- First Class Judicial Magistrate or Metropolitan Magistrate
- Police
- Family Courts
- Any person(s) called upon by the State Government to assist

Reporting Child Marriages

- Any person can report an incidence of child marriage before or after it has been solemnized. An immediate report needs to be made to:
    - The Police
    - The Child Marriage Prohibition Officer or such persons as may be appointed to assist him/her
    - First Class Judicial Magistrate or Metropolitan Magistrate
    - Child Welfare Committee or a member of the Child Welfare Committee set up under the Juvenile Justice (Care and Protection of Children) Act, 2000 as amended in 2006
    - CHILDLINE (1098)
    - District Magistrate

Major points of Prohibition of Child Marriage Act 2006

- The legal age for marriage is 18 years for females and 21 years for males;
- Child marriage is an offence punishable with rigorous imprisonment, which may extend to 2 years, or with fine up to Rs. 1 Lakh, or both;

- Child marriage is a cognizable and non-bail able offence;
- Child marriages are voidable and can be annulled;
- Persons who can be punished: those performing child marriages; male adults above 18 years marrying a child; and persons responsible for the child (i.e. Parent, guardian promoting, permitting, participating or failing to prevent a child marriage).

Child marriage still rampant in India

There are many factors which sustain the continuation of the practice of child marriage in India. Poverty and social norms intended to ensure family honour and protect girls are significant factors that increase the risks for a girl to be married while still a child.

These factors manifest themselves in the following collective and individual attitudes and beliefs which are still widespread in India:

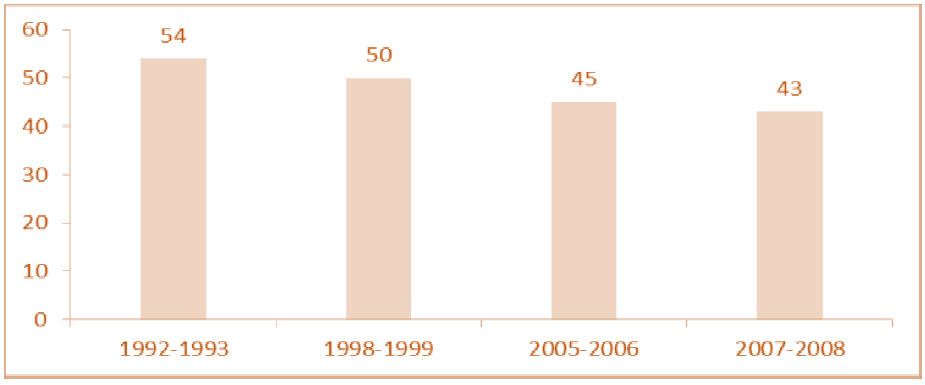
- Unmarried girls are considered a liability to family honour. Child marriage is a way to ensure chastity and virginity of the bride, thus avoiding potentially dishonouring of the family
- Dowry perpetuates child marriage as it encourages parents to marry off their girls early to avoid an increase in the dowry amount (more educated girls usually require a higher dowry). Although giving or receiving dowry is a crime under the DowryProhibition Act, 1961, it is still a common practice.
- Girls are considered an economic burden for their family of origin and a "paraya dhan" or property that belongs to the marital family. Hence, the tendency is to marry girls as early as possible and reduce investment in their daughters.
- Investing in girl's "education is not considered worthy as girls will be moving to the groom's household and will be employed in household chores. On the other hand, the limited education and livelihood options for girls lead to marriage being one of the few options for girls‟ future.
- Impurity, weak law enforcement and limited knowledge of the law by society perpetuate child marriage.

Data Related to Child Marriage

In India, nearly half (43%) of women aged 20 to 24 are married before the age of 18. There has been a decline in the incidence of child marriage nationally and in nearly all states (from 54% in 1992-93 to 43% in 2007-08), but the pace of change remains slow.

Percentage of women age 20-24 married before age 18 in India

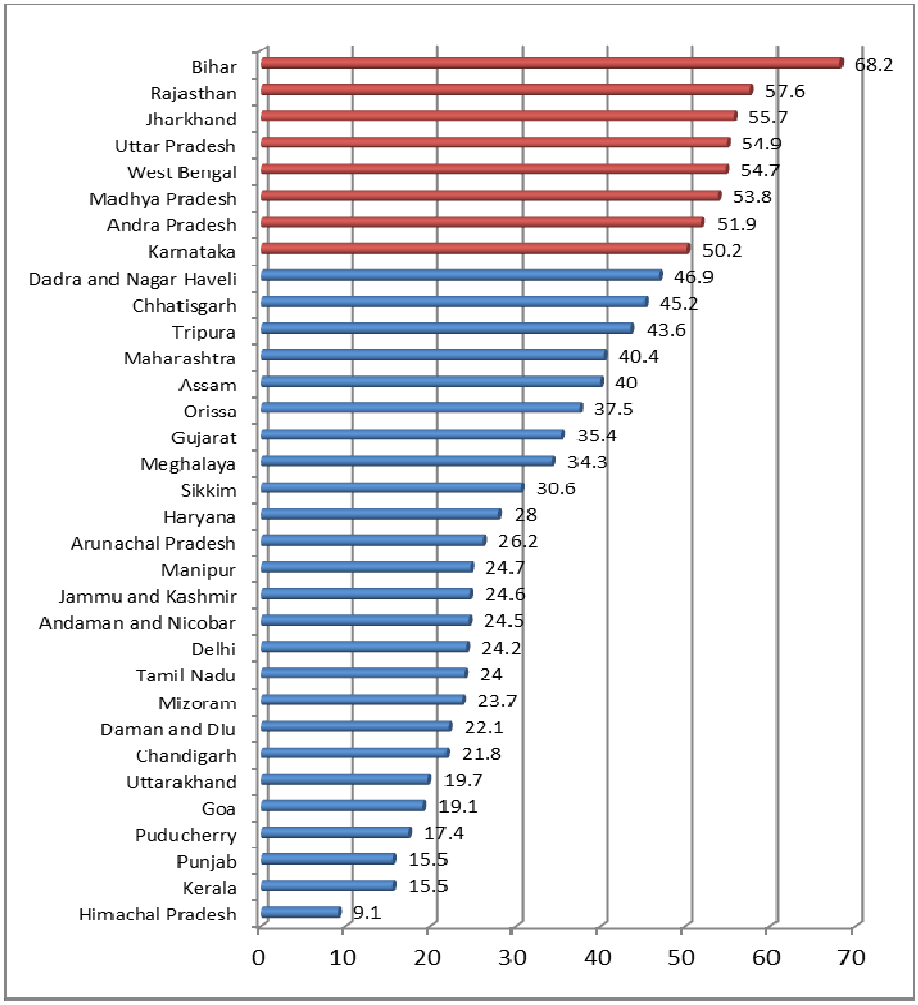
(DLHS3, 2007-2008)



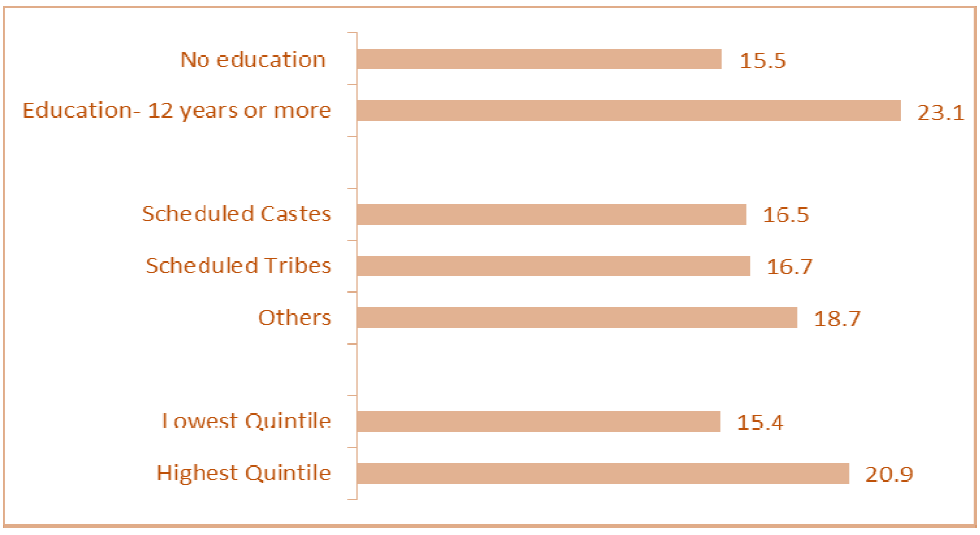
The states with the highest incidence of child marriage in the country are Bihar, Rajasthan, Jharkhand, Uttar Pradesh, West Bengal, Madhya Pradesh, Andhra Pradesh and Karnataka.

Percentage of women aged 20-24 married before age by State

(DLHS3, 2007-2008)



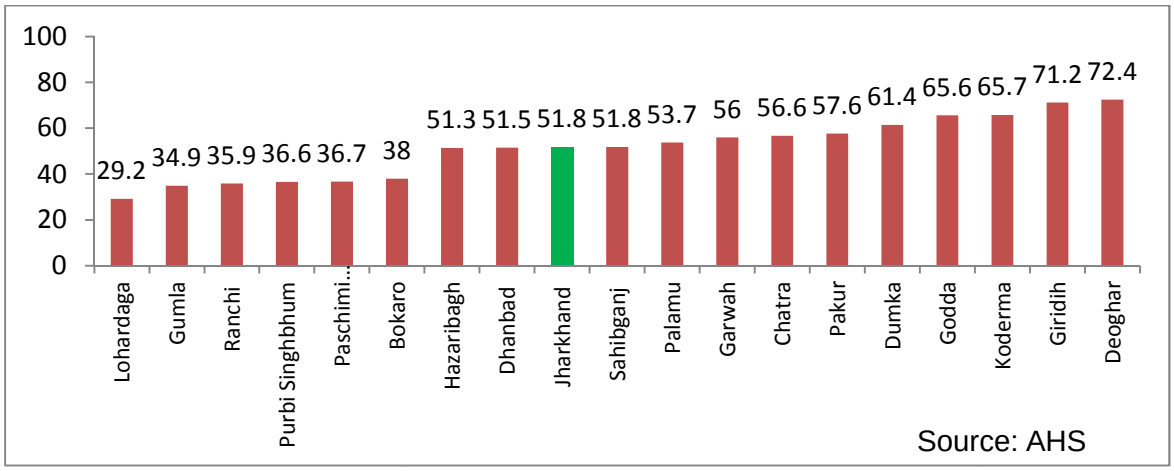
Median age at first marriage among women of age 25-29by different population characteristics in India–(NHFS) 2005-06



Jharkhand Scenario

- Jharkhand has been among the top three states of the country where practice of child marriage is the highest - and the average cases has never gone below 50% - in the past 10 years.
- Various national reports say the percentage of child marriage is much higher in Jharkhand compared to the national average of 47%.
- Similarly, the report of National Family and Health Survey-III 2005-06 said 63.2% women of Jharkhand got married before 18 years and Jharkhand was at the second position after Bihar.
- According to the data of district level health survey-III 2007-08, this average is 55.7% with Jharkhand being on third position.
- According to the Annual Health Survey of 2010-11, Jharkhand comes on the third position after Bihar and Rajasthan with 51.8% girls being married below 18 years.

Percentage of Child marriage by district of Jharkhand State



Odisha Scenario

Percentage of child marriage by district of Orissa state

State / District	Marriages among Females below legal age (18 years) (%)#			Marriages among Males below legal age (21 years) (%)#			Currently Married Women aged 20-24 years married before legal age		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	**Urban**
Odisha	4.6	5.0	2.7	5.4	6.0	2.9	28.8	29.3	**25.6**
Anugul	6.3	6.6	4.9	4.5	4.9	2.9	27.9	27.7	**29.4**
Balangir	2.6	2.8	0.0	2.8	3.1	0.0	18.0	17.9	**18.2**
Baleshwar	2.4	2.4	2.2	2.5	2.5	2.0	21.9	20.9	**31.0**
Bargarh	4.8	4.8	5.0	3.4	3.4	3.6	24.1	24.2	**23.1**
Baudh	6.7	6.7	-	7.5	8.0	-	38.5	38.7	**-**
Bhadrak	1.4	1.2	2.7	2.3	2.2	2.9	16.5	15.5	**22.0**
Cuttack	1.0	1.3	0.2	1.6	1.4	2.0	15.6	15.4	**16.2**
Debagarh	2.5	2.7	0.0	5.3	5.4	4.2	24.6	24.4	**26.7**
Dhenkanal	3.9	4.3	0.0	3.9	4.2	1.3	16.2	16.9	**7.1**
Gajapati	9.5	10.9	2.4	7.8	9.0	2.1	43.4	44.8	**29.6**
Ganjam	7.4	8.1	3.0	2.9	3.3	0.8	38.0	39.2	**25.9**
Jagatsinghapur	0.6	0.6	0.9	1.6	1.6	1.6	15.1	13.4	**24.8**
Jajapur	2.3	2.4	-	1.8	1.9	-	16.4	16.4	**-**
Jharsuguda	1.7	1.2	2.3	2.4	1.9	3.2	15.4	11.6	**21.9**
Kalahandi	4.0	4.3	-	8.9	9.5	-	31.0	31.6	**-**
Kandhamal	6.0	6.1	4.8	7.6	8.2	2.9	36.5	37.3	**27.3**
Kendrapara	0.8	0.8	1.1	1.3	1.3	1.2	10.0	10.0	**8.8**
Kendujhar	7.4	8.1	4.4	6.9	7.8	3.1	29.4	29.5	**29.0**
Khordha	2.3	2.9	1.7	2.1	2.4	1.8	23.1	20.7	**26.1**
Koraput	13.5	14.2	10.9	23.2	25.7	13.5	53.7	55.6	**40.6**
Malkangiri	12.6	13.1	4.4	20.1	21.1	5.4	48.8	48.8	**47.9**
Mayurbhanj	5.5	5.7	2.7	4.9	5.0	3.6	36.4	36.8	**29.3**
Nabarangapur	19.1	19.8	-	23.5	24.4	-	51.1	51.4	**-**
Nuapada	6.1	6.0	-	10.1	10.4	-	34.1	34.6	**-**
Nayagarh	7.0	7.1	-	3.3	3.0	-	31.6	31.9	**-**
Puri	0.9	0.5	2.4	1.2	1.0	2.2	19.3	16.5	**30.0**
Rayagada	9.3	10.3	4.8	10.4	12.2	2.2	38.4	38.2	**39.4**
Sambalpur	2.2	1.5	3.3	3.6	3.0	4.6	17.3	14.3	**22.0**
Sonapur	4.1	4.2	2.7	4.0	4.1	3.3	33.0	33.5	**24.2**
Sundargarh	**2.7**	**2.6**	**3.0**	**5.0**	**6.3**	**2.7**	**20.4**	**19.1**	**23.9**

 # based on marriages taking place during 2008-10

Source: AHS

State / District	Currently Married Men aged 25-29 years married before legal age (21 years) (%)			Mean age at Marriage#					
				Male			Female		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	**Urban**
Odisha	18.7	18.9	16.8	26.8	26.5	28.4	22.4	22.2	**23.4**
Anugul	18.5	19.2	14.2	26.8	26.5	28.1	21.3	21.1	**22.4**
Balangir	13.0	13.1	11.4	26.5	26.2	29.0	21.6	21.4	**23.6**
Baleshwar	13.8	14.1	11.4	27.4	27.2	28.7	21.8	21.7	**22.7**
Bargarh	11.9	12.2	6.4	26.8	26.7	28.0	21.0	20.9	**22.1**
Baudh	20.6	20.5	-	25.5	25.2	-	20.7	20.6	**-**
Bhadrak	10.1	9.6	13.3	27.5	27.4	27.9	22.8	22.9	**22.7**
Cuttack	11.6	10.8	14.1	28.5	28.4	28.9	23.2	22.9	**24.1**
Debagarh	14.5	14.1	18.5	26.8	26.6	28.5	21.4	21.3	**22.8**
Dhenkanal	13.0	12.9	13.7	27.7	27.5	29.6	22.0	21.8	**23.7**
Gajapati	21.3	22.6	7.5	25.9	25.4	27.5	21.1	20.7	**22.5**
Ganjam	15.2	15.3	14.0	26.7	26.2	29.6	21.3	21.0	**23.1**
Jagatsinghapur	6.0	6.6	2.5	28.6	28.5	31.1	24.7	24.8	**23.3**
Jajapur	10.1	10.1	-	28.1	28.1	-	23.4	23.3	**-**
Jharsuguda	11.6	8.6	16.7	27.2	26.9	27.6	22.2	22.0	**22.5**
Kalahandi	24.2	24.9	-	25.1	24.7	-	21.5	21.2	**-**
Kandhamal	22.6	22.6	22.1	26.5	26.4	26.7	22.7	22.4	**24.7**
Kendrapara	5.6	5.5	6.3	28.1	28.0	29.5	23.5	23.5	**24.3**
Kendujhar	19.2	19.1	19.7	26.5	26.1	27.9	21.5	21.4	**21.9**
Khordha	13.7	11.9	16.0	27.9	27.5	28.3	23.6	23.1	**24.1**
Koraput	46.0	47.7	34.8	23.2	22.4	25.4	21.5	21.5	**21.4**
Malkangiri	37.0	37.4	30.2	23.0	22.8	26.5	19.8	19.7	**20.8**
Mayurbhanj	25.8	25.6	30.5	26.7	26.4	30.9	21.2	21.1	**23.3**
Nabarangapur	34.3	34.5	-	22.9	22.7	-	20.0	19.8	**-**
Nuapada	20.8	21.2	-	25.0	24.9	-	22.3	22.3	**-**
Nayagarh	9.3	9.3	-	27.2	27.1	-	20.6	20.7	**-**
Puri	11.7	10.8	16.2	28.3	27.9	30.0	23.7	23.4	**24.9**
Rayagada	21.1	21.1	21.1	25.1	24.4	28.8	21.8	21.4	**24.4**
Sambalpur	11.5	10.3	13.4	27.0	26.5	27.7	22.3	22.0	**22.8**
Sonapur	16.4	16.7	9.1	27.1	26.8	29.7	21.9	21.7	**23.2**
Sundargarh	**18.7**	**17.8**	**20.9**	**27.0**	**26.3**	**28.3**	**22.8**	**22.6**	**23.0**

 # based on marriages taking place during 2008-10
Source: AHS

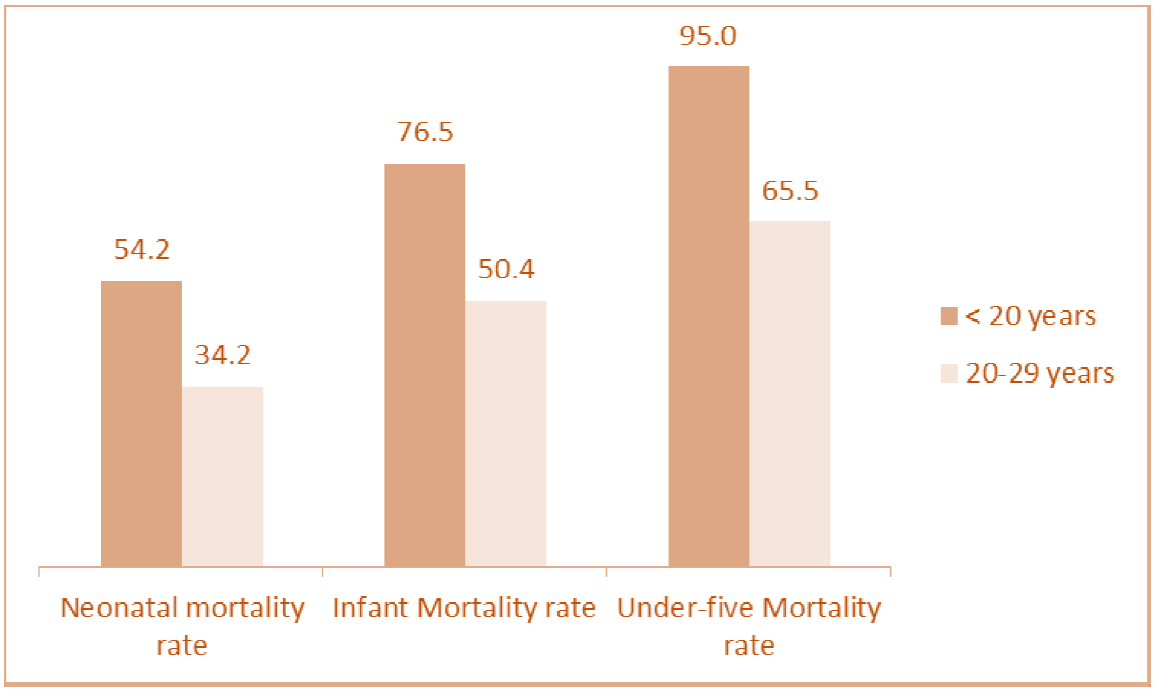
Harmful Effects of Child marriage

Child marriage has adverse effects for the child and for the society as a whole. For both girls and boys, marriage has a strong physical, intellectual, psychological and emotional impact, cutting off educational opportunities and chances of personal growth. While boys are affected by child marriage, this is an issue that impacts upon girls in far larger numbers and with more intensity. The consequences for girls are especially dire, as they are usually compelled into early childbearing and social isolation. Child brides will frequently drop out of school and be exposed to higher risk of domestic violence and abuse, increased economic dependence, denial of decision-making power, inequality at home, which further perpetuates discrimination and low status of girls/women.

Child Marriage and Health

Child marriage is associated with several health risks for the young mother, as early marriage may translate into repeated pregnancies at a tender age when the body is not fully prepared for child bearing. Girls age 15-19 are more likely (66.6%) to experience delivery complications compared to 30-34 year-old women (59.7%) and neonatal, infant and child mortality rates are much higher for younger girls, as shown in the graph below.

