Child sexual abuse in India: A wake-up call

The World Health Organization (WHO) defines Child Sexual Abuse (CSA) as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.”[1] In India, the Protection of Children from Sexual Offences (POCSO) Act, 2012 (that regards any sexual activity with a child below 18 years a crime) describes various forms of sexual offenses.[2] CSA includes an array of sexual activities like fondling, inviting a child to touch or be touched sexually, intercourse, exhibitionism, involving a child in prostitution or pornography, or online child luring by cyber-predators.[3,4] Because of the sensitive and taboo nature of the issue, it is extremely difficult to access this population of victims of CSA for research. It is affected by socio-cultural traditions and often goes unreported, as a culture of privacy, fear of indignity, and social humiliation prevent the disclosure of such crimes.[5] Also, certain forms of CSA, namely, like touching, fondling of child’s genitals, or breasts are wrongly perceived as minor types and are often ignored.

Prevalence of Child Sexual Abuse

A meta-analysis conducted in the year 2009 analyzed 65 studies in 22 countries and estimated an “overall international figure.” The main findings of the study were[6](i) an estimated 7.9% of males and 19.7% of females universally faced sexual abuse before the age of 18 years,[6] (ii) the highest prevalence rate of CSA was seen in Africa (34.4%);[7] Europe, America, and Asia had prevalence rate of 9.2%, 10.1%, and 23.9%, respectively[6] and, (iii) with regards to females, seven countries reported prevalence rates as being more than one fifth i.e., 37.8% in Australia, 32.2% in Costa Rica, 31% in Tanzania, 30.7% in Israel, 28.1% in Sweden, 25.3% in the US, and 24.2% in Switzerland.[6]

Review of Indian Data

The number of rape incidents in India per 100,000 citizens is 28.1% in Sweden, 25.3% in the US, and 24.2% in Switzerland.[6] The number of rape incidents in India per 100,000 citizens is 28.1% in Sweden, 25.3% in the US, and 24.2% in Switzerland.[6] The Indian children, at 440 million, constitute 19% of the world’s population of children. United Nations International Children Education Fund study during 2005–2013 reported that CSA in Indian girls was 42%.[8] A Government of India, Ministry of Women and Child Development (MWCD) study in 2007 which interviewed 125,000 children in 15 Indian states revealed that the prevalence of all forms of child abuse is extremely high (physical abuse [66%], sexual abuse [50%], and emotional abuse [50%]). This major state-sponsored survey in India reported the prevalence of CSA as 53%.[9] Boys were equally affected and more than 20% were subjected to severe forms of sexual abuse that included: sexual assault, making the child fondle private parts, making the child exhibit private body parts, and being photographed in the nude. In both the major surveys, majority of the abusers were people known to the child or in a position of trust and responsibility. Several reports indicate that neighbors, friends, close relatives, and acquaintances, and employers at workplaces are the most common abusers.[10-18] The Honourable Delhi High Court observed that in 2014, of the 1704 cases of rape registered in the capital, 213 cases were instances of child incestuous rape.[19]

The National Crime Records Bureau (NCRB) revealed that crimes against children increased by 4.5% in 2019 as compared to 2018.[20] In its report, NCRB stated that as many as 148,185 crimes against children were reported in 2019 in the country.[20] In this, 31.2% cases of crimes against children were registered under the POCSO Act, 2012.[20] Maharashtra is the state where the maximum number of 8,505 cases under the POCSO Act, 2012 were registered in the country during 2017–2019. In nearly 50% of these cases, minors were lured online into meeting people, who then subjected them to sexual abuse or entered into sexual relationships with the promise of marriage.[20]

On the list of states, Maharashtra is followed by Uttar Pradesh with 6,978 cases, Madhya Pradesh (5,348), Karnataka (4,339), and Gujarat (4,228).[21] In Maharashtra, it was found that cases of abuse of minors have been on the rise, going up from 2,398 cases in 2017 to 2,944 in 2018 to 3,161 in 2019.[21] The most vulnerable underage persons are between 16 and 18 years of age, followed by 12–16 years, 6–12 years, and then even those aged below 6 years following the enactment of the Criminal Law (Amendment) Act, 2013.[21]

Under the Criminal Law (Amendment) Act, 2013, the age of consent for sex has been increased to 18 years from 16 years in India, which means any sexual activity irrespective of the presence of consent with a girl below the age of 18 years will constitute statutory rape.[22]
Table 1: Number of rape incidents per 100,000 citizens in different countries in year 2020

| Ranking | Country (Continent)     | Rape Rate (per 100,000 citizens) | Incidents | Population (in millions) |
|---------|-------------------------|----------------------------------|-----------|--------------------------|
| 1       | South Africa (Africa)   | 132.4                            | 66196     | 59.6                     |
| 2       | Botswana (Africa)       | 92.9                             | 1865      | 2.4                      |
| 3       | Lesotho (Africa)        | 82.7                             | 1777      | 2.1                      |
| 4       | Swaziland (Africa)      | 77.5                             | 849       | 1.2                      |
| 5       | Bermuda (North America) | 67.3                             | 43        | 0.06                     |
| 6       | Sweden (Europe)         | 63.5                             | 5960      | 10.1                     |
| 7       | Suriname (South America)| 45.2                             | 223       | 0.59                     |
| 8       | Costa Rica (North America)| 36.7                           | 1685      | 5.1                      |
| 9       | Nicaragua (North America)| 31.6                           | 1829      | 6.7                      |
| 10      | Grenada (North America) | 30.6                             | 32        | 0.11                     |
| 97      | India (Asia)            | 1.8                              | 22172     | 1393.4                   |

Consistently, in other studies, the highest numbers of registered cases were falling in this age group where teenagers (16 to less than 18 years old) were engaging in consensual relationships (sexual intercourse by mutual consent).

The Honourable Madras High Court in a present ruling in June 2018 stated, “Any consensual sex after the age of sixteen or bodily contact or alleged acts could be excluded from the rigorous provisions of POCSO Act and sexual assault could be tried under more liberal provisions which can be introduced in the act, differentiating sexual assault and teenage relationship.” This verdict has suggested that the minimum age of consent for sexual intercourse should be made 16 years again; and therefore, it would decriminalize the consensual sex for adolescents of the age group 16 to 18 years.

**How to Suspect CSA?**

Healthcare professionals function as advocates for child health and play a critical role in recognizing children who are victims of sexual abuse. There are often very few physical signs of sexual maltreatment and less than 5% of victims show physical signs of abuse. Victims are identified during the history component of examinations or are not identified at all. Because of the taboo nature of CSA, clinics must acknowledge the risk factors for CSA and the value of a thorough evaluation of children for victimization. The physical injuries include bleeding, bruises, or swelling in the genital area, bloody, torn, or stained underclothes, difficulty walking or sitting, frequent urinary infections, pain, itching, or burning in the genital area. Common findings in adolescents tend to include behavioral signs like violation of laws and social conduct, lower academic performance and absenteeism, sexualized behavior, e.g., prostitution, exhibition of violent behavior, increased tendency to grow up as perpetrators. As these physical signs are often not prevalent from the evaluation, it is important that healthcare professionals respond appropriately to behavioral, verbal, or nonverbal communication like sign language or series of gestures that may suggest a history of abuse. However, no single health professional can be considered to be responsible for detecting these clues; instead, a multidisciplinary approach involving experts from departments of forensic medicine, obstetrics and gynecology, pediatrics/general medicine, pediatric surgery, and psychiatrist can increase the probability of detection.