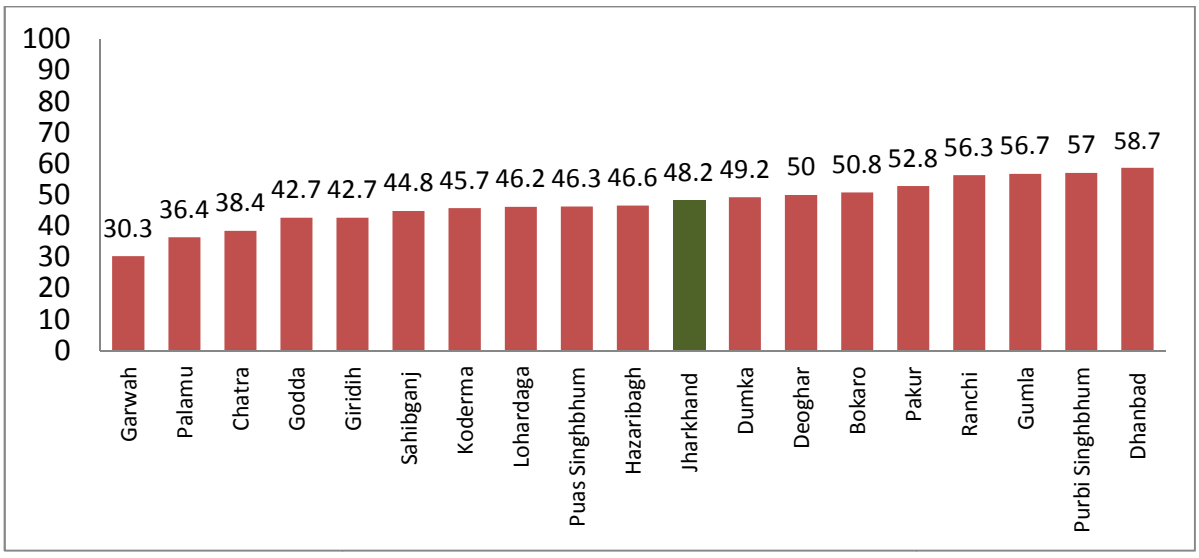
Child mortality rates by age-group of mother in India - 2005-2006



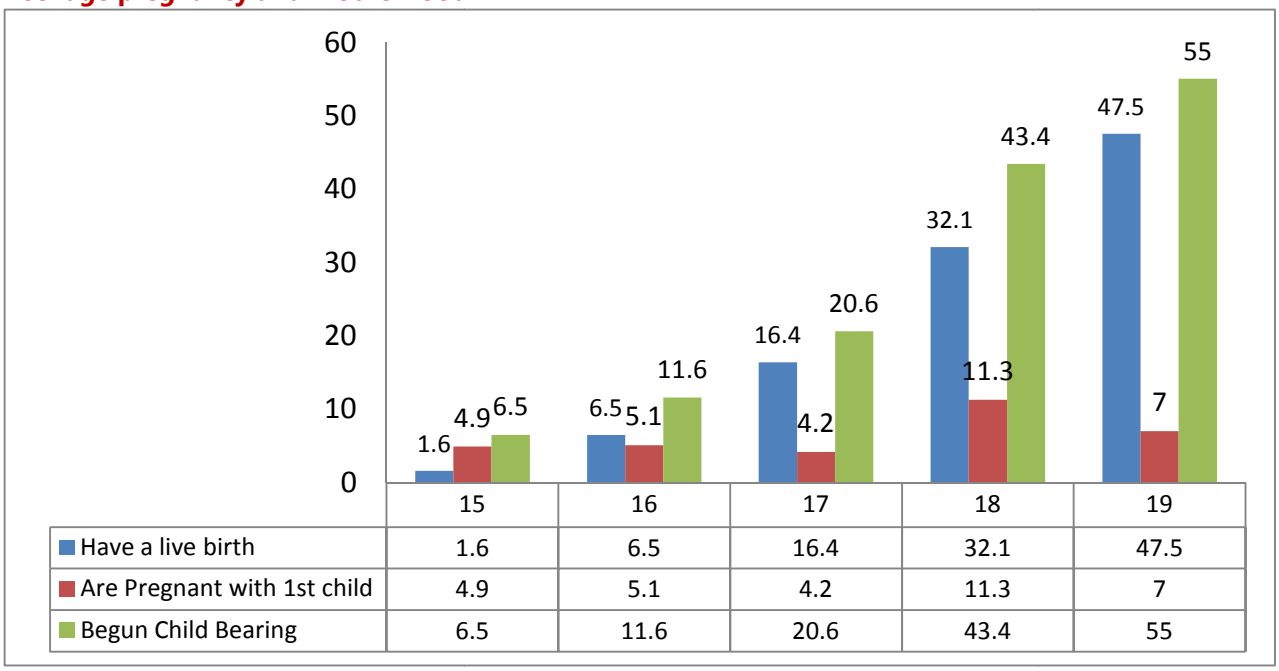
Risks of HIV/AIDS infection are higher among young girls as their negotiation skills and experience to ensure a healthy sexual life are less developed.

Impact of child marriage on reproductive health outcomes

Women aged 15-19 years who were already mothers or pregnant at the time of survey (%)

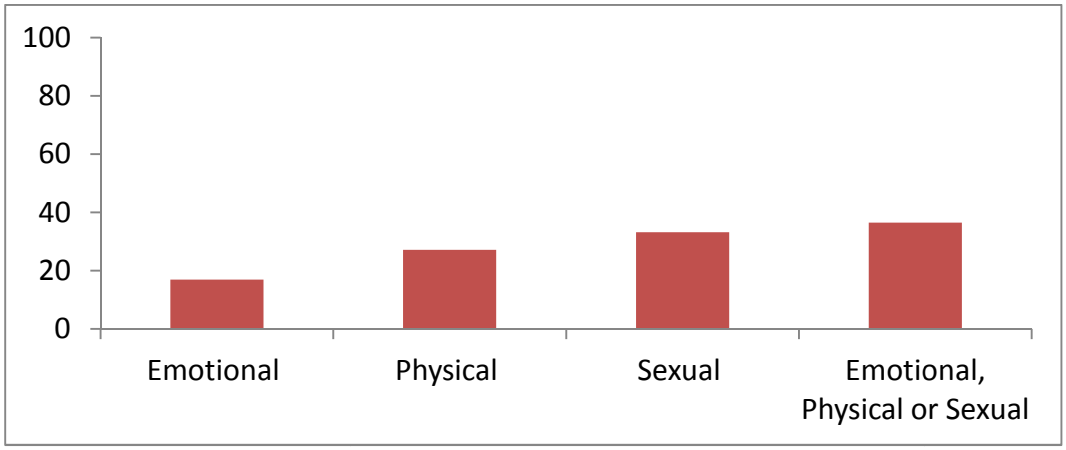


Teenage pregnancy and motherhood

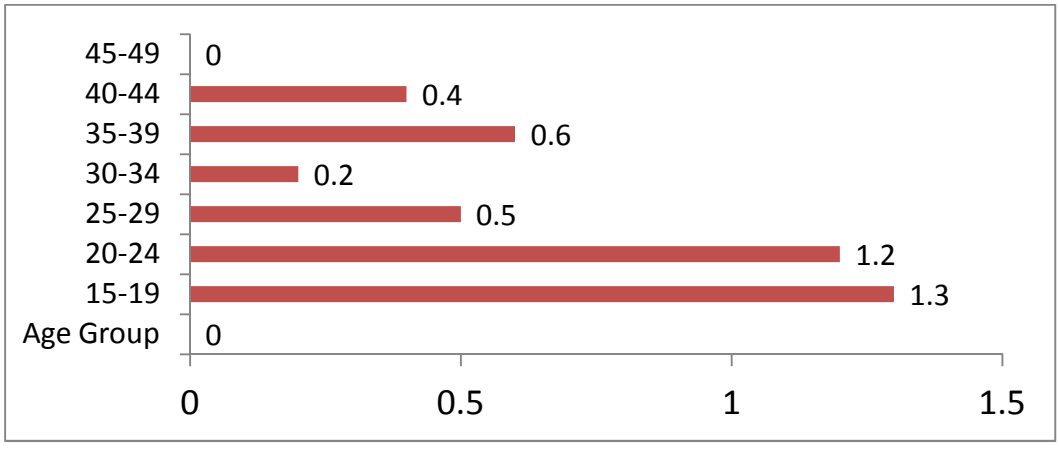


	15	16	17	18	19
Have a live birth	1.6	6.5	16.4	32.1	47.5
Are Pregnant with 1st child	4.9	5.1	4.2	11.3	7
Begun Child Bearing	6.5	11.6	20.6	43.4	55

Percent of ever-married women age 15-19 who have ever experienced committed by their husband



Pregnancy outcome (Still birth) of married women



Module IV: Role of different stakeholders in prevention of child marriage

Learning Objectives	**By the end of the session, participants will be able to:**
	Understand role of different stakeholders to address child marriage

Flip Chart, Marker, Laptop, projector, Chart paper

60 min

Methodology: Discussion & Role Play

Step I

In this session the facilitator will start from recapitulation of legal aspect of The Prohibition of Child Marriage Act, 2006. The Trainer will ask the participant that who will be the key person for stop child marriage. The discussed point will be note down in a chart paper

Step II

Then the facilitator should ask the participants to do a role play to prevent child marriage which is going to take place in their village.

Step III

The facilitator will finally summarise the role of different stake holder. (Ref Trainer Guide)

Trainer Guide

Role of Different Stake Holder that have been identified in the law is as follows

1. **Child Marriage Prohibition officer**: As a CMPO, s/he is the most critical person for ensuring child marriage in your block/district. The CMPO has the power to intervene and petition before a child marriage taking place as well as after the marriage also. A CMPO has role in different situation also –

   A) If a marriage about to take place :

   - Visit the home of both contracting parties and make them aware that it's a punishable offence under the law
   - Speak with the child and generate awareness to him/her about the consequence of CM and also make him/her understood that it's his/her right not to get married.
   - Speak to the guardian/relatives /other and convince them against child marriage
   - Speak with the Panchayats member, Local leader, NGO member and ask them to convince the parents against child Marriage
   - Monitor the situation closely
   - Complain to the police station and with the assistant of police get the offender arrested
   - File a complaint to a 1st class judicial magistrate if the parents refuse to concede

   B) The marriage is currently taking the CMPO must:

   - Report immediately to a judicial magistrate for him or her issue an injunction to prevent child marriage
   - Collect evidence of the marriage taking place Such as photograph, invitation receipts of payments made for marriage proposal
   - Make a list of offenders who was responsible for arranging, performing supporting, engaging and helping in the marriage or attending it.
   - Complain to the police and the assistance of the police get the offender arrested. The police have the power under section 151 of the criminal procedure code to make arresting order to prevent any cognizable crime from taking place
   - If the child is at risk of being forced threaten or inducted into child marriage or risk of child life provide immediate protection and produce in front of Child welfare committee
   - Provide all support and aid including medical legal counselling and rehabilitation support to children once they are rescued

   C) If a child marriage has already taken place then CMPO must:

   - Collect evidence of the marriage that has taken place such as photography invitation receipts of payment made for marriage purpose, witness etc.
   - Make a list of offender who was responsible for arranging, performing encouraging and helping in the marriage or attending it.
   - Complain to the police and with the assistance of the police get the offenders arrested.
   - Produce the child before the nearest child welfare committee as required under juvenile justice act 2000 immediately or within 24 hours.
   - In case no child welfare committee is available produce the child before judicial

magistrate first class for appropriate decision regarding his or her safety, care and protection.
- Ensure that the child is not subjected to having to repeat her/his statement before different authority at different point of time.
- Provide all support and aid including medical legal counselling and rehabilitation to children once they are rescued.

2. Police

On receiving a complaint, as a police person you should follow the procedures laid down in the Code of Criminal Procedure, 1973:

- Register an FIR and investigate. No police can refuse to accept the complaint, which may be made orally or in writing. All complaints must be converted into an FIR without delay.
- Report the matter to the Child Marriage Prohibition Officer (CMPO) for him/her to gather evidence about the instance of a child marriage.
- Report the matter to the District Magistrate for her/him to issue an injunction.
- Accompany the CMPO or the appointed person for investigation
- Arrest the offender as offences under the law are cognisable and non-bailable.
- Do not arrest or handcuff the child.
- In case of non-availability of CMPO or the appointed persons, visit the scene of crime (i.e. Where a child marriage is being conducted/or has been conducted) and take necessary action, including rescue of the minor(s) if necessary.
- Avoid being in uniform when dealing with children to make them more comfortable and less intimidated
- Ensure presence of a lady police officer in dealing with a girl child along with a female social worker/teacher/anganwadi worker/ANM/ child's next friend (a person trusted by the child). Only in case there is no lady officer available immediately, should a male police person interact with the girl child, but in the presence of a female social worker/teacher/anganwadi worker/ANM/child's next friend.
- Produce the child/minor before the nearest Child Welfare Committee within 24 hours or before a Judicial Magistrate of First Class where such Committee is not available. Victims of child marriage are also children in need of care and protection under the Juvenile Justice Act and the rules made for its implementation.
- Removal of children from the custody of parents/legal guardians must be the last resort and taken only in the best interest of the child. No such child shall be placed in police lock-up or police custody. Such child can only be placed in a fit institution recognised and registered under the Juvenile Justice (Care and Protection of Children) Act, 2000 as amended in 2006.

3. District Magistrate

As the District Magistrate, you are the prohibition officer with regard to section 13 (4) i.e. When mass child marriages are taking place. You are responsible for enforcing an injunction under section 13. Along with these powers, you are answerable for the enforcement of the legislation.

- Take suo motu cognisance of offences under the Act.
- Educate Panchayat Members on their role to prevent child marriage and encourage their involvement in reporting and filing of complaints.
- Set up necessary child help in centres that provide assistance to children in need of care and protection, including children who want to resist child marriage and children rescued from child marriage

4. Panchayat Members

As members of the gram panchayat/gram sabha you are closest to the community and also have the constitutional mandate to perform functions of the legislature. It is imperative that you play a leading role in preventing child marriages, protecting the victims as well as supporting the concerned authorities in evidence building so as to prosecution of the offenders.

- Assist the Child Marriage Prohibition Officer in preventing child marriages as per section 16 (2) of the Act. This could be done by convincing parents against conducting child marriages, educating parents and the community on the implications of child marriage for a child, providing information about the law, ensuring that children have access to education and their attendance and retention in schools is promoted.
- Assist the Child Marriage Prohibition Officer or the police in enforcing the law by providing necessary support and information.
- Ensure that no member of the gram sabha or gram panchayat is involved in promoting child marriages.
- For offenders within the gram panchayat, apart from legal action according to the law, their membership must be revoked. Other elected representatives in the panchayat must ask the Member Secretary to take necessary action in this regard.
- Create awareness within the community about the law and educate the community about the implications/consequences of early marriage for their child such as early childbearing, poor maternal health and mortality, poor infant health and mortality, and higher risk of HIV infection, lower levels of education, lower economic status and livelihood opportunities, higher likelihood of domestic violence endless decision-making power at home, especially for girls. Encourage the parents to wait for their children to reach the age of maturity (i.e. Age 18 for girls and 21 for boys) before they are married.
- Assist enrolment and retention of all children, especially of girls, in school by making the village Education Committee aware of the issue of child marriage and enabling them to play a vigilant role in preventing child marriages. This could be done by keeping track of dropout out children and ensuring their enrolment and retention in schools, and making education accessible to all.
- Set up a Child Protection Committee within the Panchayat to create awareness and monitor child protection issues such as child marriage.

5. Teachers

Every school teacher has been made liable under section 16 to provide assistance to the Child Marriage Prohibition Officer to prevent child marriages. School teachers can play a key role in preventing child marriages.

- Inform the nearest police station as soon as you know that a child marriage is being performed or is about to be performed.
- Visit the nearest Judicial or Executive Magistrate to record a complaint, if it is not feasible to go to the police station or if the police fail to record your report
- Make a phone call or write to the nearest police station/SP (Superintendent of Police)/Child Line/Child Welfare Committee/ the Department of Women and Child Development or the Social Welfare Department in the state, etc. in case the police station is far away or there are no Courts in the vicinity. You could also solicit support from the nearest non-governmental organization working with children
- Keep a direct check over the children in school who could be potential victims of child marriage, by keeping regular attendance at school.
- Make immediate visit to the house of the child if his/her absence is alarming and there is a potential of the child being married.
- Talk to the parents and try to convince them not to marry off their children early by informing them about its negative consequences.
- Inform parents about the law against child marriage, that the law declares child marriage an offence and lays down the legal consequences for parents who get their children married.
- Educate the children in school that child marriages are barred under the law.
- Educate children in school on their rights and availability of these to every child irrespective of their gender, caste, ethnicity or religion.
- Encourage participation of children in voicing their concerns and views about child marriages through different ways such as drawings, writings, plays and discussions.
- Conduct special sessions and invite members of the police and the CMPO to talk about child marriage.

Module V: Strengthening protective environment

Learning Objectives	**By the end of the session, participants will be able to:**
	Understand the preventive mechanism for ensuring protective environment
	Understand on national and state policies to address child marriage

Flip Chart, Marker, Laptop, Projector, Chart paper, Flash card

60 min

Session	Topic	Methodology	Time
1	What is protective/child friendly environment	Group discussion	30 min
2	How to enhance the protective environment	Presentation	30 min

Session 1: What is protective/child friendly environment and how to enhance the protective environment

Step I

The session will start through brainstorming. In this session the facilitator will ask the participant what would be considered as a "protective environment." Discuss and list the key points on the flipchart, building on their responses, explain the term protective environment.

Step II

Ask participants to suggest ways in which child protection can be enhanced in their community. Discuss and list the key points on the flipchart.

Step III

On a flip chart paper, draw a child. Draw 6 circles around the child. Explain that there are various levels of protection around children and each ring reinforces one another. Many people are responsible for the protection of children.

Step IV

Ask participants who they think the rings might represent. Discuss the varying levels of family, community, institution (school, church, etc.), national (country laws), and international. Give examples of each of the rings. For example, who in the community supports a particular child? What types of institutions?

Session 2: How to enhance the protective environment

Step I

Facilitator starts discussion with what it means to take responsibility for creating a protective environment.

Step II

Discuss the available national and state policies to address child marriage and entitlements available for adolescents. (Ref Trainer Guide)

Trainer's Guide

Families are the basic unit of society. In almost all cases, the family provides the best environment for meeting a child's developmental needs. In addition to providing care and protection the family is where children learn how to interact with other people, where they discover their family history and the language and customs of their community. In some cultures the family is defined as the child's immediate relatives: their parents and siblings. Elsewhere, there may be a far wider extended family that includes grandparents, aunts, uncles and more distant relatives within a clan, village or community. Ways of caring for children may vary but almost all societies recognize that the best place for a child is with his or her family.

Enabling or protective environment is one of the most important aspects of child protection. Without a protective environment child protection problems will continue to grow. Key to understanding the protective environment is the 10 elements that society must address and uphold if they are to truly say a child is protected. Although we recognize that not all governments, countries, organizations, and/or communities have fully attained these elements entirely, our work towards protecting children should incorporate these elements into our programs, activities, and overall mission to protect children.

Elements towards a Protective/Enabling Environment

- A country's attitudes, traditions, behaviours, practices respect children
- The Government is committed to fulfilling protection rights
- Governments have created protective legislation and have ensured its enforcement for the safeguarding and protection of children
- Children feel free to speak openly about issues that concern them and they are aware of their right not to be abused
- Local resources are tapped into and community structures and families understand and are committed to the protection of children
- There is open discussion, engagement, and advocacy initiatives on child protection issues
- Organizations and their staff have the capacity to understand and respond to child protection problems
- Monitoring, Evaluation and Reporting systems are in place
- Support systems are established for assisting in recovery and reintegration
- Society recognizes children's positive development and resilience

Government Initiatives

In addition to the national legal and policies to eliminate child marriage, the central and state governments have many initiatives in place to address child marriage indirectly by focusing on the development of the girl child and promoting girls education. At central government level, such schemes and programmes include:

Ministry of Women and Child Development

- Dhan Laxmi Scheme (2009) conditional cash transfer scheme to encourage retention of the girl in school;
- Balkier Samridhi Yojana (BSY) (1997) scheme to address the problem of declining sex-ratio and gender discrimination through cash transfers at different stages.
- Integrated Child Protection Scheme (ICPS) (2009) promotes convergence of services for children in need of protection and care at all levels.
- Kishori Shakti Yojana(Adolescent Girls Scheme) (2001)focusing on improving the nutritional and health status of adolescent girls between 11-18 years of age, and promoting school attendance
- Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (Sabla) (2011) – recently launched with the objective of promoting empowerment, better nutrition and healthy habits, including reproductive health, education and life skills

Department of Education

- Mahila Samakhya (Education for Women‟s Equality) (1989) - scheme which promotes residential and bridge schools for girls called Mahila Shikshan Kendra
- Sarva Shiksha Abhiyan – SSA (Education for All) (2010) programme which aims to universalise elementary education for all children in the 6 to 14 age group through community-ownership of the school system
- National Programme for Education of Girls at Elementary level (2003) - a component of the SSA which provides additional support for education of underprivileged/disadvantaged girls at elementary level beyond the normal SSA interventions.
- Kasturba Gandhi Balika Vidyalaya (KGBV) (2007) a component SSA for setting up residential schools at upper primary level for girls belonging predominantly to the Scheduled Castes, Scheduled Tribes and Other Backwards Castes and minorities in difficult areas.

National Commission for Women

- Bal Vivah Virodh Abhiyan (Child Marriage Protest Programme) (2005) - a nationwide awareness-raising programme against child marriage.

The Central Government has also established mechanisms for public recognition of positive role models, such as the National Bravery Award for Indian Children of Indian Council for Child Welfare in place since 1957, to children who performed outstanding deeds of bravery and selfless sacrifice. Several children have been awarded this prize for their actions against child marriage.

Entitlements for Adolescents (Jharkhand)

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
1	**Adolescent Reproductive and Sexual Health(ARSH)**	To achieve the reduction in IMR, MMR and TFR through Adolescent health Technical strategy	Adolescents	Enrolment of newly married couples. Provision of spacing Methods. Routine ANC care and institutional delivery. Referrals for early and safe abortion. RTI/STIs and HIV/AIDS prevention education. Nutrition counseling including anemia prevention and menstrual hygiene. Immunization for pregnant adolescent mothers. Contraceptives, condom programming. Management of menstrual disorders, menstrual hygiene guidance. RTI/STI and HIV/AIDS preventive education and management. Counseling and services for pregnancy termination. Nutritional counseling. Counseling for sexual problems. Immunization for pregnant adolescent mothers.	Services are to be made available for all adolescents, married and unmarried, girls and boys. Focus is to be given to the vulnerable and marginalized sub-groups. The package of services is to include promote, preventive, curative and referral services. Primitive Services: Focused care during the antenatal period. Counseling and provision for emergency contraceptive pills. Counseling and provision of reversible contraceptives. Information/advice on SRH issues Preventive Services: Services for Tetanus Immunization. Services for Prophylaxis against Nutritional Anemia. Nutrition Counseling: Services for early and safe termination of pregnancy and management of post abortion Complication. Curative Services: Treatment for common RTIs/STIs. Treatment and counseling for menstrual disorders. Treatment and counseling for sexual concerns of male and female adolescents. Management of sexual abuse among girls. Referral Services: Voluntary Counseling and Testing Centre. Prevention of Parent to Child Transmission. Outreach Services : Periodic health checkups and community camps. Periodic health education activities, Co-curricular activities

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
2	**School Health Program**	To address the health needs of children, both physical and mental, and in addition, it provides for nutrition Interventions, yoga facilities and counseling.	Children enrolled in classes 1st to 12th in Government and Government aided schools: 6 to 18 years	Free Child Health Screening and Early Intervention Services. Free diagnosis to Identify 30 health conditions for early detection and free treatment and management.	Health service provision: Screening, health care and referral Screening of general health, assessment of Anemia /Nutritional status, visual acuity, hearing problems, dental checkup, common skin conditions, Heart defects, physical disabilities, learning disorders, behavior problems etc. Basic medicine kit will be provided to take care of common ailments Prevalent among young school going children. Referral Cards for priority services at District / Sub-District hospitals. Immunization: As per national schedule. Fixed day activity. Coupled with education about the issue Micronutrient (Vitamin A & IFA) management: Weekly supervised distribution of Iron-Foliate tablets coupled with education about the issue. Administration of Vitamin-in needy cases. De-worming As per national guidelines. Biannually supervised schedule. Prior IEC. Siblings of students also to be covered. Health Promoting Schools. Counseling services. Regular practice of Yoga, Physical education, health education. Peer leaders as health educators. Adolescent health education-existing in few places. Linkages with the out of school children. Health clubs, Health cabinets. First Aid room/corners or clinics.

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
3	**Weekly Iron Folic Acid Supplementation (WIFS) Programme**	To reduce the prevalence and severity of nutritional anemia in adolescent population (10-19 years).	Adolescent girls and boys enrolled in government/government aided/municipal schools from 6th to 12th classes. Adolescent Girls who are not in school. Married adolescent girls. Pregnant and lactating adolescent girls.	Administration of Weekly Iron and Folic Acid Supplementation. Screening of target groups for moderate /severe anemia and referring these cases to an appropriate health facility. Biannual de-worming (Albendazole 400mg), six months apart, for control of worm infestation. Information and counseling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.	Implementation of school based WIFS School children from 6th to 12th standard, in rural and urban regions will be reached through this program. Each school will designate two teachers as the WIFS nodal teachers. Nodal teachers will ensure supervised ingestion of IFA tablets by adolescents enrolled in classes 6th to 12th on a fixed day preferably Monday at a fixed time after Mid-Day Meal (where applicable)/lunch. Teachers will also be encouraged to consume IFA. The first dose of de-worming tablet i.e., 400 mg of Albendazole should ideally be administered in month of August and the second dose should be given by February (six months after the first dose). If the child is absent on a Monday or misses out on the consumption of the IFA tablet, subsequent follow-up during the week needs to be done to ensure that the tablet is consumed. The programme could be initiated preferably in the month of April after beginning of new session in all schools. Teachers will screen adolescents for presence of moderate/severe anemia by assessing nail bed and tongue pallor and refer anemic adolescents to appropriate health facility for management of anemia. • Separate time should also be allotted during the school year to provide Nutrition and Health Education (NHE) to the adolescents. The nodal teacher should conduct monthly NHE session(s). • Before the school closes for vacations, the children can be given the requisite number of IFA tablets for consumption during the holidays under parental supervision. Implementation of WIFS through ICDS system for out of school adolescent girls Administration of weekly iron- folic acid supplements (WIFS). (IFA tablet containing 100mg elemental iron and 500 microgram Folic acid) for 52 weeks in a year, on a fixed day preferably Monday. Screening of target groups for moderate /severe anemia and referring these cases to an appropriate health facility for management of anemia. Biannual Albendazole (400mg), six months apart, for control of worm infestation. Information and counseling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
4	**Scheme for Promotion of Menstrual Hygiene among Adolescent Girls in Rural India (MHS)**	To increase awareness among adolescent girls on menstrual hygiene, build self- esteem, and empower girls for greater socialization. To increase access to and use of high quality sanitary napkins by adolescent girls in rural areas. To ensure safe disposal of sanitary napkins in an environment friendly manner.	Adolescent girls in the age group of 10-19 years, residing in rural areas	Distribution of sanitary napkins worth Rs.6/pack to all APL and BPL adolescent girls. Information on the hygienic practice of sanitary pads during the menstrual period. Information on the safe disposal mechanism of used napkins. Health education	Service Delivery Framework Village level by ASHA (Sahiyya)/SHG/CBO's Mobilize adolescent girls. Conduct monthly meetings. Provide health education to adolescent girls. Conduct women's group meetings. Distribute sanitary napkins to adolescent girls. Ensure regular refill and supply of sanitary napkins to the village from the Sub-Centre. Sell sanitary napkins and maintain accounts. Track supplies and estimate requirement for the following month. Submit progress report on key indicators. Service Delivery through sub center level by ANM Training of the ASHA on menstrual hygiene booklet, and conduct periodic refreshers. Monitor the monthly meetings periodically. Transport the sanitary napkin stock from block PHC to Sub-Centre. Ensure safe storage of the sanitary napkin stock. Supply requisite number of sanitary napkin packs to ASHA in her Sub-Centre area. Provide funds and transportation costs to ASHA. Conduct spot checks during regular field visits and Village Health and Nutrition Day (VHND). Review and validate ASHA tracking system and accounts register. Maintain inventory, tracking and accounts register.

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
5	**Kishori Shakti Yozana (KSY)**	To improve the nutritional and health status of girls in the age group of 11-18 years. To provide the required literacy and numeracy skills through the non-formal stream of education, to stimulate a desire for more social exposure and knowledge and to help them improve their decision making capabilities. To train and equip the adolescent girls to improve/upgrade home-based and vocational skills. To promote awareness of health, hygiene, nutrition and family welfare, home management and child care, and to take all measure as to facilitate their marrying only after attaining the age of 18 years and if possible, even late.	Adolescent girls	Educational activities through non-formal & functioned literacy pattern. Immunization A general health check up every six months Treatment for minor ailments De worming Prophylaxis measures against anemia, goiter, and vitamin deficiencies etc. Referral to PHC/District Hospital in the case of acute need Convergence with Reproductive Child Health Scheme. All unmarried adolescent girls in the age group of 11-18 years and belonging to families whose income is below Rs.6400/- per annum in the rural areas will be eligible to receive additional services under the scheme	GIRL TO GIRL APPROACH (FOR GIRLS IN THE AGE GROUP OF 11-15 YEARS) In each selected Anganwari area 2 girls in the age group of 11-15 years will be identified. These adolescent girls would be provided with a meal on the same scale of the pregnant women or nursing mother namely one that would provide 500 calories of energy and 20 gms of protein. The 2 girls so identified are to receive in service training at the Anganwari from the worker and supervisor over a period of six months to become fully equipped individuals, capable of managing the center on their own, so as to fully realize the objectives in all aspects, of the Anganwari worker, including management of stores, the organization of the feeding programme, immunization schedules, weight gain of children, home visits, pre-school activities etc. BALIKA MANDAL (FOR GIRLS IN THE AGE GROUP 15-18 YEARS) While it is essential to concentrate on the adolescent girls from the earliest stages i.e. from 11 years onward, the crucial age from the point of view of her transformation to adulthood starts from the time she nears 15 years. Thus scheme has more focus on social and mental development of girls mainly in the age group 15-18 years. Special emphasis would be laid to motivate and involve the uneducated groups belonging to this age group in non-formal education and improvement and up gradation of home based skills. PERIOD OF ACTIVE ENROLLMENT The need is to provide non-formal education, develop literacy skills and improve the home based skills among adolescent girls. The period of an adolescent girl's active enrollment in the Balika Mandal would vary from the one adolescent girl to another, depending upon her previous educational background, her power to grasp; her possessions of a home based skill and allied factors. For the purpose of calculating the financial requirement, however, it is presumed that, on an average, an adolescent girl may be active in a Balika Mandal for a period of six months with an average attendance of about 20 adolescent girls, each Balika Mandal may cater to about 40 adolescent girls in a year

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
6	**Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) Sabla**	Promote awareness about health, hygiene, nutrition, adolescent reproductive and sexual health (ARSH) and family and child care. Upgrade home-based skills, life skills and integrate with the National Skill Development Program (NSDP) for vocational skills. Mainstream out of school adolescent girls into formal/non formal education.	adolescent girls 11–18 years	Nutrition provision Iron and Folic Acid (IFA) supplementation Health check-up and Referral services Nutrition & Health Education (NHE) Counseling/Guidance on family welfare, ARSH, child care practices and home management. Life Skill Education and accessing public services. Vocational training for girls aged 16 and above under NSDP	The scheme focuses on all out-of-school AGs, who would assemble at the Anganwadi Centre (AWC) as per timetable and frequency to be Decided by the State Governments /UTs concerned. The others, i.e. school-going girls, Would meet at the AWC at least twice a month, and more frequently (once a week) during vacations/holidays. Here they will receive life skills education, nutrition and health education, awareness about socio-legal issues, etc. This will provide an opportunity for mixed group interaction between school going and out -of - school girls, motivating the latter to also join school and help the school going to receive the life skills

#	Name of the Program	Objective	Beneficiary	Benefits	Process of program
6	**Integrated Child Development Services (ICDS)**	To reduce instances of mortality, malnutrition and school dropouts among Indian Children. To coordinate activities of policy formulation and implementation among all departments of various ministries involved in the different government programmes and schemes aimed at child development across India.	All children below 6 years of age. Girl child up to adolescent. Pregnant and lactating mothers.	Immunization Supplementary nutrition Health checkup Referral services Pre-school non formal education Nutrition and Health information.	For nutritional purposes ICDS provides 300 calories (with 8-10 grams of protein) every day to every child below 6 years of age. For adolescent girls it is up to 500 calories with up to 25 grams of protein every day.

Mukhyamantri Ladli Laxmi Yojna

Jharkhand Govt. launched Mukhyamantri Ladli Laxmi Yojna to promote girl child and safe motherhood. Under MLLY scheme, Jharkhand government will deposit Rs. 6000 every year up to five years age of the girl. This way the state will deposit Rs 30,000 in name of the girl in five years. When the girl will enter in sixth class she will get Rs 2000 one time. When the girl will enter in the ninth and eleventh standard then she will get Rs 4000 and Rs 7500 respectively. When the girl will enter in the 12th standard then the state will provide Rs 200 per month as stipend. When the girl will pass standard 12th and turns 18 then the state government will provide Rs 60,000 at time of marriage. The money will be deposited in the bank account which will be opened in name of the girl in post offices. There are certain conditions while giving benefits to girls of BPL families. There should be only two children. If both children are girl then both will get the benefit. The girl should not get married before 18 or break the education before passing standard 12th.

Entitlements for Adolescents (Odisha)

Rainbow Festival

Rainbow is a benchmark festival of Odisha State Child Protection Society, observed at state level every year followed by observance of its district chapters. Rainbow creates a platform of inclusive growth for children living in child care institutions and special need children, where the children showcase their innate abilities. This two-day-long residential festival involves a series of workshops, competitions, events, etc. where children get an opportunity for their creative reflection.

Kishori Shakti Yojana

Kishori Shakti Yojana under the ambit of ICDS aims at the empowerment and holistic development of adolescent girls by improving their self-perception and creating opportunities for realizing their full potential through Balika Mandals. The scheme primarily aims at breaking the intergenerational life cycle of nutritional & gender disadvantage and providing a supportive environment for self-development.

Objective:

- To provide the required literacy and numeric skills through the non-formal stream of education.
- To stimulate a desire for more social exposure and knowledge and to help them improve their decision making capabilities.
- To improve the nutritional, health and development status of adolescent girls, promote awareness on health, hygiene, nutrition and family care,
- To link them to opportunities for learning life skills, to train and equip the adolescent girls to improve/upgrade home based and vocational skills.
- To help them gain a better understanding of their social environment and take initiatives to become productive members of the society.

Target Group:

Adolescent Girls (11-18 yrs.) - both school going and out of school girls.

Coverage:

In all the 21 districts of the State except in the districts where the SABLA scheme is implemented.

Adolescent Anaemia Control Programme

Adolescents (10-19 years) in Odisha constitute 22% of population. As per Census 2011, there are estimated 37, 75, 262 adolescent girls in the State. There are a number of socio- economic and cultural reasons for them to be out of school get married early and work in vulnerable situations. These factors have serious public health implications and calls for health interventions that are responsive to their needs.

Objective: To control anaemia in adolescent girls through a comprehensive approach by providing weekly IFA supplements, biannual de worming and improving dietary practices.

Target:

Adolescent Girls of age group (10-19 years)

Program Strategy:

- Participatory nutrition education for girls
- Causes, consequences and control of anaemia
- Delaying age of marriage
- Improving adolescent girls' dietary behaviour
- Importance and impact of weekly IFA supplementation
- Importance of de worming
- Delivery of weekly IFA supplements under supervision
- Formation/Activation of adolescent groups (Balika Mandals) and identifying peer educators.
- Weekly meeting of Balika Mandals
- Quarterly Kishori Swasth Melas
- De worming twice a year

Coverage:

Adolescent girls (10-19 years) in all the districts of the state

Ujjawala Program

Objective

- To prevent trafficking of women and children for commercial sexual exploitation through social mobilization and involvement of local communities, awareness programmes, workshops/seminars and other innovative activity.
- To facilitate rescue of victims from the place of their exploitation and place them in safe custody.
- To provide rehabilitation services both immediate and long-term to the victims by providing basic amenities/needs such as shelter, food, clothing, medical treatment including counselling, legal aid and guidance and vocational training.
- To facilitate reintegration of the victims into the family and society at large.
- To facilitate repatriation of cross-border victims to their country of origin.

Target group:

Women and children who are vulnerable to trafficking and commercial sexual exploitation.

Helpline:
The contact details of the Helpline at the office of the Principal Resident Commissioner in Odisha Bhawan, New Delhi is as follows:
Tel: 011 24679201 (Ext 4003), 011-23792002 (Direct)
Fax: 011-23010839/23013135
e-mail: rcodisha@yahoo.co.in / rc.odisha@gmail.com / rescm-or@nic.in
This information to be displayed in all Gram Panchayats.

Facilities provided in the Ujjawala

- Facilitate rescue of victims from the place of their exploitation and provide them safe custody.
- Rehabilitation services both immediate and long term to the victims by providing basic amenities/needs such as shelter, food, clothing, medical treatment including counselling, legal aid and guidance and vocational training.
- Facilitate reintegration of the victims into the family and society at large.
- Facilitate repatriation of cross-border victims to their country of origin.

Short Stay Home

Objective:

To help women who have been victimized by the society by providing short stay facility assuring them their safety and security.

Target Group:

- Women being forced into commercial sex work.
- Leaving home due to family discord or marital discord.
- Sexually assaulted and not accepted by the family.
- Females between the age group of 15 to 35. SC/ST, minority/disabled women.
- Temporary accommodation to women coming to town to attend court cases or their legal matters.
- Children accompanying the mother or born in the Home up to the age of 7 years.

Facilities provided in the Short Stay Home

- Children accompanying the mother or born in the institution may be permitted to stay in the home till the age of 7 years, after which they may be transferred to children's institutions or provided foster care facilities.
- The Home should have an average of 30 residents at a time, with facilities for a minimum of 20 and a maximum of 40 residents. Efforts have to be made, however, to give individual attention and treatment to each case. The number of residents therefore, should be controlled by this very vital over riding clause.

Mahila and Shishu Desk

The Mahila and Shishu desks provide round the clock service to women and children in distress by establishing helpdesks in all the police stations of Odisha to promote a multi-pronged approach for prevention, rescue and rehabilitation. Five hundred thirty seventh such helpdesks have already been established in Odisha. The Help Desk acts as a place of respite for the survivors of violence, providing them with the facilities of drinking water, toilet, medical, legal, and psycho- social support and to ensure privacy.

The Help Desk ensure the following:

- Follow the guidelines prescribed relating to arrest and treatment of woman while at police station to ensure privacy.

- Desk officer to be conversant with the laws in force and judicial pronouncement and guidelines of courts relating to women and children and ensure that they are implemented in letter and spirit.
- Traumatized woman and juvenile accused of any offence shall be examined and interrogated in a separate room at the police station to ensure privacy.
- Maintain a list of family centres. Short Stay Home, Swadhar Home for woman and child and the telephone number of the functionaries to contact them at the time of need.
- Traumatized woman victims and children may require medical attention for their medico-legal examination and treatment. The desk to maintain a list of lady Doctors available in the police station jurisdiction subdivision and district headquarters for reforming the women and victims.

Anti-Trafficking

The government policy on trafficking covers various aspects such as Prevention of trafficking, intelligence sharing, rescue, rehabilitation, economic empowerment, health care, education, housing, legal reforms and creation of corpus fund for addressing the problem of trafficking.

For the purpose of prevention of trafficking, twelve Integrated *Anti-Human Trafficking Units (IAHTU)* have been set up at Bhubaneswar (Commissionerate of Police, Bhubaneswar-Cuttack), I.G (Crime Branch), Cuttack, I.G (Rourkela), D.I.G Sambalpur, D.I.G, Berhampur, DIG, Balesore (six in the first phase) Et D.I.G. of Police, C.R., Cuttack, D.I.G. of Police, N.C.R., Talcher, D.I.G. of Police, S.W.R., Koraput, I.G. of Police, Railways / SRP, Cuttack, Sundargarh District Et Kandhamal District (six in the second phase). These lAHTUs are funded by the Ministry of Home Affairs, Government of India and each IAHTU is provided with an annual contingency of 1Lakh per annum by W&CD Department.

Objectives of Integrated Anti-Human Trafficking Unit (IAHTU)

- Ensuring focused attention in dealing with offences of human trafficking.
- Providing a multi-disciplinary approach and a joint response by all stakeholders, such as Police, prosecutors, NG0s, civil society and media.
- Bringing about inter-departmental collaboration among the Police and all other Government agencies and Departments such as Women, Child, Labour, and Health etc.
- Bringing about collaboration among Government agencies and the civil society.
- Bringing about effective networking among various civil society partners, especially those working on specialized aspects of anti-human trafficking.
- Ensuring a human rights approach in the response systems.
- Ensuring a victim-centric approach which takes into account the best interest of the victim/survivor and prevent secondary victimisation/re-victimisation' of the victim.
- Ensuring a gender sensitive and child rights sensitive approach in dealing with the victims.
- Ensuring an 'organised crime' perspective in dealing with trafficking crimes.

As some components of the Action Plan have to be implemented at the District Level, the Government has decided to constitute District Level Committee headed by District Collector for taking up activities of prevention, rescue and rehabilitation of victims. The Government has also instructed that Panchayat Samiti and Gram Panchayats be involved in the process for efficacious remedy

Prohibition of Child Marriage

The Prohibition of Child Marriage Act, 2006 is an act to provide for the prohibition of solemnization of child marriages and for matters connected therewith or incidental thereto.

- As per Sub Section (1) of Section 16 of the Prohibition of Child Marriage Act 2006(6 of 2007) Et Rule 4(1) of Orissa Prohibition of Child Marriage Rules 2009 the State Government appointed Director, Social Welfare as Chief Child Marriage Prohibition officer vide notification no-16786 dt-30.09.09.
- According to Clauses (a) to (g) of Sub-Section (3) of Section 16 of the Prohibition of Child Marriage Act 2006 (6 of 2007) all Child Development Project Officers (CDPOs) as Child Marriage Prohibition Officers vide notification no-16777 dt-30.09.09.
- District Collector is the Nodal Officer at the district level for the purpose of implementation of the Act. He/she shall periodically review the implementation of the Act within the respective district and take all necessary measures for the proper and effective implementation of the Act.

Duties and functions of Child Marriage Prohibition Officer

- To act immediately upon any information of the solemnization of any child marriage that may be received through any mode of communication including writing or oral i.e. through a letter, telephone, telegram, e-mail, etc. or by any other means to initiate all necessary action;
- To furnish quarterly return and statistics to the Chief Child Marriage Prohibition Officer in Form I;
- To file petition for annulling a child marriage in the district court, if the petitioner is a minor;
- To file petition before the district court to pay maintenance to the female contracting party of the marriage until her re-marriage; and
- To file petition to the district court for the custody and maintenance of children of the child marriage.

Module VI: Gender and Sexuality

Learning Objectives	**By the end of the session, participants will be able to:**
	Understand the concept of Gender and its difference from sex
	Understand on the influence of gender on the health and development of males and females
	Enhance interpersonal relationship skills that foster gender relationships based on equality and mutual respect
	Understand in depth concept related to sex and sexuality

Flip Chart, Marker, Flash card, Laptop & Projector, Chart paper

1hr 15 min

Session	Topic	Methodology	Time
1	difference between gender and sex	Game	15 min
2	Influence of gender on development of individual	Role Play	30 min
3	Understanding concept of sexuality	Group Work & Presentation	30 min

Session 1: Gender and difference from sex

Step I:

The trainer will begin a small discussion with the following questions:

"Let's play a small game. I'll say a word or a phrase and you have to say the first thing that comes to your mind when I say it."

Example

- *Boys who cry*
- *Girls who enjoy playing cricket*

For the other sentence first few words could be:

- A boy should be.....
- A girl should be.....
- In our society, men.....
- In our society, women.....
- Taking care of children....
- When girls grow up they study ....
- When boys grow up they study....

- Boys who cry….
- Girls who enjoy boxing games ….
- Earning for a family…..
- During puberty boys….
- During puberty girls…..

Step II

As the participants are expressing their thoughts, the facilitator writes down adjectives, values and characteristics of males and females as they surface. The facilitator has to make three columns on flip chart/black board as shown below and write as many points as possible.

(Notes: If participants do not give any negative or positive traits, abilities or roles for either sex, add some to ensure that both columns include positive and negative words.)

Man		Woman
Tough		**Sensitive**
Decision makers		**Weak**
Strong		**Soft**
Aggressive		**Beautiful**
Moustache		**Having babies**
Violent.		**Loving**
Responsible		**Menstruation**
Breaking of the voice during puberty		**Gossip mongers**
		Teacher
Engineering		**Cooking**
Aeronautics		**Fashion designing etc.**
Army		

Step III

The facilitator now asks the participants to think whether the words mentioned in the columns are interchangeable. For eg. Can a woman be tough and can a man be sensitive, or can a woman join the army and earn money, can a man cook food and manage household activities.

As the facilitator works through the list, there will be some points that can be interchanged while some that cannot be. These include: having a moustache, having babies, breaking of the voice during adolescents etc. While discussing, the facilitator re-labels the column as shown below in the flip chart/blackboard:

~~Man~~ Woman	Sex	~~Woman~~ Man
Tough	Moustache	Sensitive
Decision makers	Having babies	Weak
Strong	Breaking of voice during puberty	Soft
Aggressive	Menstruation	Beautiful
~~Moustache~~		~~Having babies~~
Responsible		Loving
~~Breaking of the voice during puberty~~		~~Menstruation~~
Engineering		Gossip mongers
Aeronautics		Teacher
Army		Cooking
		Fashion designing etc.

Step IV

The facilitator would then explain this concept by using the following:

Every characteristic that has an arrow towards the middle column is an example of sex, or what it means to be male or female (biological differences). The remaining characteristics are those related to gender, certain norms decided by the society. Be sure to point out how much similarity there is between men and women and that often the differences we think exist are really just societal expectations and stereotypes of the two sexes.

Session 2: Influence of gender on development of individual

Step I:

The facilitator would divide the participants into two groups and assign each group a story for discussion. The facilitator can give script 1 to a group with a majority of male and few female and script 2 to a group with a majority of female and only a few male. This will help each gender to be more empathic towards the needs of the other.

Ask the groups to discuss how they would like to change in Arti's /Sohan's story. Ask them to build a role play based on the new story that they would be developing and give it an appropriate ending.

Note for Facilitator:

As the participants would be discussing and changing the original stories about Arti and Sohan. Encourage them to think how each character need to change their attitude and beliefs so that Arti and Sohan's can have equal and important say in their lives.

Script 1:

Arti is 18 years old and lives with her parents. She passed out of school a year back and is a good student. Her brother is two years older to her and about to complete his graduation. Her parents have already started to look for a suitable match for her and are planning to get her married as soon as possible. Her parents feel that if she gets older and more educated, it will be difficult to find a match in their own community and also they will have to pay a significant dowry. Arti always had a dream to become a teacher. She wants to continue her studies like many of her classmates. She is wondering if all her dreams will soon be shattered.

Script 2:

Sohan is a class 12 student. Sohan has always been an average student in studies. Since the beginning of this year, Sohan has been under tremendous pressure from his parents to study hard and score well in the examination for class 12th so that he can join a reputed institute. The pressure has been mounting as the board exams are approaching. Sohan secretly harbours the dream to become a chef in a reputed hotel one day. He wants to share this with his parents but is skeptical about how they will take it. They want him to become a pilot just like his father. Sohan does not know how to share his future plans with his parents or convince them about this choice.

Note for Facilitator

Ask the groups to discuss how they would like Arti and Sohan's stories to end. Ask them to build a story based on equal opportunities for the characters. Encourage them to think about how each character needs to change their attitude and beliefs so that Arti and Sohan can achieve their full potential and pursue their dreams.

Step II

After the role plays, the facilitator should summarize the session by gathering some of the unique and important messages that emerged from the new stories that the participants presented in the class room. Through this discussion, the facilitator can ask the participants to elicit how gender inequality affects our education, health, livelihood aspect etc. The facilitator can make some key notes on the flip chart and how stereo-typed gender roles can limit our potential as an individual.

Step III

End the session by discussing on the following points:

- Girls in villages are often deprived of education, when resources are scant
- A girl child is unwanted and not given a fair chance to be born- as a result, we see a poor sex ratio and increasing evidence of female foeticide
- In some societies it is expected or condoned that men will be sexually experienced- this makes them take unnecessary risks and often do not admit that they lack information about these matters

Session 3: Understanding concept of sexuality

Step I:
Divide participants in six small groups and give each group one of the following to discuss
•A baby boy and a baby girl
•A baby boy and girl aged 6 years
•A baby boy and girl aged 15 years
•A married man and woman aged 22 years
•A woman and man with a baby
•An Elderly man and woman

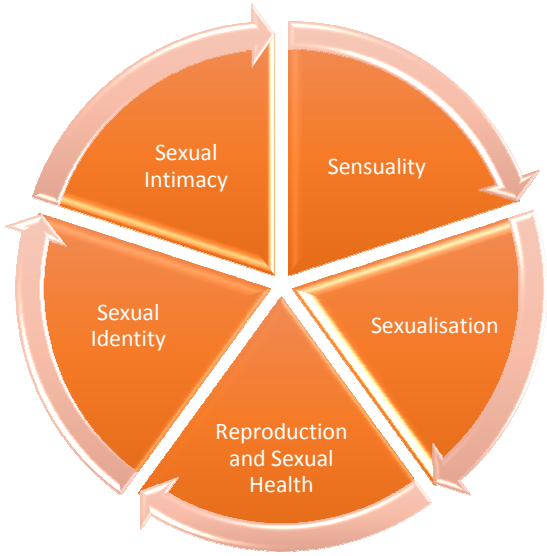
Ask every group to discuss how the person they have been given might feel and express his or her sexuality. For example a 6 year old boy or girl plays the role of a father and mother.

Step II: Ask the group to tell the explain their ideas about sexuality in the age group they talked about. Other groups may add their ideas.

Step III: Ask the participants what they have learnt from this activity.

Step IV: Point out that we can enjoy our sexuality at all ages even without having sexual intercourse. We should be in a hurry to have sexual intercourse, but wait until our minds and bodies are mature. We should trust ourselves that when the time comes, we shall do it...

Step V: Discuss with the participants concept of sexuality with the sexuality framework as depicted below taking reference from trainer guide



Trainer Guide

Gender

Sex can be defined as something we are born with: i.e. male or female and which cannot be changed.
Gender is differences created between men and women by the society, which can be changed.

Sex Role

A sex role is a function or role which a male or female assumes because of the basic physiological or anatomical differences between the sexes. It is a biologically determined role, which can be performed by only one of the sexes, e.g., women give birth to children.

Female Sex Role	Male Sex Role
Child-bearing Lactation	Ovum fertilization Produces spermatozoa which determine child's sex

These roles are not exchangeable because they are biologically determined.

Gender Role

A gender role refers to society's evaluation of behavior as masculine or feminine, e.g. cooking is feminine, while fishing is a masculine role in most societies.

Feminine Role	Masculine Role
Cooking	Fishing
Childcare	Hunting
House care	Repair work in the home

Contrary to sex, 'gender' has ***social***, ***cultural*** and ***psychological*** rather than biological connotations. It is defined in terms of femininity and masculinity. 'Gender' is the amount of masculinity or femininity found in a person. Masculinity and femininity are some set of behavior that is expected of a male and female respectively. Thus, while the proper terms for describing sex, for example, are '***male and female***', the corresponding terms for gender are '***masculine and feminine***.'

One's gender can be determined in many ways, e.g., behavior, dress, gestures, occupation, social network, etc. In most societies, for example, humility, submissiveness, etc., are considered feminine behavior and women are expected to behave that way. Men, on the other hand, are expected to be dominant, aggressive, etc.

Feminine	Masculine
Submissive	Dominant
Gentle	Aggressive
Emotional	Not emotional
Quiet	Talkative

Differences between Sex and Gender Roles

Gender Roles	Sex Roles
May differ from society to society	Same in all societies: they are universal, e.g., it is only women who give birth to children all over the world
Can change with history	Never change with history
Can be performed by both sexes	Can be performed by only one the sexes.
They are socially, culturally determined.	They are biologically determined.

Gender Stereotypes

According to the Pocket Oxford Dictionary, a ***stereotype*** is when a 'person or thing seems to conform to accepted norms of the society'. Stereotypes may reflect the generally observable characteristics of a particular sex group. However, stereotypes can be unfair because they tend to generalize. They are unfair to those people who do not possess those traits or characteristics. It is important to remember that stereotypes do not reflect real behavioral differences.

In some societies, for example, the following stereotypes are thought to pertain either to males or females only.

Females are thought to be:	**Males are thought to be:**
♦ Emotional	♦ Unemotional
♦ Not aggressive	♦ Very aggressive
♦ Not good at making decisions	♦ Very good at making decisions
♦ Dependent	♦ Independent
♦ Gentle	♦ Rough
♦ Tactful	♦ Blunt

Gender Discrimination

Many societies value men and boys more highly than women and girls:

- Girls often receive less food than boys and are less likely to receive health care.
- Girls are less likely to go to school or to complete school and their brothers' education is given priority.
- Girls are expected to help with domestic chores in preparation for being wives.
- Women may not be allowed outside the household alone or at all.
- Girls are married, and become mothers at a very young age in some countries.

- Girls who become pregnant often have to drop out of school.
- Girls and women cannot own or inherit land or property or decide about divorce or obtain custody of children in some cultures.
- Girls and women are more likely to be subjected to violence, especially sexual violence.
- Girls and women are not allowed to work or to do certain types of jobs and often receive lower pay for doing the same work as men.
- Women are under-represented in decision-making bodies.

Gender Discrimination and its impact: on the health of both men and women.

For women: Gender has important consequences for women's health. The negative impact of gender begins at or even before birth when a preference for sons may put baby girls at risk of infanticide—or with new ultrasound technology, at risk of sex-selective abortion. Throughout childhood and adolescence, girls also are more likely than boys to be sexually abused by male authority figures. After marriage, women's low status continues to limit their ability to control their own lives, including their fertility and their access to health care. A woman may not be able to determine and how many children to have or which family planning methods to use. In communities where having a large family is a woman's only way to improve her social status women may feel pressured to have many, closely spaced children despite the toll it takes on their health. As a result, women cannot protect themselves against unwanted pregnancies, STIs, and their adverse health consequences.

For men: In many societies, boys are expected to be sexually active. They may be under pressure from their peers to experiment sexually which may put them at risk of infections. The boys are also expected to have knowledge about sexual matters. Boys frequently pretend to be sexually experienced and to be very knowledgeable about the reproductive process. However many of them do not have a reliable source of information and are reluctant to ask for information because they do not want to appear uninformed or inexperienced. They may also take risks to prove their 'manliness'.

Alcohol and other substance use often accompany the early sexual experiences of young men and increase the risk of STI, HIV infections and unwanted pregnancy.

Gender Discrimination and its impact: Female Foeticide, Sex selective abortions

According to a recent report by the United Nations Children's Fund (UNICEF) up to 50 million girls and women are missing from India's population. In most countries in the world, there are approximately 105 female births for every 100 males. In India, there are less than 93 women for every 100 men in the population (Census of India, 2001). The accepted reason for such a disparity is that female foeticide and female infanticide has become one of the social problems. The easy availability of technology and misuse of pre-natal sex detection has led to an increase in sex selective abortions.

It is significant to note that the figures show that the fall is much higher in the economically developed States in India. There is steep fall in sex ratio in States like, Punjab, Haryana, Gujarat and Maharashtra, along with the Union territories of Delhi and Chandigarh. Kerala is the only state where females are 1,058 per 1,000 males.

Government of India had enacted Pre Conception Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 which clearly says that determination of sex of an unborn child is

prohibited. It also prohibits advertisements relating to pre-natal determination of sex and punishment if these rules are not followed.
The consequences of rampant sex selection are already there to see. Recent reports in local media show that young men in Punjab and Haryana were finding it hard to find brides. There are families with only sons who are importing women from other states who are often treated badly.

Gender Discrimination: What can be done?

The only long-term solution is to change attitudes. Traditionally girls are seen as a burden, as huge dowries have to be paid for their weddings. When girls are educated and earn an income, it adds only benefits the family into which they marry.

The situation can change only when women's contribution to the society is recognized and her status improves. The opportunities for girl child to be educated should be increased and all efforts should be made to retain them in school. Vocational training can help girls/ women become financially independent and see them as an equal earning partner/member in the family. In addition the Law should be implemented so that medical practitioners offering such services and those seeking sex selective abortion can be brought to book.

Sex and Sexuality

During puberty the need for being in a relationship, feelings of love and readiness for sexual involvement with the opposite sex become stronger. As a result, boys begin to have wet and erotic dreams accompanied by night-time semen emission. Likewise, girls can also have wet dreams and experience lubrication of the vagina resulting into an internal urge to satisfy the dissatisfied sexual need.

Young adolescents' may experience sexual feelings and this is a natural feeling. These feelings however may provoke many questions about sex:

"What is sex? How would I feel if I had sex? What is love? Will I find someone I love and who loves me?"

What is Sex?

Sex refers to whether or not a person is male or female, whether a person has a penis or a vagina. Many of you may have noticed on different forms you have completed for school or at the doctor's office that there is often a question on the form called "Sex." You are required to check either male or female. Sex is also commonly used as an abbreviation to refer to sexual intercourse.

What is sexuality?

Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she/he will become. It includes all the feelings, thoughts, and behaviours associated with being female or male, being attractive and being in love, as well as being in relationships that include sexual intimacy and sensual and sexual activity. It also includes enjoyment of the world as we know it through the five senses: taste, touch, smell, hearing and sight.

Sexuality may be defined as the way

- People think and the attitudes they hold about others,
- The way they relate with each other and the opposite sex,
- The way they behave, as a result of being females or males

Sexuality begins at birth and stops at death. However, it differs with age and social exposure. Sexuality refers to the total expression of who you are as a human being, your femaleness or your maleness. Everyone is a sexual being. Your sexuality is interplay between body image, gender identity, gender role, sexual orientation, eroticism, genitals, intimacy, relationships, and love and affection. A person's sexuality includes his or her attitudes, values, knowledge and behaviours. How people express their sexuality is influenced by their families, culture, society, faith and beliefs.

Factors leading to young adolescents engaging in sex

- Lack of knowledge on the possible consequences of sexual activity
- Sexual abuse: rape, incest
- Poverty
- Lack of life skills: assertiveness, self-awareness, negotiation skills, self-esteem and decision-making.
- Alcohol and substance abuse
- Peer pressure
- Environmental social setting: poor housing, slums
- Influence of media
- Insecurity

Possible consequences of young adolescents' engaging in sex

- Early or unwanted pregnancy
- STI's/HIV & AIDS
- Emotional consequences: shame, guilt, fear
- Social consequences: dropping out of school, stigmatisation, forced marriage, stunted growth for the young adolescent, low social status

The Sexuality Framework

1. Sensuality

Sensuality is awareness and feeling about your own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies' look and feel and what they can do.

Body image: Feeling attractive and proud of one's own body and the way it functions influences many aspects of life. Adolescents often choose media personalities as the standard for how they should look, so they are often disappointed by what they see in the mirror.

Experiencing pleasure: Sensuality allows a person to experience pleasure when certain parts of the body are touched. People also experience sensual pleasure from taste, touch, sight, hearing, and smell as part of being alive.

Fantasy: The brain also gives people the capacity to have fantasies about sexual behaviours and experiences. Adolescents often need help understanding that sexual fantasy is normal and that one does not have to act upon sexual fantasies.

Feeling physical attraction for another person: The centre of sensuality and attraction to others is not in the genitals. The centre of sensuality and attraction to others is in the brain, humans' most important "sex organ."

Sexual Intimacy

Sexual intimacy is the ability to be emotionally close to another human being and to accept closeness in return. Several aspects of intimacy include:

Sharing: Sharing intimacy is what makes personal relationships rich. While sensuality is about physical closeness, intimacy focuses on emotional closeness.

Emotional risk-taking: To have true intimacy with others, a person must open up and share feelings and personal information. Sharing personal thoughts and feelings with someone else is risky, because the other person may not feel the same way.

Vulnerability: To have intimacy means that we share and care, like or love, and take emotional risks. That makes us vulnerable: the person with whom we share, about whom we care, and whom we like or love, has the power to hurt us emotionally.

Caring: Caring about others means feeling their joy and their pain. It means being open to emotions that may not be comfortable or convenient. Nevertheless, an intimate relationship is possible only when we care.

Liking or loving another person: Having emotional attachment or connection to others is a manifestation of intimacy.

2. Sexual Identity

Sexual identity is a person understands of who she/he is sexually, including the sense of being male or of being female.

Gender identity: Knowing whether one is male or female. Most young children determine their own gender identity by age two. Sometime, a person's biological gender is not the same as his/her gender identity: this is called being transgender.

Gender role: Identifying actions and/or behaviours for each gender. Some things are determined by the way male and female bodies are built or function. For example, only women menstruate and only men produce sperm. Other gender roles are culturally determined. There are many "rules" about what men and women can/should do that have nothing to do with the way their bodies are built or function.

Sexual orientation: Whether a person's primary attraction is to people of the other gender (heterosexuality) or to the same gender (homosexuality) or to both genders (bisexuality) defines his/her sexual orientation. Sexual orientation begins to emerge by adolescence although many gay and lesbian youth say they knew they felt same sex attraction by age 10 or 11. Heterosexual, gay,

lesbian, and bisexual youth can all experience same-gender sexual attraction and/or activity around puberty.

Reproduction and Sexual Health

These are a person's capacity to reproduce and the behaviours and attitudes that make sexual relationships healthy and enjoyable.

Factual information about reproduction: Is necessary so youth will understand how male and female reproductive systems function and how conception and/or STD infection occur. Adolescents often have inadequate information about their own and/or their partner's body. Teens need this information so they can make informed decisions about sexual expression and protect their health.

Feelings and attitudes: Are wide-ranging when it comes to sexual expression and reproduction and to sexual health-related topics such as STD infection, HIV and AIDS, contraceptive use, abortion, pregnancy, and childbirth.

Sexual intercourse: Is one of the most common behaviours among humans. Sexual intercourse is a behaviour that may produce sexual pleasure that often culminates in orgasm in females and in males. Sexual intercourse may also result in pregnancy and/or STDs. In programs for youth, discussion of sexual intercourse is often limited to the bare mention of male-female (penile-vaginal) intercourse. However, youth need accurate health information about sexual intercourse: vaginal, oral, and anal.

Reproductive and sexual anatomy: The male and female body and the ways in which they actually function is a part of sexual health. Youth can learn to protect their reproductive and sexual health. This means that teens need information about all the effective methods of contraception currently available, how they work, where to obtain them, their effectiveness, and their side effects.

Sexual reproduction: The actual processes of conception, pregnancy, delivery, and recovery following childbirth are important parts of sexuality. Youth need information about sexual reproduction: the process whereby two different individuals each contribute half of the genetic material to their child. The child is, therefore, not identical to either parent. A sexual reproduction is a process whereby simple one-celled organisms reproduce by splitting, creating two separate one-celled organisms identical to the original [female] organism before it split.

Sexualisation

Sexualisation is that aspect of sexuality in which people behave sexually to influence, manipulate, or control other people. Often called the "shadowy" side of human sexuality, sexualisation spans behaviours that range from the relatively harmless to the sadistically violent, cruel, and criminal. These sexual behaviours include flirting, sexual harassment, sexual abuse, and rape. Teens need to know that no one has the right to exploit them sexually and that they do not have the right to exploit anyone else sexually.

Flirting: Is relatively harmless sexualisation behaviour. Nevertheless, upon occasion it is an attempt to manipulate someone else, and it can cause the person manipulated to feel hurt, humiliation, and shame.

Seduction: Is the act of enticing someone to engage in sexual activity. The act of seduction implies manipulation that at times may prove harmful for the one who is seduced.

Sexual harassment: Is an illegal behaviour. Sexual harassment means harassing someone else because of her/his gender. It could mean making personal, embarrassing remarks about someone's appearance, especially characteristics associated with sexual maturity, such as the size of a woman's breasts or of a man's testicles and penis. It could mean unwanted touching, such as hugging a subordinate or patting someone's bottom.

Rape: Means coercing or forcing someone else to have genital contact with another. Sexual assault can include forced petting as well as forced sexual intercourse. Force, in the case of rape, can include use of overpowering strength, threats, and/or implied threats that arouse fear in the person raped.

Unwanted Pregnancy:

Unwanted pregnancy is a pregnancy that occurs when it is not wanted, mostly by the woman or her partner or both. There are various factors determining whether a couple wants to have a child at a certain point, including the age of partners, influence of the family and the community, financial constraints and a person's plan for life.

Causes of unwanted pregnancy

The following are possible factors leading to unwanted pregnancy:

- Early marriage
- Peer pressure
- Sexual experimentation
- Unavailability of contraceptives
- Misinformation or myths on male/female sexuality
- Fear or myths about contraceptive use
- Not using contraceptives
- Lack of knowledge or information
- Wish to express love
- Failure to use contraceptive methods properly
- Sexual abuse or sexual violence, such as rape and defilement
- Lack of ability to negotiate contraceptive use or safer sex
- Poverty
- Early/Teenage pregnancy

Teenage pregnancy refers to pregnancy in a female under the age of 20 (when the pregnancy ends). A pregnancy can take place at any time before or after puberty, with menarche (first menstrual period) normally taking place around the ages 12 or 13, and being the stage at which a female becomes potentially fertile.

Note: A young girl can become pregnant if she has unprotected sexual intercourse around the time of her first ovulation before her ever first menstrual flow.

Module VI: What is SRHR and advocating for sexual health rights

Learning Objectives	**By the end of the session, participants will be able to:**
	Understand the relationship between reproductive rights and human rights
	Understand the effect of promotion of rights or violation on reproductive and sexual health
	Understand the advocacy strategy for SRHR and gender equality
	Aware on available policy and schemes for adolescents and children

Flip Chart, Marker, Laptop & Projector,

75 min

Session	Topic	Methodology	Time
1	What is SRHR – A Concept	Discussion & Presentation	45 min
2	Advocating for sexual health, rights & gender equality	Discussion & Presentation	30 min

Session 1: What is SRHR – A Concept

Step I:

The session will start through discussion, asks the participant to recall any incident when they felt a right was violated. The discussed point will be note down in the flip chart. Some of the rights can be listed down as:

- Right to dignity
- Right to respect
- Right to security
- Right to information
- Right to be treated equally
- Right to education
- Right to earn

Step II:

Ask the participants to volunteer about what they consider to be violations of rights which have impact upon sexual and reproductive health, or the violation of reproductive and sexual rights. Again the discussed point will be noted down in flip chart

Some examples that have come up include:

- the right to be informed when one's partner tests positive for HIV
- the right to choose one's marriage partner, and not to be forced into an arranged marriage
- the right to freedom from non-consensual sex
- the right to use a contraceptive method of one' own choice without overt or covert coercion for the health system
- Female genital mutilation

Step III:

- Draw a circle in the centre of a flip chart or board and write **"A woman's right to choose the number and spacing of her children and how she wants to do this"** in the circle.
- Draw other circles around it and ask participants to suggest what rights are useful or necessary to make this right real.
- Then draw lines between these rights as they relate to each other it will end up with a molecule-like figure.
- Place factors that are not rights but necessary conditions on the outer rim of the diagram.

- Note the different actors that are required to make each of these rights actionable.

Step IV:

Summarize and explain the SRHR through presentation *(Ref: Trainer Guide)*

Session 2: Advocating for sexual health, rights & gender equality

Step I:

The facilitator will start the discussion with multiplicity of definitions around the words 'youth' and 'adolescence' which has significant implications in terms of programming and interventions for this segment of the population.

Step II:

Elaborate the discussion with help of presentation and Trainer Guide.

Trainer Guide

What is SRHR?

The concept of 'SRHR' has evolved since the 1980s in terms of understanding the problems and goals for sexual and reproductive health and rights, and in particular how to fulfil such goals. However, despite much agreement, much aspect remains politically controversial and contested in many countries as they are closely related to gender, human rights and to the role of those rights in intimate and interpersonal relations.

Reproductive Health is the complete physical, mental and social well-being related to the reproductive system throughout the life cycle.

Reproductive Rights are those of couples and individuals to freely decide the timing, number and spacing of their children and to access information and care in all matters related to reproduction and sexuality.

Sexual Health is a state of physical, mental and social well-being in relation to sexuality throughout the life cycle.

Sexual Rights includes the right to not to be subjected to sexual violence and coercion, as well as to a safe and satisfying sex life - including the right to say 'no' to sex. It includes:

- The right to sexual freedom.
- The right to sexual autonomy, sexual integrity, and safety of the sexual body.
- The right to sexual privacy.
- The right to sexual equity.
- The right to sexual pleasure.
- The right to emotional sexual expression.
- The right to sexually associate freely.
- The right to make free and responsible reproductive choices.
- The right to sexual information based upon scientific inquiry.
- The right to comprehensive sexuality education.
- The right to sexual health care.

Political Framework for SRHR

Since January 2008, the Millennium Development Goals (MDGs) have made reference to reproductive health under the goals to reduce child mortality (MDG4) and to provide maternal health (MDG5).

MDG4A: "Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

MDG TARGET 5.A: "Reduce by three quarters the maternal mortality ratio

5.1 Maternal mortality ratio: Number of death per 100 000 live births

5.2 Proportion of birth attended by skilled health personnel: Number of deliveries attended by accredited health professional - such as midwife, doctor or nurse.

MDG TARGET 5.B: "Achieve, by 2015, universal access to reproductive health"

5.3 Contraceptive prevalence rate: Number of women of reproductive age (15-49) married or in union who are using contraception to the total number of women of reproductive age in union

5.4 Adolescent birth rate: The number of live births occurring to all women aged 15-19 per 1000 women in the 15-19 age groups

5.5 Antenatal care coverage: Percentage of women who used antenatal care provided by skilled health personnel for reasons related to pregnancy at least once and at least four times during pregnancy, as a percentage of live births in a given time period.

5.6 Unmet need for family planning: The proportion of women who are married or in consensual union who are at risk of pregnancy who desire to delay their next birth at least two years or avoid another one who are not using a method of family planning

United Nations conferences and women's human rights

- Prior to the 1990s, there had been several UN conferences on population but they did not have a focus on rights.
- There had also been several UN conferences on women, but they had not focused on human rights, or on issues concerning reproduction and sexuality.
- The first world Conference on Human Rights, which took place in Tehran in the 1960s, made a mention of the right to determine the number and spacing of one's children.
- In 1993,the second world Conference on Human Rights, which took place in Vienna, set the stage for what happened first in Cairo and then in Beijing. It affirmed that women's rights are human rights; that the eradication of all forms of discrimination on the basis of sex should be a priority for governments; and, finally, that women have a right to the enjoyment of the highest standard of physical and mental health throughout the life cycle, and that this includes a right to accessible, adequate health care and to a wide range of family planning services.
- The first time a comprehensive framework for realizing reproductive rights was set out at the international governmental level was in Cairo in 1994. It emphasized the link between population and development, and meeting the needs of individuals. This was a departure from the focus on abstract demographic targets, and it affirmed the focus on reproductive rights

Reproductive health in the context of human rights, and therefore reproductive rights

Reproductive rights are not new rights. They relate to an individual woman's or man's ability to control and make decisions about her or his life which will impact on her or his reproductive and sexual health. According to international consensus no new rights have been created. Rather, the constellations of rights that together makeup what we call reproductive rights have been identified from within the existing human rights documents.

Reproductive rights are understood to been titled to protection for their own sake, but also because they are essential as a precondition for the ability to exercise other rights without discrimination.

Reproductive rights mean considering governmental obligations under the human rights documents in a whole new light. For example, consider the rights to education, health and social services in relation all of the well-known causes of maternal mortality. A government which fails to provide education, health and social services to young women of reproductive age could well be found to be in violation of these rights now recognized as part of reproductive rights. This is likely not to have been the case before the Cairo conference.

Consider the additional elements of information that a gender perspective and recognition of the existence of reproductive and sexual rights would bring to governmental accountability under the human rights treaties it has ratified. Think through the added dimensions that considering a right from this perspective brings. For example, the right to bodily integrity and security of the person was traditionally understood to relate to actions concerning individuals in the custody of the state. But now it can also be interpreted as security from sexual violence and assault at the hands of one's intimate partner or others.

Discussion Points

1. The right to life should be invoked to protect women whose lives are currently endangered by pregnancy.
2. The right to liberty and security of the person should be invoked to protect women currently at risk from genital mutilation, or subject to forced pregnancy, sterilisation or abortion.
3. The right to equality and to be free from all forms of discrimination should be invoked to protect the right of all people, regardless of race, colour, sex, sexual orientation, marital status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status, to equal access to information, education and services related to development, and to sexual and reproductive health.
4. The right to privacy should be invoked to protect the right of all clients of sexual and reproductive health care information, education and services to a degree of privacy, and to confidentiality with regard to personal information given to service providers.
5. The right to freedom of thought should be invoked to protect the right of all persons to access to education and information related to their sexual and reproductive health free from restrictions on grounds of thought, conscience and religion.
6. The right to information and education should be invoked to protect the right of all persons to access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that any decisions they take on such matters are made with full, free and informed consent.
7. The right to be free from torture and ill treatment should be invoked to protect children, women and men from all forms of sexual violence, exploitation and abuse.
8. The right to freedom of assembly and political participation should be invoked to protect the right to form an association which aims to promote sexual and reproductive health and rights.
9. The right to the benefits of scientific progress should be invoked to protect the right of all persons to access to available reproductive health care technology which independent

studies have shown to have an acceptable risk/benefit profile, and where to withhold such technology would have harmful effects on health and well-being.

10. The right to health care and health protection should be invoked to protect the right of all persons to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
11. The right to decide whether or when to have children should be invoked to protect the right of all persons to reproductive health care services which offer the widest possible range of safe, effective and acceptable methods of fertility regulation, and are accessible, affordable, acceptable and convenient to all users.
12. The right to choose whether or not to marry and to found and plan a family should be invoked to protect all persons against any marriage entered into without the full, free and informed consent of both partners.

Relevant policy documents:

- **The Tenth Five Year Plan** includes provisions that address certain aspects of adolescents' reproductive health. The Tenth Five Year Plan specifically recognises that the process of empowering women necessitates a "life cycle approach" and that "every stage of women's lives counts as a priority in the planning process." One of the plan's main objectives is to eliminate discrimination and all forms of violence against women and the girl child, recognising the increasing violence against these groups and the persistent discrimination against the girl child are critical areas of concern requiring government action.

- **The National Population Policy (NPP)** acknowledges that the needs of adolescents have not been specifically addressed in previous policies. It calls for programmes to encourage delayed marriage and childbearing and to educate adolescents about the risks of unprotected sex. It highlights the needs of adolescents in rural areas where early marriage and pregnancy are widespread and calls for information, counselling, education on population, affordable contraceptive services, food supplements, and nutritional services. It also advocates for the enforcement of the Child Marriage Restraint Act. The action plan of the NPP includes the creation of a health package for adolescents. It asserts the need for community outreach to adolescents about the availability of safe abortion services and the dangers of unsafe abortions. This policy also outlines the need for separate strategies, which account for the differing needs of boys and girls especially in rural areas.

- **The National Youth Policy 2003** takes a broad look at youth in terms of their overall emotional, physical and psycho-social development, and their potential as citizens of the country. It does not, however, specifically address the wide range of reproductive and sexual health issues and situations that adolescents experience. It recognises adolescence as a time of upheaval, and that necessitates the understanding and support of adults, but does not regard adolescents as sexual and reproductive beings in a complete sense.

The National Youth Policy provides a detailed description of how it envisages gender justice for youth. Section 5.2 states

"The Policy recognises the prevailing gender bias to be the main factor responsible for the poor status of health and economic well-being of women in our society and that any discrimination on grounds of sex violates the basic rights of the individual concerned and it, therefore, stands for the elimination of gender discrimination in every sphere. The Policy enunciates that:

- Every girl child and young woman will have access to education and would also be a primary target of efforts to spread literacy.
- Women will have access to adequate health services (including reproductive health programmes) and will have full say in defining the size of the family.
- Domestic violence will be viewed not only as violation of women's freedom but also as that of their human rights.
- All necessary steps should be taken for women's access to decision-making processes, to professional positions and to productive resources and economic opportunities.
- Young men, particularly the male adolescents shall be properly oriented, through education and counselling to respect the status and rights of women.

The Policy further goes on to say in section 5.2.1 that

- Action would be pursued to eliminate all forms of discrimination in respect of the girl child, negative cultural attitudes and practices against women, discrimination against women in education, skill development and training, and the socio-economic exploitation of women, particularly young women.
- Concerted efforts will be made to promote a family value system that nurtures a closer bond between men and women, and ensures equality, mutual respect and sharing of responsibility between the sexes.

While in spirit this policy has all the right intentions, there is no mention of how various state programmes, functionaries, and partners might work together to bring the benefits of gender justice to young people. These seem to be lofty ideals rather than actionable points.

What is usually problematic with a notion of gender and sexual rights is that their reach often does not extend into the home. In a rights based approach, the responsibility to fulfil rights lies with the State. But the power of the State does not cross the threshold of the household. As a result, gender and sexuality are issues that confound the discourse on rights. Thus it is not easy to influence the power dynamics that operate in families and in intimate relationships. This does not mean that the State can be absolved of its responsibilities to respect, protect and fulfil the rights of all people. There has to be clear indication from the State of the recourse to justice in the case of discrimination based on gender or sex. It also has to ensure that the organisations working on the rights of young people adhere to the basic tenets of the policies and frameworks laid out by them.

The Impact of International Law and Policy in India

India has ratified certain key international documents, which are relevant to this discussion, including the ICPD Programme of Action and the CRC, as well as the Declaration arising out of the Fourth World Conference on Women, 1995. These international commitments have necessitated

changes in policies on adolescent reproductive and sexual health and have affected programme interventions not only by the State but also by NGOs.

The ICPD resulted in the consensus definition that marked the global recognition of reproductive health needs. It postulated the need for affirmative action towards ensuring that women's health needs in particular, which had long been neglected, were better met. The ICPD also marked a shift from traditional population programmes, which aimed at reducing population through fertility control and provision of family planning services, to a more holistic approach and a broader definition of reproductive health.

India's commitment to the reproductive health approach put forward at the ICPD has resulted in a welcome shift in policy towards adolescents. Until then, the reproductive health needs of adolescents were subsumed within programmes dealing with population control, family planning services and child health services, catering to the well-being of children and women. The primary aim of the Government of India in this regard over the last fifty years has been to reduce infant mortality, and ensure population control and safe motherhood. The minimal attention given to adolescents did not reflect the considerable size of the country's adolescent population or any recognition of the specific challenges facing them. However, after the ICPD, the family welfare programme has been reshaped into a broad-based Reproductive and Child Health (RCH) Services Programme. This programme is supposed to explicitly recognise that the adolescent population group has specific health and developmental needs.

Reflections on the State of Policy on Adolescent Sexual and Reproductive Health and Rights

Despite ambitious planning to ensure a coordinated public policy effort through a nodal agency (Ministry of Youth and Sports Affairs) and the framing of various policy documents, which ostensibly aim to provide adequate services and to ensure improvement in the reproductive and sexual health status of adolescents, problems still remain.

- Explicit references have been made to adolescents being a 'vulnerable group' but this has not been extended to address vulnerability regarding reproductive and sexual health needs. The Reproductive and Child Health Programme of India, post ICPD, committed itself to a holistic programme addressing the needs of all age groups. This was the life cycle approach within which adolescents' reproductive and sexual health needs would be addressed within the scope of the programme. However, as Ramchandran mentions, the concept of sexuality is conspicuous by its absence. Instead the RCH programme introduces 'family life education' (instead of the earlier population education) for adolescents. This translates into education for the future mother. The focus, therefore, remains on reproduction, conception, menstrual, and genital hygiene.
- Since the government does not officially recognise adolescent sexuality and its attendant issues, problems such as sexual abuse of young people, child prostitution and sexual violence are brushed under the carpet or seen as aberrations. Teenage pregnancies and other critical needs of unmarried girls are also ignored.
- The denial of the fact that adolescents are increasingly sexually active outside of marriage hinders any attempts to include youth as an active partner in formulating programmes, policies

and services that would address their needs. Sexual pleasure is ignored and a disease control model that focuses on motherhood persists.

- On the issue of young men, the policy merely states that they need to be properly oriented towards the rights and status of women, rather than seeing them in need of health and education for their own situations.
- The 2003 National Youth Policy presents a limited articulation of youth health and SRH. Youth sexuality is discussed only in reference to HIV/AIDS, STDs and reproduction. The Policy demonstrates the GOI's lack of trust in young people's abilities to make healthy decisions, referring to them as "highly impressionable and, therefore, prone to high-risk behaviour".
- The Ministry of Youth Affairs and Sports has failed to spearhead public policy implementation through coordinating agencies such as the Department of Women and Child Development and the Ministry of Health. With various ministries (health, education, youth affairs, and women and child development) working on desperate approaches and States implementing conflicting policies, empowerment of the adolescent through holistic and participatory programming sometimes seems little more than a worthy illusion.

Civil Society Interventions

The ICPD document states that government and civil society organisations should work in collaboration and partnership with each other towards a better and healthier life for adolescents. "Governments in collaboration with non-governmental organisations are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs."

In recent years, NGOs have been attempting to implement programmes that are reflective of needs of adolescents as identified by them. Two distinct models of implementation exist; one focusing on unmarried adolescents and the provision of information on puberty/reproductive and sexual health and the other consisting of information and awareness programmes on general health and linked to literacy and skills training programmes.

More research is needed on civil society interventions, their scope and their impact. However, certain critical aspects should be noted for the design of future interventions:

- Programmes need to be aware that adolescents are not a homogeneous group but a very diverse one with needs that differ according to age, region, socio-economic status and gender.
- The identification of various needs should be done using a participatory approach and must reflect the views of adolescents themselves.
- Programmes must promote consensual and respectful sexual behaviour in both boys and girls while advising them on health risks and consequences of unprotected sex.
- The differing needs of boys and girls should be addressed.
- Programmes should promote accurate and easily comprehensible information in order to enable adolescents to make informed decisions and choices.
- There has to be an acknowledgement of different sexual behaviours, thereby preventing the creation of a false hierarchy of heterosexuality over homosexuality in young people's minds.

- Programmes must provide information free from values, morality and judgement, thereby enabling young people to make choices based on their own decisions.
- Programmes must promote understanding of gender and sexual diversity and equality.

Recognising the sexual and reproductive realities of young people is not an easy journey for adult caregivers and caretakers in most societies. To wrench anything out of its accustomed course takes energy and effort. However, the effects of denial, as evident today in countries around the world, are more devastating than the difficulties of change. If we want adolescents in India to grow into adults that make informed decisions, we have to recognise and affirm their rights as young people. Before we can admonish the decisions that they make and decide what is best for them, we have to recognise their decision making capacity and make them part of the solution, rather than the problem.

Module VIII: Sexual and reproductive health life skills

Learning Objectives	**By the end of the session, participants will be able to:**
	Learn about the categories and types of life skills
	Learn about the importance of life skills in practicing healthy sexual behaviour
	Practice skills for resisting pressure especially in reference to high risk behaviours

Flip Chart, Marker, Flash Card, Laptop, Projector, Chart paper, Situation Sheet

90 min

Session	Topic	Methodology	Time
1	Categories & type of Life skills	Discussion and presentation	20 min
2	Use of Life skills in practicing healthy sexual behaviour	Discussion & Role Play	40 min
3	Learning to Negotiate	Case study & presentation	30 min

Session 1: Categories & type of Life skills

Step I

Ask the participants whether they have heard the term "life skills"? What do they know about it?

Step II

Explain that everybody possess certain skills that allow us to live our lives. For example, the skill to write, work with others or make a decision. Distribute two-three flash cards (square or rectangle piece of coloured or white chart paper) to each participant, and ask her/him to write the most important skills she/he possesses.

Step III

Allow the participants 5 minutes to do this exercise. Invite the participants to display their flash cards by spreading them out on flip chart Ask if the cards represent most of the skills required for leading a healthy and productive life.

Step IV

Summarize and close the discussion by using the WHO definition of life skills. Explain to the participants that there are ten core life skills that we are likely to use in our day to day life. Enumerate and explain these life skills.

Session 2: Use of Life skills in practicing healthy sexual behaviour

Note for the Facilitator

We encounter a lot a situation in our day to day life when we must take decisions. Sometimes we face dilemmas and find it difficult to reach a decision or choosing an option that would be in accordance with our values and goals. In this session we will learn about ways in which we can make decisions that are informed and well thought out.

Tell participants that it is all right to feel/ discuss negative/positive or ambiguous aspects about a situation. They should think about the positive & negative aspects of each situation with stress on the positive one and the required ability to relieve of & cope up stress. Remember to include in the discussion some questions about where and from whom they got the information, which has helped in making the decisions, were they always the right decisions, etc. Difficult decisions should be about practicing abstinence, relationships, family, school, friends, drugs, alcohol, violence etc.

Step - I

Active Interaction

Remind the group that they make decisions every day e.g. what to wear, what to eat, when to do one activity or another. Ask the participants to describe the steps they take when making a decision. Ask them to think of how they dealt with a difficult decision or how they dealt with a difficult decision in their life.

The participants are asked to explore the advantages and disadvantages of different ways of making decisions, such as:

- by impulse
- by procrastinating, or "putting off" making a decision
- by not deciding
- by letting others make decisions for us
- By evaluating all choices and then deciding.

The facilitator then tells the group that the last way - evaluating different aspects of the situation - is the best process to use when making an important decision. And the following model, which is called power model, influence our decision making process.

Step - II

Explain the POWER model to the participants to make them understand how they take decision and what can influence their decisions.

POWER Model

P = PROBLEM Step 1: Stop and state (or identify) the problem.

O= OPTIONS Step 2: Think of different things you can do and use them. The more options you have, the better.

W = WEIGHT the options Step 3: Look at the good things and weigh them against the bad things of every option you thought of to solve your problem. The things you value, should guide you in your decision-making.

E= ELECT Step 4: Choose the best option; talk to a person you respect, then take the best option action. Elect the option, which obtains what is important to you (values).

R = REFLECT Step 5: Think or reflect about what happened because of your decision. Was it is the best choice? Did you learn something for the next time you have to make a decision?

Step III

The participants go through the model for the following example decision making dilemmas/ situations, first together and then in small groups. Then the participants compare how different people handled the same dilemma. The facilitator asks if anyone wants to share a real dilemma that the group could try to look at using the decision-making steps.

Decision making dilemmas/situations

Following are a few situations which can be selected for the discussion and further additional situations can be added depending on the need of the group.

- Your friend has invited you for a night out at her house. You are not sure who are the other invites and you suspect that hard drinks will be served there. No adults will be present there.
- You have gone out for a trip from your institute. At night you have to stay in a room along with some your seniors. They woke you up at night. You see them drinking. They tell that you should not let anyone know about this.
- Your friend is really upset, as her boyfriend has asked her for physical intimacy to prove her love. She feels that though she really loves him and wants to be his life partner but she doesn't want physical intimacy before marriage.
- A girl is going to get married in a couple of months. Her fiancée demands to have physical intimacy and threatens to break the engagement if she does not agree.
- A girl is unexpectedly visited by a neighbour. Her parents have gone out of the house for some work. Should she ask him to stay for a cup of tea, or ask him to leave immediately?

The following questions are raised:

- Has anyone in the group ever made a decision that didn't turn out well? Would the decision-making model have helped? How?
- How do you know if you have all the facts you need to make a decision? Who could you talk to?
- Do you think you could really use this model?

Step IV

Tell the participants that many decisions have severe/irreversible consequence, such as to have unprotected sex. This could lead to pregnancy, or infection. It is therefore very important that participants learn and be informed about the pro and cons of the situation before making any decision.

At the end of the session explain to the participants that when we were children our decision-making was based on the moral values we received from out parents. As young people and adults, we begin to judge, and our decision-making becomes based on our own views of situations many a time we negotiate to assert our decision.

Session 3: Learning to Negotiate

This section would help the participants to learn: The skills of negotiation so that the participants can communicate their decision to others and be able to take informed decision.

Introduction:

Before initiating the session the facilitator must explain that, everybody in their lifetime face such situations where the best way out is an assertive "No". The peer pressure and the rapid changes happening around make adolescents vulnerable in many situations. Therefore it becomes mandatory for them to understand the strength of being able to say "No" as well as to negotiate with the situation. In this unit the participants will learn the life skill of how to negotiate and take decision to save them.

Step I

The facilitator group the participants into four - five groups based on the number of participants and ask them to enact the role-play scenarios (as mentioned in the box) in their respective groups.

Step II

Discussion Points for role-plays:

- What are the best ways of avoiding being pressurized to do something you do not want to do?
- Can peer pressure be positive?

Yes, positive norms among friends in keeping with your values (Intend to do well in exams as all your friends are studying hard and aiming high; Practicing abstinence is "Cool and Hip"/Smoking cigarettes is uncouth/"Not in")

Remind the group that there are many ways to say "NO" – they need to practice saying "NO" and in a way that it is clear that it means "NO".

It is very important to say what you want to say assertively and that it is important to stand by your values.

Have the right information, and the assertiveness to make the argument and make the right decision. It is also important that you think ahead and do not put yourself in the wrong situation or place.

Role Play Scenarios

Saying 'No'

1. A friend of your family meets you after school and asks if you want a ride back home in his car. You don't feel very good about this person and you feel uncomfortable about the situation. You decide to be assertive and to refuse the ride.

2. You are talking to some of your friends. They share that they have been sexually active and are teasing you about the fact that you have not made it out with anyone. You decide to give an assertive reply.

3. A person of the other sex has asked you to go to another city with him/her. You don't know anyone who else is going, which makes you feel a little uncomfortable. You have also heard that this person likes you however he/she does not have a very good reputation at school. You decide to be assertive and say no to him/her.

4. You have gone to a friend's place to sleep over as her/his parents are away. When you get there, you realize that her boyfriend/his girlfriend and his/her friends are also visiting. Some alcohol is also being passed around. The friend you are with is close to you and you have known him / her for years. He/she comes to you with a glass of alcohol and wants you to have only one glass, if you are his/her friend. You do not want to have the alcohol and decide to be assertive.

5. Your friend wants you to skip school and go to see a movie. He/she tells you that the whole group is going. He/she says', "you are afraid, aren't you? You got caught skipping school last month and don't want to get caught again". You decide to tell him/her that you don't want to go.

6. Your parents are at a wedding in another city and you invite a friend of the opposite sex over to study. After doing the homework he/she holds your hand. You push him/her away but he/she says, "come on, you didn't invite me over just to do the homework." All our friends are doing it – You take a firm stand so it won't happen again.

7. Two of your friends have started smoking and are "showing off" in front of the others. Some of the others in the group want to try smoking. They ask you also to try. You do not want to smoke and decide to say no.

Trainer's Guide

The World Health Organization defines **life skills** as "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life".
It can also be defined as:
"Life skills are capabilities that empower young people to take positive action, to protect themselves and have positive social relationships, thereby promoting both their mental well-being and personal development as they are facing the realities of life."

With life skills, one is able to explore alternatives, consider pros and cons, and make rational decisions in solving problems or issues that arises. Life skills will also bring about productive interpersonal relationships with others, since effective communication in terms of being able to differentiate between hearing and listening, and the assurance that messages are transmitted accurately to avoid miscommunication and misinterpretations, the ability to negotiate, to say "no", to be assertive but not aggressive and to make compromises that will bring about positive solutions.

Categories and Types of life skills

Life skills are numerous and it can be categorised into three main areas:

- Skills of knowing and living with oneself
- Skills of knowing and living with others
- Skills of making effective and good decisions

Skills of knowing and living with oneself:

1. Self-awareness

Self-awareness is an individual's ability to increase the strengths and weaknesses of one's own character. Realising this will enable one to take actions, make choices and take decisions that are Consistent with one's own abilities.

- Examples of self-awareness skills include the ability to:
- Recognise the weak and strong sides of one's own behaviour.
- Recognise the weak and strong sides of one's own abilities.
- Differentiate what one can do or cannot do by her/himself.
- Recognise things which cannot be changed, and accept them (example: height, size of breasts, etc.).
- Appreciate oneself - people are not alike, and diversity is a good thing.
- Recognise one's own unique talents.

2. Self-esteem

Self-esteem is the way an individual feels about her/himself and believes others to feel. It has been described as the 'awareness of one's own value as a unique and special person endowed with various attributes and great potential'. A person's self-esteem can be damaged or enhanced through relationships with others. High self-esteem tends to encourage and reinforce healthy behaviour. Low self-esteem tends to encourage unhealthy behaviour.

Examples of self-esteem include the ability to:

- Develop a positive self-image.
- Respect oneself and one's choices.
- Not be unnecessarily influenced by what others think.

3. Coping with emotions and stress

It's a skill to manage or deal effectively with an emotional situation or problem. Emotions such as fear, passion, anger, jealousy etc. are subjective responses to a situation. They can result in behaviour which one might later regret. Coping with emotions means to be able to recognise them as such and deal with them to make a positive decision nonetheless.

4. Coping with emotions and stress

Stress is a state of increased motion in the body, which can overpower the individual beyond his/her capacity. It can be originated by physical, emotional or psychological factors. Family problems, broken relationships, examination pressure, the death of a friend or a relative are examples for situations that can cause stress. As stress is an expected part of life, it is important that to recognise stress, its causes and effects and know how to deal with it.

Skills of knowing and living with others

5. Interpersonal relationships

Interpersonal relationships are supported by the ability to:

- Co-exist amicably with other people and establish meaningful and healthy associations with them.
- Understand, form and develop mutually beneficial friendships.
- Understand that human beings tend to build profound one-to-one relationships with those they love and are committed to. Between sexual partners, it is only in the context of such loving and respectful relationships that sexuality can be lived in a healthy and fulfilling way for both partners.

Examples of interpersonal skills are:

- The skill to establish a lasting partnership.
- The ability to enter into an intimate relationship.
- The ability to end a temporary or undesirable sexual partnership.
- The ability to be faithful to a partner.
- The ability to make contacts.
- The willingness to be committed to friendship.
- The skill to develop respect and trust in a partner.
- The skill to develop positive relationships through effective communication.
- The desire to help, cares, and sympathise with others.
- The ability to overcome a disappointing relationship.

6. Empathy skills

Empathy is the ability to understand, consider and appreciate other peoples' circumstances, problems and feelings (step in ones shoes). Empathy also enables a person to give support to another in order to enable him/her to still make a good decision despite of the circumstances.

7. Effective communication

Effective Communication is the ability of expressing oneself clearly and effectively during interactions with other people in any given circumstances.

Verbal or nonverbal communication forms the essence of human relationships. It is one of the most important life skills. Simply exchanging words or ideas does not ensure good communication. Effective communication is a skill that can be learned and developed through constant practice. It involves, among others; active listening, effective use of verbal and body language, observation, and respect for others' feelings. Although good communication does not guarantee an end to problems, it can go a long way in improving relationships and minimising possibilities of conflict.

The following are examples of abilities in effective communication:

- The ability to communicate ideas skilfully and be able to persuade but not bully a partner.
- The ability to use the appropriate tone of voice in expressing anger, sadness, happiness, nervousness, respect, shame and understanding.
- The ability to use the appropriate verbal and non-verbal language in asking for and
- Presenting information, influencing and persuading.
- The ability to use non-verbal methods during negotiations by sustaining eye contact and using appropriate facial expressions.
- The ability to use verbal hints to communicate i.e. "Yes", "I see" etc.
- The ability to demonstrate active listening and to communicate empathy, understanding and interest.

Skills of making effective and good decisions

8. Critical thinking

Critical thinking is the ability to think through a situation properly, assessing the advantages and disadvantages so as to be able to make appropriate decisions concerning one's course of action. Young people are confronted by multiple and contradictory issues, messages, expectations and demands. They need to be able to critically analyse sexual situations and challenges and confront them.

Examples for critical thinking are abilities to:

- Identify the positive and negative aspects of a partner's behaviour (sexual or otherwise).
- Assess a potential partner.
- Assess promises that a partner/potential partner might make.
- Assess and judge a risky sexual situation.
- Differentiate between myths and facts.
- Recognise risky behaviours.

9. Decision-making

Decision-making is the ability to utilise all available information to assess a situation, analyse the advantages and disadvantages, and make an informed and personal choice. As a person grows up he/she is frequently confronted with serious choices that require his/her attention. These situations may present conflicting demands that cannot possibly be met at that same time. ("I want to have sex but I am afraid of STIs and I don't know my partner's status"). One must prioritise and make choices, but at the same time be fully aware of the possible consequences of those choices. One must learn to understand the consequences before making a decision.

Examples of abilities in decision-making:

- "No, I don't want to have sex" or "Yes, I do want to have sex", and understand the consequences of both decisions.
- To decide on the appropriate contraceptive (condom, the pill) to use if you do have sex.
- To decide to remain faithful to one partner.
- To decide to avoid high risk activities, such as drug and alcohol use.
- To decide to visit a health clinic to be tested for STIs and HIV.

10. Problem solving

Problem solving is the ability to identify, cope with and find solutions to difficult or challenging situations. Problem solving is related to decision-making and the two may often overlap. It is only through practice in making decisions and solving problems that young people can develop the skills necessary to make healthy choices for themselves.

Saying No: Negotiation Skills

Definition of negotiation?

Negotiation can be understood as the use of information and power to affect behaviour within a "web of tension" or "conflicting situation".

Why it is important to develop good negotiation skills and what does it accomplish?

Negotiation allows a person to solve an issue, problem or conflict. It is away to get what one wants without using anger, intimidation, in subordination, aggressive behaviour or force. In a conflicting situation, it is best to negotiate as soon as possible for effective communication.

What do negotiation skills depend on?

These depend on many personal and external factors.

Personal factors:

a. Education
b. Power
c. Motivation
d. Experiences
e. Knowledge

External factors:

a. Family upbringing
b. Traditions and culture

c. Socioeconomic status
d. Religion

How does one develop negotiation skills?

To negotiate one must decide which alternative can be accepted and what issues cannot be compromised. This can be done in following stages:

- Identify the problem/issue
- Collect more information/knowledge
- Identify the physical, emotional and psychological feelings associated with the problem on either side.
- Ascertain the possible ways of solving the problem.
- To communicate with the persons involved.
- To offer possible alternatives by effective communication skills.
- To reach a mutual decision.

Which are the elements present in every negotiation?

Three crucial elements present are:

- *Information:* The other side seems to know more about you and your needs than you know about them and their needs.
- *Time:* The other side doesn't seem to be under the same kind of pressure, time constraints and restrictive deadlines you feel you're under.
- *Power:* The other side always seems to have more power and authority than you think you have.

How are negotiating skills important to an adolescent?

Good negotiating skills help the adolescent to deal constructively with various problems. Significant problems that are left unresolved can cause mental stress and give rise to accompanying physical strains.

Key points

- It is important to analyse the information before taking a decision
- Environmental factors such as peer pressure often influence our decision.
- It is important to evaluate the consequences for each of the options and only then take the decision.
- If there is a problem in obtaining right information regarding a decision, you should take help of a trusted adult.
- Decision-making is strongly influenced by our self-esteem.
- When we value ourselves as special, unique and as important members of the society, then we have high self-esteem.
- With a positive self-esteem one is able to think independently and make wise decisions.

- Factors which influence our decision making process are peers, family, society, culture, education, attitudes, traditions, experiences, knowledge, religion, government and social conflicts.
- For every reason to say 'No', someone will find a reason to push you to say 'Yes'.
- Think ahead and do not put yourself in a dangerous situation or place
- It is very important to say what you want to say assertively and to stand by your values and beliefs
- Be assertive and stand up for your decision
- Remove yourself from a situation where you are facing peer pressure.
- There are many ways to say "NO" you need to practice saying "NO" and in a way that it is clear that it means "NO".
- Ways of Saying "No" to negative peer pressure.
    - Be Assertive and stand-up for your decision.
    - Avoid the situation.
    - Get out of the situation.
- Have the right information, and the assertiveness to make the argument and keep the right decision

Module IX: Know Your Body

Learning Objectives	**By the end of the session, participants will be able to:**
	State the physical and psychological changes that take place in adolescence
	Explain the structure and function of male and female reproductive organs
	Understand menstrual cycle and how to maintain hygiene practices

Flip Chart, Marker, Laptop, Projector, Posters of male & female body

60 min

Session	Topic	Methodology	Time
1	Physical and psychological changes that take place in adolescence	Group Work	30 min
2	Structure and function of male and female reproductive organs	Body Mapping	30 min
3	Menstrual cycle & hygiene practices	Group Exercise	30 min

Session 1: Physical and psychological changes that take place in adolescence

Step I

The session will start through discussion; ask the participants what they felt when they were adolescent, the discussed point will be noted down in the flip chart.

Step II

Then the participants will divide into two groups. Ask each group to make a list of physical and psychological changes of boys and girls, which occurs during adolescence.

Step III

After each group has finished listing, ask them to share their list in front of the whole group.

Step IV

Arrange the presentations on the chart paper. Then classify into physical and psychosocial changes that occur during this period. Add some more points if the participants have left out some. State the reasons for these changes**.**

Discussion guidelines:

- Puberty happens for all boys and girls. But the timing of the changes can vary greatly among individuals, which is dependent on a number of factors.
- The major psychological changes that may be identified during this age are being curious, exploring, adventurous, imitating role models, tendency to disobey elders, attraction towards

opposite sex, fluctuations in moods, confused about their identity, day dreaming, spending more time outside home, reduced attention span, etc.

- The above changes may be seen as the characteristics of adolescence, which occurs due to major hormonal changes, which comes especially from the pituitary glands.

Note to facilitator:

Encourage the group to ask as many questions as possible in this context. This will help to identify the existing misconceptions among the group. The psychological changes are to be dealt with sensitivity. The facilitator must make the group feel that both physical and psychological changes are normal which occurs due to sudden spurt in sex hormones in both boys and girls.

Session 2: Structure and function of male and female reproductive organs

Step I

The discussion will start by sharing with the participants that in order to understand the changes during adolescence it is very important to know the various parts of our body and its functions.

Step II

Ask for a volunteer from the participants. The volunteer is asked to draw the outline of a human body on the chart paper.
{The body map can also be easily drawn – one person from the group should lie on a sheet of paper (you may have to join 2 to 3 sheets together) while someone else traces the outline of his/her body}

Step III

Then each participant is called to the chart paper one by one. Each participant has to name one major internal (reproductive/sexual) organ and explain its function. The Trainer will explain the additional necessary thing if required especially male and female reproductive organs where the participants feels shy to discuss.

Step IV

The facilitator through an open discussion enumerates the terminology, information, and functions of the different parts of the male and female reproductive system.

Discussion Guidelines:

While discussing, the facilitator needs to refer to the following points:

- Different systems and parts of a human body including its functions
- Share with the participants that a majority of the changes during adolescence occurs due to change in our reproductive and sexual organs. There is therefore a need to know the structure and function of our reproductive and sexual organs.
- Discuss the functions of the male and female reproductive organs.

Note to facilitator:

- Encourage the group members to participate actively in the group activity. Some participants will experience shyness and embarrassment. Tell them that this is quite normal. It may be the first chance for many of them to understand how their bodies actually look.

- After the session the participants will feel more comfortable to participate in a discussion about the way the reproductive systems and sexual organs work

Session 3: Menstrual cycle & hygiene practices

Step I

Facilitator would ask the participants what they understand by menstruation and the changes that take place in the body once a girl starts menstruating, note down on the flip chart

Step II

Using the menstruation chart explain how it occurs, the changes that take place inside and outside the body

Step III

Ask the participants how they think cleanliness should be maintained by young girls, note down on the flip chart

Step IV

Discuss the advantages of using a sanitary napkin and the process of correct use and disposal of the same

Trainer Guide

Changes in Adolescence

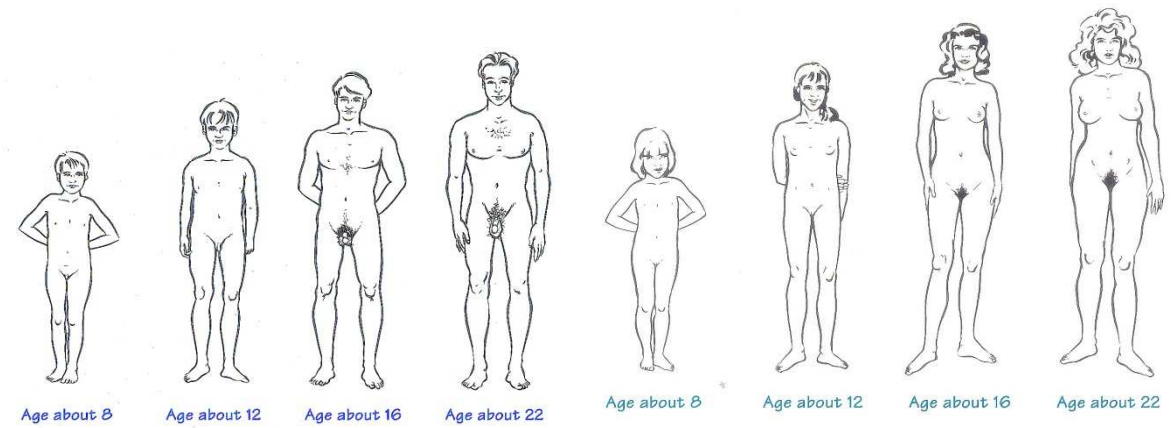
Adolescence is marked by various changes. The normal growth of any individual begins from birth but the starkest differences are noticed at this stage. Adolescence marks the transition between childhood and adulthood. It is during this stage that hormone induced physical differences between a boy and a girl child become evident. In case of females, these hormones target the ovaries, which are responsible for the growth of eggs in the ovary and in case of males; they target the testes, which are responsible for the production of sperm and testosterone.

The following chart shows the variations of physical changes at puberty

Physical Changes in Men	**Physical Changes in Women**
♦ Voice Cracks and Adams Apple becomes prominent	♦ Breasts develop
♦ Height and weight increases	♦ Height and weight increases
♦ Pimples appear on face	♦ Pimples appear on face
♦ Muscles develop	♦ Back becomes heavier
♦ Nightfall occurs	♦ Menstruation starts
♦ Hair appears on face, chest, underarms and genital areas	♦ Hair appears on genital areas and underarms
♦ Increase in the size of genital organ	♦ Increase in the size of genital organ

The various emotional changes that occur in adolescents are:

- Curiosity increases
- Attraction develops for the members of the other sex
- Get excited at the slightest provocation
- Becomes aware about their looks and their body
- Considers themselves to be correct always
- Friends rather than parents seem to be closer
- Want to imitate or copy
- Mind becomes diverted very easily
- Gets very imaginative and works very impulsively
- Mood swings are very common.



Human Body

The different system of out body and their functions are as follows.

Nervous system	➢ Controls all the functions of the other systems ➢ Is the seat of all our intelligence, emotions, reasoning and memory.
Skeletal System	➢ Provides the framework for the body. ➢ Protects vital organs like-Skull (brain), Ribcage (Heart &Lungs)
Muscular System	➢ The muscles attached to the bones are responsible for movement of the body.
Cardiovascular System	➢ Pumps the blood from heart and circulates it around the body.
Respiratory System	➢ Carries Oxygen into the lungs and expels carbon dioxide.
Digestive system	➢ Digests food with the help of digestive juices, and the digested nutrients are absorbed and the solid waste is eliminated.
Urinary system	➢ Wastes from body are eliminated through urine. ➢ Helps to maintain the fluid balance.
Endocrine system	➢ Hormones are responsible for ensuring growth. ➢ Development of the various changes that occur during puberty in males and females.
Reproductive system	➢ Responsible for reproductive process ➢ The reproductive system also has a sexual function.

Social Changes in Adolescence

There are certain changes that are observed in adolescents as a result of certain expectations and responsibilities that are placed on them by society. Changes are

- Boys start working and looking at ways to contribute to family income.
- Girls take on additional responsibilities of sibling care traditionally but with time girls are also looking at ways to earn money.
- Restrictions are placed on movements of girls outside the home- strict rules are enforced on mixing with members of the opposite sex.

- Boys are given more freedom than girls and spend a lot of time with peers and older men.
- Both boys and girls have serious concerns about their life ahead especially in relation to marriage, income and their roles beyond those defined within the family.
- Adolescents develop a sense of responsibility towards the community that they live in and often participate actively in community events. This gives them recognition beyond their family – this is very important to them.

Human Reproductive Physiology

To understand our body, and therefore, ourselves better, we need to understand the critical functions of our reproductive organs and the processes, which are associated with reproduction and growing up.

Female Reproductive System

The female reproductive system enables a woman to produce eggs (ova), have sexual intercourse, protect and nourish the fertilized egg until it is fully developed and give birth. Unlike the male, the female sexual organs are mostly hidden.

Female reproductive system constitutes the following:

- Ovaries
- Fallopian tube
- Uterus
- Vagina

} **INTERNAL PARTS**

- Vaginal mouth/ Vulva
- Labia Majora and Labia Minora
- Clitoris

} **EXTERNAL PARTS**

Ovaries-The ovaries are one of the important reproductive organs of a woman, situated in the pelvic region, one on either side of the uterus and below the fallopian tube. The two ovaries, which are about the size and shape of almonds, produce female hormones (estrogen and progesterone) and eggs (ova) and are responsible for development of secondary sex characteristics in girls. The ovary contains ovarian follicles, in which eggs develop. Once a follicle is mature, it ruptures and the developing egg is ejected from the ovary into the fallopian tubes. This is called **Ovulation**. An ovum or egg is about the size of a pinhead; usually one egg is released monthly, from either the right or left ovary at random. Occasionally more than one egg is released from the ovaries.

Fallopian tubes – Two thin tubular structures arising from the upper part of the uterus and having funnel-shaped free ends. This is the passage for the egg from the ovary to the uterus and the place where fertilization occurs.

Uterus- It is a hollow muscular, pear shaped pouch located in the pelvic cavity (lower part of the abdomen) and measures the size of one's fist. Here the baby grows until birth. During pregnancy the uterus enlarges to accommodate the foetus (baby).In non-pregnant state the uterus lining passes out of the body through vagina during monthly menstrual cycle.

Vagina – Passage extending from the uterus to the outside of the body. Canal through which

- Menstrual blood flows outside
- Intercourse occurs
- Delivery of a baby takes place.

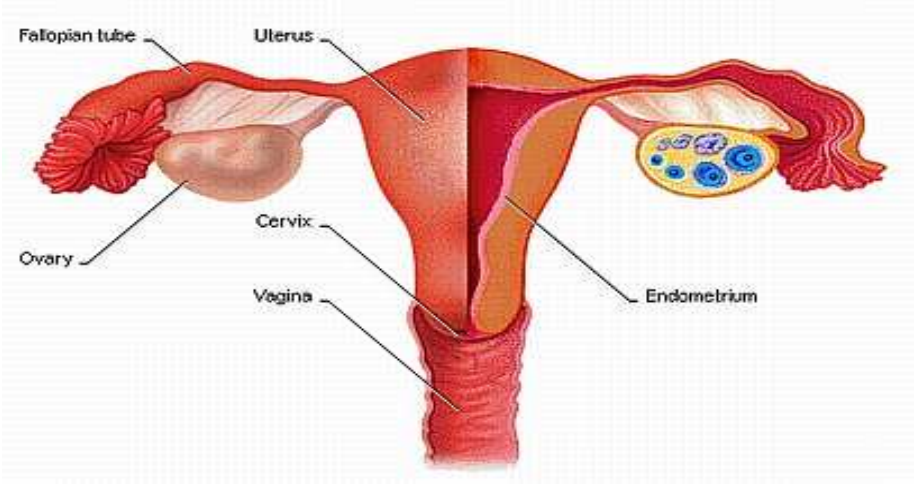
Vaginal Opening – Located between the urethral opening and the anus; usually covered by a thin membrane (hymen). It is the opening for menstrual flow and penetration of the penis during intercourse.

Labia Majora and Labia Minora– These are two pairs of lip-like structures on either side of the vaginal opening and provide protection to the clitoris, the urethral and vaginal opening.

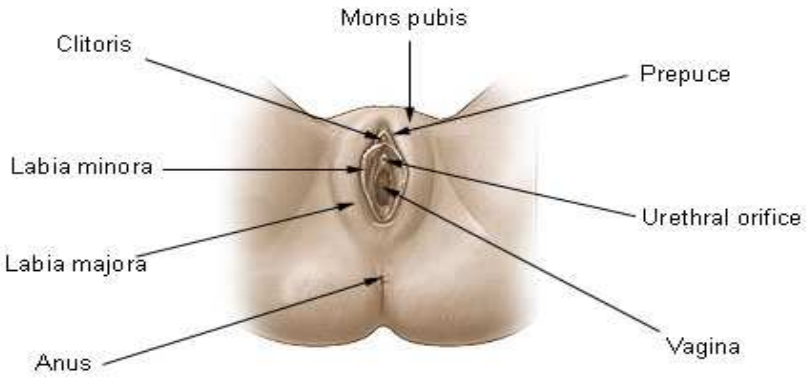
Clitoris-It is a small triangular and fleshy structure located above the urethral opening at the point where the labia meet. It is the focal point of sexual stimulation for females.

Functions:

Ovulation - Ovulation is the release of a ripe egg from one of the ovaries once in a month. This egg is picked by the funnel shaped end of the fallopian tube and starts moving in the tube. A woman can become pregnant only if she ovulates because the released egg can get fertilized by a sperm from a man. Usually only one egg is released during ovulation. Sometimes, however, two eggs are released at the same time. If this happens and both are fertilized, twins will be born.



Female External Genitalia



Male Reproductive System

The male reproductive system enables a man to have sexual intercourse and to fertilize ova (eggs) with sperm (male sex cells).The male organs produce and transfer sperm to the female organs for fertilization. The sexual organs of the male are partly visible and partly hidden within the body.

- Penis
- Scrotum

EXTERNAL PARTS

- Testes
- Vas deferens /Sperm Duct
- Seminal Vesicle
- Prostate Gland
- Urinary bladder
- Urinary Tract

INTERNAL PARTS

Penis **–** A rod like structure for sexual intercourse and the passage for urination. When a man is sexually excited, the penis becomes hard, big and gets erect. At the height of excitement, ejaculation of semen occurs, called orgasm.

The size of the penis may vary from person to person but the size of the penis however does not affect normal functions. In an excited state when the penis becomes big and hard then its tip may be pointed upwards, straight, downwards or sideways. This is very natural and is not a problem during sexual intercourse. Though the passage for semen (containing sperms) and urine is the same, both urine and semen cannot pass at the same time. The penis places the sperms in the woman's vagina during intercourse.

Scrotum–The pouch located behind the penis, which contains the testes and provides protection to the testes. Scrotum protects the testicles and controls the temperature necessary for sperm production and survival. It is placed outside the body. Normal body temperature hampers sperm production. Scrotal sac is made so that it keeps pairs of testes at a lower temperature than our usual body temperature.

Testes **–**Two spherical structures within the scrotum, which produce and store sperms from the age of puberty. The male sex hormone, testosterone which is responsible for the secondary sexual characteristics in males is also produced by the testes.

Seminal Vesicles- This is where the sperms are stored after production in the testes. They are thin sac like structures behind the testes within the scrotum.

Two Vas Deferens **–**From each seminal vesicle, a thin and long tube arises and is called vas deferens. Sperms are carried from each seminal vesicle to the urethra through the vas deferens

Prostate Gland **-** A small sac like structure lying exactly below the urinary bladder secrete a thick milky like fluid that forms part of the semen.

***Urinary** Bladder*-This is a sac like structure inside the body, which stores urine for some time. The urine, which is created by the kidney gets stored in the urinary bladder before passing through the urinary tract out of the body.

Urinary Tract- This is a pipe like structure through which urine comes from kidney to bladder and then passes through lower urinary tract called urethra which is situated within the penis to pass out of a man's body.

Functions:

***Erection of Penis*-** In response to romantic thoughts, fantasies, temperature, touch or sexual stimulation, the penis fills with blood and becomes hard and erect for sexual intercourse. Sometimes even when the bladder is full the penis becomes erect.

Ejaculation

Semen- From adolescence onwards a white thick liquid comes out of the penis. This liquid is called semen. This white colour fluid, which comes out during ejaculation is secreted by two glands the Seminal Vesicle and Prostate gland. This fluid contains Sperms. Sperms are the male sex cells, too small to be seen without a microscope, shaped like tadpoles whose movement is aided by lashing of their tails. Production usually begins between ages 12 –14 years. Total number per ejaculation is 200 to 500 million, but only a few are capable to fertilize properly and only one among them can fertilize an egg.

Semen - the sperm containing fluid that passes out of the penis at the time of ejaculation helps in conception. Semen comes out of the penis only when one is sexually excited, for e.g., when one is fantasizing or having some sexually stimulant thought, penis can harden and get erect and semen can eject out of it. This is called ejaculation. It is however not necessary that every time penis gets hard and erect, that one needs to have sexual intercourse or get an ejaculation. If given some time the penis will again assume its normal shape and this does not harm the body in any way. During ejaculation the urethra is closed for urination.

Menstrual Hygiene & Practices

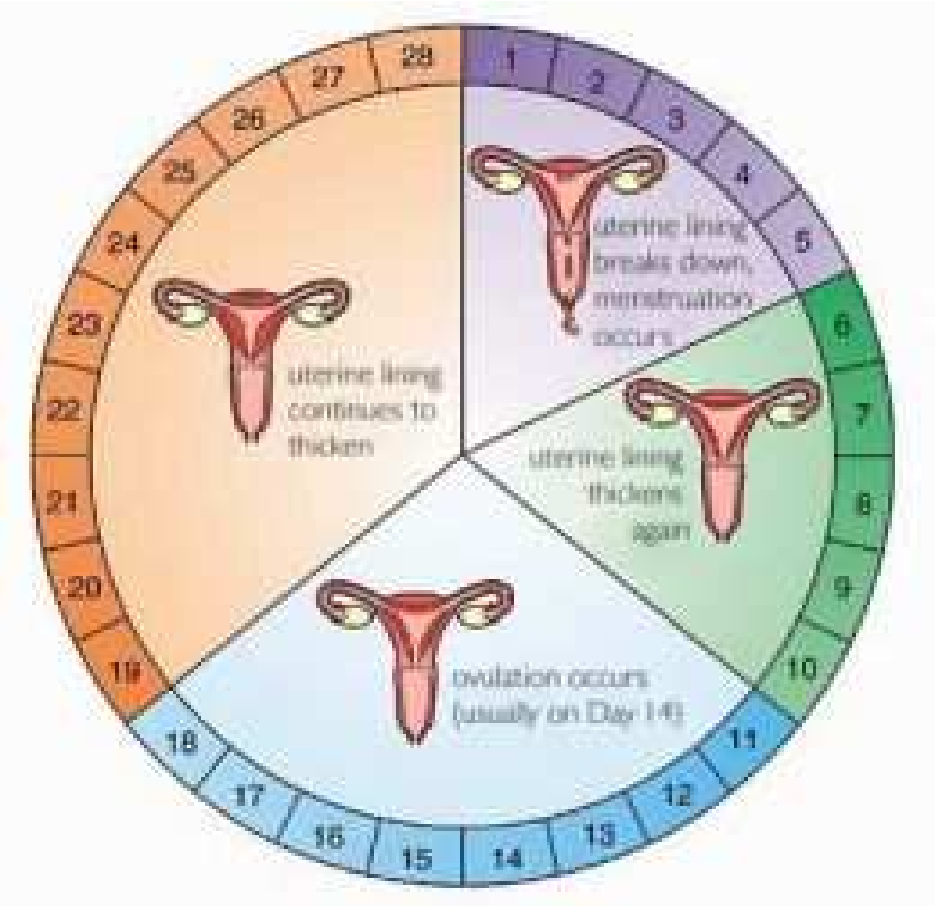
Every normal female experience some changes in her body as she grows up and develops. One of the changes that usually occur in adolescent girls is menstruation which is a natural part of female reproductive cycle. Issues relating to menstruation and menstrual hygiene have always been avoided and are not discussed freely by community and parents. This has made the discussion of these issues difficult. Menstrual hygiene is essential for the health and dignity of girls and women, it reduces the likelihood of infections resulting from poor hygiene practices. Providing girls with the knowledge and skills on maintaining menstrual hygiene improves school attendance among girls.

Menstruation is a woman's monthly bleeding. When you menstruate, your body sheds the lining of the uterus (womb). Menstrual blood flows from the uterus through the small opening in the cervix and passes out of the body through the vagina. Most menstrual periods last from 3 to 5 days.

Reasons for poor menstrual hygiene:

- Taboo subject: not discussed, most girls not prepared thus frightened

- Secret and shameful, associated with impurity and negative attitudes, lack of emotional support
- Limitations in mobility: preventing from going to school
- When experiencing problems – not seeking help
- No access to affordable hygienic materials/products
- Changing of pads only once or twice a day
- Facilities not adopted to the needs of girls and women
- Poor access to private and hygienic sanitation facilities at school and home



Process of Menstruation

- **Days 1-7:** The period is considered the beginning of the menstrual cycle. A period normally lasts for around five days, but can be as short as two days or as long as seven. A period occurs because the uterus will shed its lining if an egg (ovum) is not fertilised.
- **Days 8-14:** One of the ovaries releases as egg and the uterus begins to rebuild its lining. Only one egg is released in each cycle. The egg slowly travels down the fallopian tube from the ovaries towards the uterus. If the egg is fertilized by a sperm before it arrives the uterus, the girl becomes pregnant.
- **Days 15 –28:** If the egg is not fertilised, the uterus wall continues to thicken until there is a sudden drop in hormone levels. The lining breaks down, and the next period begins.

Cleanliness to be maintained during period:

- Taking a bath regularly
- Using a sanitary napkin
- Using clean cloth if a cloth is used
- Keeping the private parts clean
- Using clean and washed underclothes daily
- Change sanitary pad at least three times a day or when soaked
- Washing of hands with soap every time you change the cloth or napkin

Advantage of use of Sanitary napkin

Sanitary napkins absorb the menstrual fluids and keep the skin surface dry, therefore preventing growth of germs and bacteria. Thus sanitary napkins when used properly will not cause infection. On the other hand if the cloth is not washed and dried properly then there is a greater chance of infection.

Disposal of Sanitary Napkin

Sanitary napkins can be disposed of properly by incineration or burial in deep pits.

Module X: Safer Sex and Contraception

Learning Objectives	**By the end of the session, participants will be able to:**
	understand what is meant by safer sex or safe sexual behaviour
	how one can protect themselves from unintended pregnancy and STI

Flip Chart, Marker, Laptop & Projector, Condoms, Pills, IUCD

105 min

Session	Topic	Methodology	Time
1	Safer Sex Practice	Group Work	45 min
2	Methods of contraception	Body Mapping	60 min

Session 1: Safer Sex Practice

Step I

Remind the group that adolescents often do not have access to sexual and reproductive health information and services. This can result in their inability to make responsible and appropriate decisions about protecting themselves from disease and pregnancy.

Step II

Ask participants what is meant by the term safer sex, then ask them to brainstorm ways to practice safer sex (including but not limited to condoms). Facilitate discussion by asking participants to brainstorm reasons adolescents may not practice safe sex. Write responses on a flip chart and fill in using the key information (trainer guide).

Step III

Facilitate a general discussion on condoms. Ask the group:

- Why don't people use condoms? What are the things that make it difficult for people to use condoms?
- Do you know of ways, other than using condoms, that young people can reduce the risk of being infected with, or transmitting HIV or STIs to their partners?
- Write answers on a flip chart and fill in using the key information.

Step IV

Introduce the penis model and demonstrate how to use condoms and then ask if anyone in the class can show how male condoms are used. Ask the participant to describe the steps out loud. Make corrections as needed according to the steps described. Ask participants what they think by the term 'dual protection'. Write on a flip chart and fill in using the key information. Remind

participants that using condoms is an effective way to prevent HIV, STIs and unintended pregnancies.

Then ask the group to brainstorm what makes negotiating safer sex difficult for young people. Ask participants if there are any other ways (besides using condoms and practicing safer sex) to reduce the risk of passing HIV to a sexual partner.

Session 2: Methods of contraception

In this session all the main categories of modern methods of family planning available for men and women will be discussed. Available samples of family planning methods needs to be collected before start of the session.

Step I

Oral Contraceptive Pills

Facilitator will start the discussion by asking the participants:
"Have you heard about oral contraceptive pills if yes, which brands are you aware of?"
Probe: Mala D, Mala N. After that samples of contraceptives pills will be passed among the participants
Facilitator will tell about how these pills work, how women need to take them, what are their advantages, limitations, what are the side effects. Will also need to discuss some common misconceptions associated with pills.
Facilitator will also discuss about emergency contraceptive pills. (Ref Trainer Guide)

Step II

Inject able (DMPA)

Facilitator tells the participants:
"Now we will talk about another female oriented method of family planning: inject able. Have you heard of inject able? If yes, who did you hear from? Do you know about the name of any Inject able?" Probe: Depo.
Do you know where inject able are available? Tell them that you would be providing them with information about how inject able work, their advantages, limitations and common side effects" (Ref Trainer Guide)

Step III

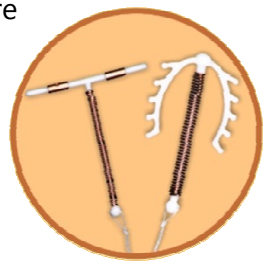
Fertility Awareness Based Methods

Facilitator tells the participants: "Now we will talk about another female oriented method of family planning: fertility awareness based methods. Have you heard of or seen the Mala Chakra that is used for this method? If yes, who showed it to you? Probe: Or the ANM? Do you know about how this method works? We will be providing you with information about how fertility awareness based methods work, their advantages, and limitations. It is very important to understand how to use this method correctly, so if you have any questions at the end of this session, please feel free to ask."(Ref Trainer Guide)

Step IV

Intra Uterine Device

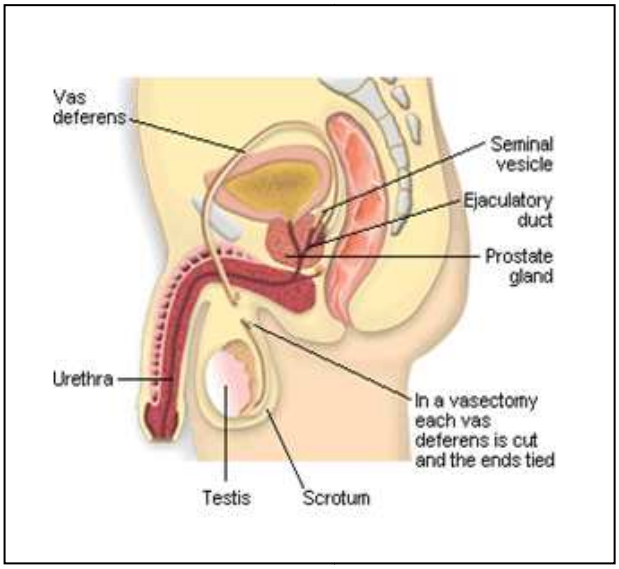
Facilitator would tell the participants: "We will now talk about another female oriented method of family planning- IUD or Copper T. Have you heard of this method? If yes, where did you hear of it? What do you know about Copper T? We will provide you information about what IUDs are, their advantages and limitations. We will also talk about common myths and misconceptions associated with IUDs. If you have any questions about this method, at the end of this session, please feel free to ask." (Ref Trainer Guide)

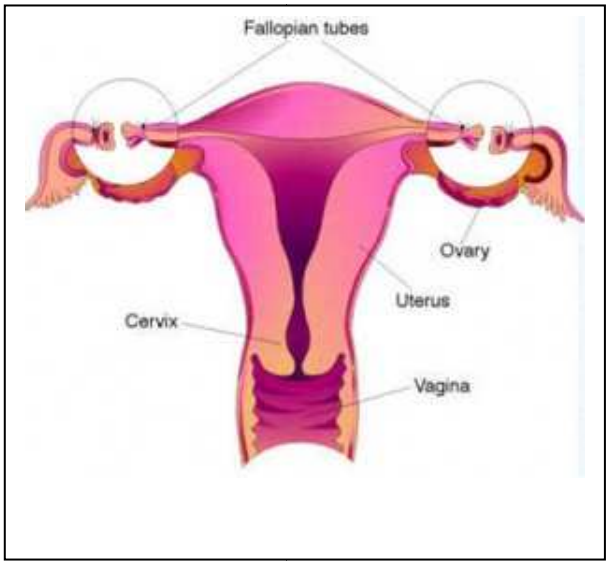


Step V

Sterilization (Male & Female)

Facilitator tells the participants: Now, we will be talking about permanent methods of family planning: Male sterilization (vasectomy) and female sterilization tubectomy). Ask participants what they know about vasectomy and tubectomy. Explain the process of sterilization with the help of model of male and female reproductive organs. (Ref Trainer Guide)





Trainer's Guide

Key Information: Safer Sex and Contraception

What is safe sex?

Being safe with sex means caring for both your own health, and the health of your partner. Being safe protects you from getting or passing on sexually transmissible infections (STIs) and an unplanned pregnancy. Whether you have vaginal, anal or oral sex, it definitely pays to play it safe!

There's more to sex than sexual intercourse!

There are lots of ways to enjoy physical intimacy with your partner without having oral, vaginal or anal sex. Safe sex also includes lots of other activities like kissing, cuddling, rubbing, massage, stroking, masturbation (touching your own genitals) or touching each other's genitals. Why not explore other ways to be intimate which do not put you at risk of sexually transmissible infections or an unintended pregnancy?

How you can stay safe?

Always use condoms if you have vaginal, oral or anal sex. Use of condoms is the only method of contraception that protects against both STIs and pregnancy. Even if you're using other methods of contraception, always use condoms as well.

If you are having unprotected sex, talk to your partner about the risks involved. Remember your decision about safe sex is important, as some STIs can be cured but some can't, including HIV (Human Immunodeficiency Virus).

Before having sex, you need to discuss the use of condoms with your partner and come to an agreement about using condoms. Remember, you have the right to say NO if your partner does not agree to use condoms.

STIs can be passed from one person to another by oral sex. If you put your month in contact with your partner's penis, you need to use a condom to avoid STIs. If you put your mouth in contact with your partner's anus or vulva (outside of vagina) while having sex, you need to use a dental dam (whether you are a guy or girl). This is especially important if you've got a cut or sore around your mouth or lips or bleeding gums.

Some more ways to have safer sex are:

- Using a condom for all types of sexual intercourse (oral sex, anal sex, vaginal sex).
- Masturbating one's partner, as long as males do not ejaculate near any opening or broken skin on their partner
- Mutual masturbation, as long as bodily fluids do not come into contact with the other's genitals
- Rubbing against each other with clothes on
- Thigh or armpit sex
- Sharing fantasies
- Massaging

- Hugging and Kissing

Reasons adolescents may not be able to negotiate safer sex:
They may not have the right communication skills to talk about protection with their partners
Young people may believe that if they suggest having safer sex, their partners will think they do not trust them
Young people may be scared or embarrassed to bring up the topic of protection
Young people may want to get pregnant: For young women, it may be a way to keep a relationship. For young men, getting a girlfriend pregnant may be a way to prove their manhood. Sometimes, young women who feel a lack of love in their lives think that having a baby will are assures them of unconditional love.

Risks of adolescent pregnancy:

- Young girls are at higher risk of complications during pregnancy because they are not fully developed and their bodies may not be ready to handle pregnancy or to give birth
- Young mothers may face problems such as: obstructed labour, long labour, anaemia, pre-eclampsia or hypertension during pregnancy, consequences of unsafe abortion, spontaneous abortion, still birth, and premature birth.
- Adolescents younger than 17 often have not reached physical maturity and their pelvises may be too narrow to accommodate a baby's head
- Pregnancy often means the end of formal education for girls, as they may be expelled from school when they become pregnant
- Adolescent pregnancy changes a girl's career options, her future opportunities and may limit her marriage choices.
- Sometimes the adolescent's partner refuses to take responsibility for the pregnancy, which makes things much harder for the young mother and child
- Young parents are often not ready to raise a child which, in extreme cases, can lead to problems like child abuse or neglect
- Early marriages that happen because of an unplanned pregnancy are often unhappy and unstable.

Contraception and Family Planning
Contraceptives and family planning methods help people prevent unintended pregnancy so that they can properly plan when they want, and are ready, to have a baby.
While family planning, pregnancy and child care have traditionally been the role and responsibility of the woman, there is an increasing shift for men to be more involved in family planning and in supporting their partner through pregnancy, and with child care.

Contraception: The use of a method or more than one method to prevent a woman from becoming pregnant
Family planning: When a couple plan the number of children they want and when they want to have them. Often this includes using a contraceptive or family planning method to prevent pregnancy or space births
Birth spacing: When a couple plan births far enough apart so she and her baby are not at risk of the health problems that can occur when babies are born too close together. It is recommended that women wait at least two years after giving birth before becoming pregnant again.

The main types of contraceptives

- Barrier methods prevent sperm from getting inside the woman. These include male and female condoms
- Hormonal methods are those that prevent eggs from being released inside the woman's uterus by altering hormone levels. These include pills, inject able, emergency contraception
- Long-term methods have to be provided at a health clinic by a trained nurse or doctor. These include IUDs (intra-uterine devices)
- Permanent methods like male and female sterilisation require surgery. These methods are not usually recommended for young people who may change their minds about wanting to have children in the future. Permanent methods are best for adults who have already had children and know that they do not want to have any more
- Natural methods do not require any materials (i.e. withdrawal, and the 'rhythm method' which is when the woman learns to recognise when she is fertile and avoids having sex during that time). In general, natural methods do not work as well as the 'modern' methods listed above. They require great self-control. The rhythm method only works well when a woman has very regular periods
- In some places, people use traditional methods. These are mostly herbs that are given to prevent pregnancy. They are not reliable because the dosage is not controlled and they have not been scientifically proven to work.

Condom Promotion

Steps to use a male condom:

- Check the condom package and the date to make sure it is still good and that the package does not have any damage
- Open the packet on one side and take the condom out. Do not use your teeth to open the package
- Pinch the tip of the condom to keep a little space at the tip. This will hold the semen and prevent the condom from breaking
- Hold the condom so that the tip is facing up and it can be rolled down the penis
- Put it on the tip of an erect (hard) penis (only use condoms on an erect penis) and unroll it down to the bottom of the penis
- After ejaculation (coming), hold the rim of the condom while the man removes his penis from his partner so that semen does not spill. The penis must be removed while it is still hard to make sure the condom does not fall off
- Take off the condom and tie it in a knot to avoid spilling. Throw it in a latrine or bury it. Do not put it in a flush toilet
- Use a new condom every time!

Oral Contraceptives

These are tablets containing artificial forms of hormones (chemicals) similar to those produced by the body to protect from getting pregnant. Different types of pills contain different levels of the hormones estrogens and progestin; there are also pills that contain only progestin. These hormones tell the ovaries not to let any ova cells ripen. The lining of the uterus becomes thinner and the entrance to the uterus is blocked by thick, jelly-like mucus, which makes it hard for sperm to reach the uterus. Birth control pills are taken every day and it is very important that the pills be taken at the same time every day, whether or not you have sexual intercourse. Pills should not be shared with anyone else.

If used properly and consistently, birth control pills can be 99.9% effective. If a woman forgets to take the pill for even a few days, it is possible for her to get pregnant. If a woman misses a pill for three or more days in a row, she should use a condom or other barrier method to protect against the risk of pregnancy. Most women do remember to take the pill on a daily basis. If a woman has problems remembering to take the pills, she should seek advice from a Family Planning Clinic about alternative contraceptive options.

How to use the pill

The most common is the 21-daysystem whereby the woman takes pill daily for 21 days then takes none (or iron containing pills) for 7 days. Women on contraceptives should see a gynaecologist at least once a year to be checked. Some women believe they should only use the pill for a year or two, and then stop. This is not necessary; the method can be used for many years provided the woman has regular check-ups.

Advantages

Taking the pill is simple, safe, and convenient. Many women who take the pill have fewer menstrual cramps and lighter periods. The pill does not interfere with having sex. Many women say it has improved their sex lives. They say it helps them feel more spontaneous. It also regulates the menstrual cycle, reduces menstrual flow, reduces acne, protects against certain cancers, and is totally reversible (once the woman using it is off the pill, her body resumes its normal cycle). When used correctly, the pill is very effective, making it the most reliable contraception available.

Other non-contraceptive benefits

It reduces the amount of blood lost and pain suffered during menstruation. Although this is a concern for some women, they can be reassured that it is not because the blood is staying inside the womb. The menstrual blood is reduced because the lining of the womb builds up less when a woman is taking the pill. When a woman stops taking the pill, she is usually able to get pregnant again quite soon.

Disadvantages

The pill doesn't protect against sexually transmitted infections and it may cause a few side effects such as irregular bleeding, breast tenderness, weight gain, headaches and nausea. These side effects usually disappear after a few months, though. If you're on the pill and still suffer from side effect after a few months, see your doctor. As mentioned above, it does not protect you against sexually transmitted infections (STI's) or HIV and AIDS.

The pill is not advisable in women who have or are suspected to have:

- Swellings in the breast
- Any unusual bleeding from the vagina

For healthy women who do not have one of these risk factors, taking the pill is less dangerous than having an unwanted pregnancy.

Effectiveness

If taken regularly and correctly, less than 1 woman per 100 will get pregnant. However, if you miss a pill or are sick or have severe diarrhoea, this could affect the performance of the pill and it is recommended that you use additional contraceptives (i.e. condoms).

Emergency Contraception

Emergency Contraception is contraceptives taken after unprotected or forced sex to help avoid pregnancy. They prevent the release of the ova only and do not disrupt existing pregnancy. Emergency contraception can be given within 72 hours to women who have had unprotected sex, forced sex or their normal method of birth control cannot be relied upon. For examples the condom may have broken or she may have missed taking her contraceptive pills.

As noted by the World Health Organisation, Emergency contraceptive pills are for emergency use only and are not appropriate for regular use as an ongoing contraceptive method because of the higher possibility of failure compared with non-emergency contraceptives. In addition, frequent use of emergency contraception can result in side-effects such as menstrual irregularities.

Fertility Awareness Method

Fertility awareness based methods are contraceptive methods based on woman's ability to identify days durind each menstrual cycle when she is most likely to get pregnant (also called fertile days).A couple wanting to avoid pregnancy has to avoid sex or use condom on these fertile days. The menstrual cycle is the time between the first day of last menses and the first day of woman's next menses. The fertile window occurs close to the middle of the cycle and consists of approximately 7 days- 5 days before ovulation,the day of ovulation (when woman's body produced an egg), and one day after ovulation.However, the exact timing of ovulation varies both among different women and across cycles of the same woman.One of the most common fertility based awareness methodstakes intoaccount this variability and calculates a wider fertile window, which covers ovulation time for all menstrual cycles as long as the time between two menses is not shorter than 26 and not longer than 32 days. This method is called **Standard Days Method (SDM)**, and a woman considers herself potentially fertile on Day 8 through 19 of her menstrual cycle. If she does not want to get pregnant, she avoids sexual intercourse on those days or her partner is using condom on those days. Memory aids, such as CycleBeads are available to help women calculate their fertile days correctly.

There are also other techniques to identify the fertile days of the menstrual cycle which could also be calendar-based or based on symptoms which indicate ovulation. Fertility awareness can also be used by couples who want to achieve pregnancy as they can time intercourse to the days when pregnancy is most likely to occur.

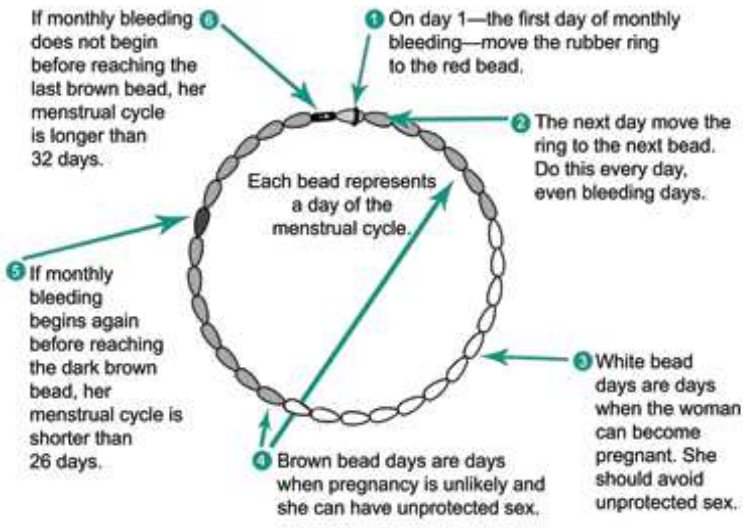
FAMs can be used in combination with other contraceptive methods, whereby a couple uses a barrier method only during the fertile phase of the cycle.

Advantages and disadvantages of fertility based awareness methods

Advantages	Disadvantages
No side- effects	Needs cooperation and commitment
Better understanding of sexual cycle.	Low effectiveness
Once trained, no assistance needed	Daily monitoring/ recordig can be a bother
Once trained, negligible cost	Difficult, if cycles are irregular
Once trained, no health personnel needed	Unpredictable if breast feeding

Standard Days Method

IMPORTANT: A woman can use the Standard Days Method if most of her menstrual cycles are 26 to 32 days long. If she has more than 2 longer or shorter cycles within a year, the Standard Days Method will be less effective and she may want to choose another method.	
Keep track of the days of the menstrual cycle	• A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1.
Avoid unprotected sex on days 8–19	• Days 8 through 19 of every cycle are considered fertile days for all users of the Standard Days Method. • The couple avoids vaginal sex or uses condoms or a diaphragm during days 8 through 19. They can also use withdrawal or spermicidal, but these are less effective. • The couple can have unprotected sex on all the other days of the cycle—days 1 through 7 at the beginning of the cycle and from day 20 until her next monthly bleeding begin.
Use memory aids if needed	• The couple can use Cycle Beads, a colour-coded string of beads that indicates fertile and non-fertile days of a cycle, or they can mark a calendar or use some other memory aid.



Intra Uterine Device

An IUD is a small, flexible plastic device shaped like a letter T. The IUD is inserted in the woman's uterus through the vagina and then cervix by specially trained provider. Most common IUDs havecopper bands or wires around the frame. IUDs containing progestin (a female sex hormone) also exist, but they are not as widely available as copper IUDs. Once it is in place, the strings of the IUD extend down into the upper vagina so provider can pull the strings and remove the IUD when woman wants to stop using it or when it is time to replace it with another one. The Copper T IUCD 380 A is one of the most widely used IUCDs in the world presently and is available as part of the National Family Welfare program.

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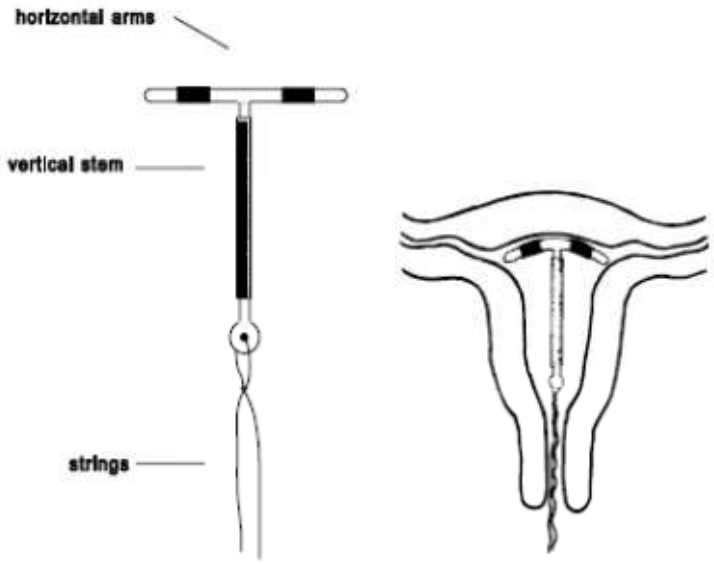

It is as effective as sterilization, but if woman wants to have another child, IUD can be removed and woman can get pregnant without a delay.

How it works

The essence of the copper wire changes the chemistry in the uterus, which makes it "unfriendly" to ova and destroys sperm before it can fertilize an ovum. An IUD does not protect against STI's.

- Copper T emits metallic ions, which kills sperm.
- Makes the sperm unable to swim and meet the ova

Advantages

IUDs are a popular form of reversible birth control. There is nothing to put in place before intercourse to protect against pregnancy. Some women say they feel free to be more spontaneous because they do not have to worry about becoming pregnant. Moreover, the ability to become pregnant returns quickly once the IUD is removed.

Side effects

Possible side effects that usually clear up after the first several weeks to months include

- Changes to menstrual flow (spotting between periods is common with IUD use)
- Menstrual cramps or backaches

- Inserting and/or removing an IUD can be very painful, especially if the women have never given birth.

Disadvantages

- Serious pain when put in and a few days afterwards, not recommended for adolescents
- Must be inserted and removed by a health care professional
- Longer and heavier periods in the first 3 months
- Increased pain during periods
- Can come out without the user noticing.

Effectiveness

It is very effective (97%) and protects for a long time, however, it is not recommended for young girls who have never given birth. When inserted, IUD can be kept in place for 10-12 years without losing its effectiveness.

Permanent methods

Male Sterilization - Vasectomy

Vasectomy is a surgical procedure for male sterilization and/or permanent birth control. During the procedure, the vasa deferentia of a man are severed, and then tied/sealed in a manner such to prevent sperm from entering into the seminal stream (ejaculate). Vasectomies are usually performed in a hospital or clinic. Due to the simplicity of the surgery, a vasectomy usually takes less than 30 minutes to complete. After a short recovery (usually less than an hour), the patient is sent home to rest. Because the procedure is minimally invasive, many vasectomy patients find that they can resume their typical lifestyle routines within a week, and do so with minimal discomfort. Because the procedure is considered a permanent method of birth control. Men are usually counselled and advised to consider how the long-term outcome of a vasectomy might affect them both emotionally and physically. Once done, it is not reversible.

Frequently Asked Questions:

What is Vasectomy?

Vasectomy is a simple operation, which interrupts the tubes that carry the sperm in your body. These two tubes arise from your testicles and go into your urinary passage. When the tubes are cut and tied, the passage of sperms in to semen is blocked. Without sperms in semen a man cannot make his partner pregnant, although he still ejaculates during intercourse the same way as before. This is a permanent method of contraception and you should get it done only when you no longer want any children.

Are there any complications after the surgery?

Complications with vasectomy are rare, but may occur as no surgery is completely free from complications. NSV has very few complications as compared to the old method, and is very safe.

Are there any chances of failure?

The chance of failure is very small, and it mostly occurs when you do not follow the doctor's advice about the precautions after the procedure. Also sometimes the ends of the tubes may become untied and let the sperm through. But this is very rare. You are usually protected from failure when you observe the precautions.

What precautions must one take to prevent failure?

One must use condoms for 3 months after the operation, if the partner is not using any method of contraception. The reason is that it takes about 3 months for tubes to empty itself of all the sperms that remain in it after the operation. After 3 months vasectomy is considered effective and other methods of contraception may be stopped. If possible, doctor will test semen for sperm at this point, but even if not, you can start relying on vasectomy for contraception.

What other precautions must be taken?

Take adequate rest and resume normal work 48 hours after surgery. Keep the operation site dry and clean for 2-3 days and avoid sex for the same period of time. Usually one can resume all activities including cycling by one week following surgery. In case there is a lot of pain or swelling one must immediately report to a doctor.

What are the effects on sex after this operation?

No change will occur compared to man's sex experiences prior to vasectomy. In some cases people even find sex more enjoyable because the fear of pregnancy is gone. Fears of lowering of sexual pleasure are completely unfounded. The sexual pleasure is regulated by hormones produced by the brain and nerves in the spine. Because the surgery doesn't affect the brain, hormone production, or spinal nerves in any way, men's sexual experiences are not affected. Man's body will continue to produce male hormones and same amount of semen but the sperms will be prevented from mixing with semen and entering female partner's body during sex.

Can one work as hard as before?

Surely one can. This operation has absolutely no relationship with physical strength as that depends on nourishment and exercise.

What happens to the sperm after the vasectomy?

Sperms continue to be produced as before but since they do not come out of the body after the operation they get absorbed into the body. This is a normal process which occurs even in non-vasectomised men who do not have sex for some time.

Advantages

- Safe and effective
- Simple procedure
- Has no side effects
- Complications are rare
- Permanent (good choice for men who want no more children)

Limitations

- It is a surgical procedure and requires a specially trained provider
- It can't be reversed (in most cases) if a man changes his mind about having no more children
- It takes 3 months before it becomes effective
- Complications are rare, but may occur
- It provides no protection from STI/HIV.

Female Sterilization

Female Sterilization (Tubal ligation) is considered a major surgery requiring the patient to undergo general anaesthesia. It is advised that women should not undergo this surgery if they currently have or have a history of bladder cancer. After the anaesthesia takes effect, a surgeon will make a small incision at each side of, but just below the navel in order to gain access to each of the 2 fallopian tubes. With traditional tubal ligation, the surgeon severs the tubes, and then ties (ligates) them off thereby preventing the travel of eggs to the uterus.

A tubal ligation is approximately 99% effective in the first year following the procedure. In the following years the effectiveness may be reduced slightly since the fallopian tubes can, in some cases, reform or reconnect which can cause unwanted pregnancy. Method failure is difficult to detect, except by subsequent pregnancy, unlike with vasectomy or IUD.

Frequently Asked Questions

Will sterilization change a woman's monthly bleeding or make monthly bleeding stop?

No. Most research finds no major changes in bleeding patterns after female sterilization. If a woman was using a hormonal method or IUD before sterilization, her bleeding pattern will return to the way it was before she used these methods. For example, women switching from combined oral contraceptives to female sterilization may notice heavier bleeding as their monthly bleeding returns to usual patterns. Note, however, that a woman's monthly bleeding usually becomes less regular as she approaches menopause.

Will sterilization make a woman lose her sexual desire? Will it make her fat?

No. After sterilization a woman will look and feel the same as before. She can have sex the same as before. She may find that she enjoys sex more because she does not have to worry about getting pregnant. She will not gain weight because of the sterilization procedure.

Should sterilization be offered only to women who have had a certain number of children, who have reached a certain age, or who are married?

No. There is no justification for denying sterilization to a woman just because of her age, the number of her living children, or her marital status. Health care providers must not impose rigid rules about age, number of children, age of last child, or marital status. Each woman must be allowed to decide for herself whether or not she will want more children and whether or not to have sterilization.

Is it not easier for the woman and the health care provider to use general anaesthesia? Why use local anaesthesia?

Local anaesthesia is safer. General anaesthesia is more risky than the sterilization procedure itself. Correct use of local anaesthesia removes the single greatest source of risk in female sterilization procedures—general anaesthesia. Also, after general anaesthesia, women usually feel nauseous. This does not happen as often after local anaesthesia.When using local anaesthesia with sedation, however, providers must take care not to overdose the woman with the sedative. They also must handle the woman gently and talk with her throughout the procedure. This helps her to stay calm. With many clients, sedatives can be avoided, especially with good counselling and a skilled provider.

Does a woman who has had a sterilization procedure ever have to worry about getting pregnant again?

Generally, no. Female sterilization is very effective at preventing pregnancy and is intended to be permanent. It is not 100% effective, however. Women who have been sterilized have a slight risk of becoming pregnant: About 5 of every 1,000 women become pregnant within a year after the procedure. The small risk of pregnancy remains beyond the first year and until the woman reaches menopause.

Pregnancy after female sterilization is rare, but why does it happen at all?

Most often it is because the woman was already pregnant at the time of sterilization. In some cases an opening in the fallopian tube develops. Pregnancy can also occur if the provider makes a cut in the wrong place instead of the fallopian tubes.

Can sterilization be reversed if the woman decides she wants another child?

Generally, no. Sterilization is intended to be permanent. People who may want more children should choose a different family planning method. Surgery to reverse sterilization is possible for only some women—those who have enough fallopian tube left. Even among these women, reversal often does not lead to pregnancy. The procedure is difficult and expensive, and providers who are able to perform such surgery are hard to find. When pregnancy does occur after reversal, the risk that the pregnancy will be ectopic is greater than usual. Thus, sterilization should be considered irreversible.

Is it better for the woman to have female sterilization or the man to have a vasectomy?

Each couple must decide for themselves which method is best for them. Both are very effective, safe, permanent methods for couples who know that they will not want more children. Ideally, a couple should consider both methods. If both are acceptable to the couple, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than female sterilization.

Will the female sterilization procedure hurt?

Yes, a little. Women receive local anaesthetic to stop pain, and, except in special cases, they remain awake. A woman can feel the health care provider moving her uterus and fallopian tubes. This can be uncomfortable. If a trained anaesthetist or anaesthesiologist and suitable equipment are

available, general anaesthesia may be chosen for women who are very frightened of pain. A woman may feel sore and weak for several days or even a few weeks after surgery, but she will soon regain her strength.

Remember

Female sterilization

- Does not make women weak.
- Does not cause lasting pain in back, uterus, or abdomen.
- Does not remove a woman's uterus or lead to a need to have it removed.
- Does not cause hormonal imbalances.
- Does not cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- Does not cause any changes in weight, appetite, or appearance.
- Does not change women's sexual behaviour or sex drive.
  Substantially reduces the risk of ectopic pregnancy.

Annexure

The Prohibition of Child Marriage Act, 2006

रजिस्ट्री सं० डी० एल०—(एन)04/0007/2006—08 REGISTERED NO. DL—(N)04/0007/2006—08

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इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह अलग संकलन के रूप में रखा जा सके।
Separate paging is given to this Part in order that it may be filed as a separate compilation.

MINISTRY OF LAW AND JUSTICE
(Legislative Department)

New Delhi, the 11th January, 2007/Pausa 21, 1928 (Saka)

The following Act of Parliament received the assent of the President on the 10th January, 2007, and is hereby published for general information:—

THE PROHIBITION OF CHILD MARRIAGE ACT, 2006

No. 6 OF 2007

[10*th January*, 2007.]

An Act to provide for the prohibition of solemnisation of child marriages and for matters connected therewith or incidental thereto.

BE it enacted by Parliament in the Fifty-seventh Year of the Republic of India as follows:—

Short title, extent and commencement.

1. (*1*) This Act may be called the Prohibition of Child Marriage Act, 2006.

(*2*) It extends to the whole of India except the State of Jammu and Kashmir; and it applies also to all citizens of India without and beyond India:

Provided that nothing contained in this Act shall apply to the Renoncants of the Union territory of Pondicherry.

(*3*) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint; and different dates may be appointed for different States and any reference in any provision to the commencement of this Act shall be construed in relation to any State as a reference to the coming into force of that provision in that State.

Definitions.

2. In this Act, unless the context otherwise requires,—

(*a*) "child" means a person who, if a male, has not completed twenty-one years of age, and if a female, has not completed eighteen years of age;

(*b*) "child marriage" means a marriage to which either of the contracting parties is a child;

(*c*) "contracting party", in relation to a marriage, means either of the parties whose marriage is or is about to be thereby solemnised;

(*d*) "Child Marriage Prohibition Officer" includes the Child Marriage Prohibition Officer appointed under sub-section (*1*) of section 16;

(*e*) "district court" means, in any area for which a Family Court established under section 3 of the Family Courts Act, 1984 exists, such Family Court, and in any area for which there is no Family Court but a city civil court exists, that court and in any other area, the principal civil court of original jurisdiction and includes any other civil court which may be specified by the State Government, by notification in the Official Gazette, as having jurisdiction in respect of the matters dealt with in this Act; 66 of 1984.

(*f*) "minor" means a person who, under the provisions of the Majority Act, 1875 is to be deemed not to have attained his majority. 9 of 1875.

Child marriages to be voidable at the option of contracting party being a child.

3. (*1*) Every child marriage, whether solemnised before or after the commencement of this Act, shall be voidable at the option of the contracting party who was a child at the time of the marriage:

Provided that a petition for annulling a child marriage by a decree of nullity may be filed in the district court only by a contracting party to the marriage who was a child at the time of the marriage.

(*2*) If at the time of filing a petition, the petitioner is a minor, the petition may be filed through his or her guardian or next friend along with the Child Marriage Prohibition Officer.

(*3*) The petition under this section may be filed at any time but before the child filing the petition completes two years of attaining majority.

(*4*) While granting a decree of nullity under this section, the district court shall make an order directing both the parties to the marriage and their parents or their guardians to return to the other party, his or her parents or guardian, as the case may be, the money, valuables, ornaments and other gifts received on the occasion of the marriage by them from the other side, or an amount equal to the value of such valuables, ornaments, other gifts and money:

Provided that no order under this section shall be passed unless the concerned parties have been given notices to appear before the district court and show cause why such order should not be passed.

Provision for maintenance and residence to female contracting party to child marriage.

4. (*1*) While granting a decree under section 3, the district court may also make an interim or final order directing the male contracting party to the child marriage, and in case the male contracting party to such marriage is a minor, his parent or guardian to pay maintenance to the female contracting party to the marriage until her remarriage.

(*2*) The quantum of maintenance payable shall be determined by the district court having regard to the needs of the child, the lifestyle enjoyed by such child during her marriage and the means of income of the paying party.

(*3*) The amount of maintenance may be directed to be paid monthly or in lump sum.

(*4*) In case the party making the petition under section 3 is the female contracting party, the district court may also make a suitable order as to her residence until her remarriage.

Custody and maintenance of children of child marriages.

5. (*1*) Where there are children born of the child marriage, the district court shall make an appropriate order for the custody of such children.

(*2*) While making an order for the custody of a child under this section, the welfare and best interests of the child shall be the paramount consideration to be given by the district court.

(*3*) An order for custody of a child may also include appropriate directions for giving to the other party access to the child in such a manner as may best serve the interests of the child, and such other orders as the district court may, in the interest of the child, deem proper.

(*4*) The district court may also make an appropriate order for providing maintenance to the child by a party to the marriage or their parents or guardians.

Legitimacy of children born of child marriages.

6. Notwithstanding that a child marriage has been annulled by a decree of nullity under section 3, every child begotten or conceived of such marriage before the decree is made, whether born before or after the commencement of this Act, shall be deemed to be a legitimate child for all purposes.

Power of district court to modify orders issued under section 4 or section 5.

7. The district court shall have the power to add to, modify or revoke any order made under section 4 or section 5 and if there is any change in the circumstances at any time during the pendency of the petition and even after the final disposal of the petition.

Court to which petition should be made.

8. For the purpose of grant of reliefs under sections 3, 4 and 5, the district court having jurisdiction shall include the district court having jurisdiction over the place where the defendant or the child resides, or where the marriage was solemnised or where the parties last resided together or the petitioner is residing on the date of presentation of the petition.

Punishment for male adult marrying a child.

9. Whoever, being a male adult above eighteen years of age, contracts a child marriage shall be punishable with rigorous imprisonment which may extend to two years or with fine which may extend to one lakh rupees or with both.

Punishment for solemnising a child marriage.

10. Whoever performs, conducts, directs or abets any child marriage shall be punishable with rigorous imprisonment which may extend to two years and shall be liable to fine which may extend to one lakh rupees unless he proves that he had reasons to believe that the marriage was not a child marriage.

Punishment for promoting or permitting solemnisation of child marriages.

11. (*1*) Where a child contracts a child marriage, any person having charge of the child, whether as parent or guardian or any other person or in any other capacity, lawful or unlawful, including any member of an organisation or association of persons who does any act to promote the marriage or permits it to be solemnised, or negligently fails to prevent it from being solemnised, including attending or participating in a child marriage, shall be punishable with rigorous imprisonment which may extend to two years and shall also be liable to fine which may extend up to one lakh rupees:

Provided that no woman shall be punishable with imprisonment.

(*2*) For the purposes of this section, it shall be presumed, unless and until the contrary is proved, that where a minor child has contracted a marriage, the person having charge of such minor child has negligently failed to prevent the marriage from being solemnised.

Marriage of a minor child to be void in certain circumstances.

12. Where a child, being a minor—

(*a*) is taken or enticed out of the keeping of the lawful guardian; or

(*b*) by force compelled, or by any deceitful means induced to go from any place; or

(*c*) is sold for the purpose of marriage; and made to go through a form of marriage or if the minor is married after which the minor is sold or trafficked or used for immoral purposes,

such marriage shall be null and void.

Power of court to issue injunction prohibiting child marriages.

13. (*1*) Notwithstanding anything to the contrary contained in this Act, if, on an application of the Child Marriage Prohibition Officer or on receipt of information through a complaint or otherwise from any person, a Judicial Magistrate of the first class or a Metropolitan Magistrate is satisfied that a child marriage in contravention of this Act has been arranged or is about to be solemnised, such Magistrate shall issue an injunction against any person including a member of an organisation or an association of persons prohibiting such marriage.

(*2*) A complaint under sub-section (*1*) may be made by any person having personal knowledge or reason to believe, and a non-governmental organisation having reasonable information, relating to the likelihood of taking place of solemnisation of a child marriage or child marriages.

(*3*) The Court of the Judicial Magistrate of the first class or the Metropolitan Magistrate may also take *suo motu* cognizance on the basis of any reliable report or information.

(*4*) For the purposes of preventing solemnisation of mass child marriages on certain days such as *Akshaya Trutiya*, the District Magistrate shall be deemed to be the Child Marriage Prohibition Officer with all powers as are conferred on a Child Marriage Prohibition Officer by or under this Act.

(*5*) The District Magistrate shall also have additional powers to stop or prevent solemnisation of child marriages and for this purpose, he may take all appropriate measures and use the minimum force required.

(*6*) No injunction under sub-section (*1*) shall be issued against any person or member of any organisation or association of persons unless the Court has previously given notice to such person, members of the organisation or association of persons, as the case may be, and has offered him or them an opportunity to show cause against the issue of the injunction:

Provided that in the case of any urgency, the Court shall have the power to issue an interim injunction without giving any notice under this section.

(*7*) An injunction issued under sub-section (*1*) may be confirmed or vacated after giving notice and hearing the party against whom the injunction was issued.

(*8*) The Court may either on its own motion or on the application of any person aggrieved, rescind or alter an injunction issued under sub-section (*1*).

(*9*) Where an application is received under sub-section (*1*), the Court shall afford the applicant an early opportunity of appearing before it either in person or by an advocate and if the Court, after hearing the applicant rejects the application wholly or in part, it shall record in writing its reasons for so doing.

(*10*) Whoever knowing that an injunction has been issued under sub-section (*1*) against him disobeys such injunction shall be punishable with imprisonment of either description for a term which may extend to two years or with fine which may extend to one lakh rupees or with both:

Provided that no woman shall be punishable with imprisonment.

Child marriages in contravention of injunction orders to be void

14. Any child marriage solemnised in contravention of an injunction order issued under section 13, whether interim or final, shall be void *ab initio*.

Offences to be cognizable and non-bailable.

15. Notwithstanding anything contained in the Code of Criminal Procedure, 1973, an offence punishable under this Act shall be cognizable and non-bailable. 2 of 1974.

Child Marriage Prohibition Officers.

16. (*1*) The State Government shall, by notification in the Official Gazette, appoint for the whole State, or such part thereof as may be specified in that notification, an officer or officers to be known as the Child Marriage Prohibition Officer having jurisdiction over the area or areas specified in the notification.

(*2*) The State Government may also request a respectable member of the locality with a record of social service or an officer of the Gram Panchayat or Municipality or an officer of the Government or any public sector undertaking or an office bearer of any non-governmental organisation to assist the Child Marriage Prohibition Officer and such member, officer or office bearer, as the case may be, shall be bound to act accordingly.

(*3*) It shall be the duty of the Child Marriage Prohibition Officer—

(*a*) to prevent solemnisation of child marriages by taking such action as he may deem fit;

(*b*) to collect evidence for the effective prosecution of persons contravening the provisions of this Act;

(*c*) to advise either individual cases or counsel the residents of the locality generally not to indulge in promoting, helping, aiding or allowing the solemnisation of child marriages;

(*d*) to create awareness of the evil which results from child marriages;

(*e*) to sensitize the community on the issue of child marriages;

(*f*) to furnish such periodical returns and statistics as the State Government may direct; and

(*g*) to discharge such other functions and duties as may be assigned to him by the State Government.

(*4*) The State Government may, by notification in the Official Gazette, subject to such conditions and limitations, invest the Child Marriage Prohibition Officer with such powers of a police officer as may be specified in the notification and the Child Marriage Prohibition Officer shall exercise such powers subject to such conditions and limitations, as may be specified in the notification.

(*5*) The Child Marriage Prohibition Officer shall have the power to move the Court for an order under sections 4, 5 and 13 and along with the child under section 3.

Child Marriage Prohibition Officers to be public servants.

45 of 1860.

17. The Child Marriage Prohibition Officers shall be deemed to be public servants within the meaning of section 21 of the Indian Penal Code.

Protection of action taken in good faith.

18. No suit, prosecution or other legal proceedings shall lie against the Child Marriage Prohibition Officer in respect of anything in good faith done or intended to be done in pursuance of this Act or any rule or order made thereunder.

Power of State Government to make rules.

19. (*1*) The State Government may, by notification in the Official Gazette, make rules for carrrying out the provisions of this Act.

(*2*) Every rule made under this Act shall, as soon as may be after it is made, be laid before the State Legislature.

Amendment of Act No. 25 of 1955.

20. In the Hindu Marriage Act, 1955, in section 18, for clause (*a*), the follwing clause shall be substituted, namely:—

"(*a*) in the case of contravention of the condition specified in clause (*iii*) of section 5, with rigorous imprisonment which may extend to two years or with fine which may extend to one lakh rupees, or with both".

Repeal and savings.

21. (*1*) The Child Marriage Restraint Act, 1929 is hereby repealed. 19 of 1929.

(*2*) Notwithstanding such repeal, all cases and other proceedings pending or continued under the said Act at the commencement of this Act shall be continued and disposed of in accordance with the provisions of the repealed Act, as if this Act had not been passed.

K. N. CHATURVEDI,
Secy. to the Govt. of India.

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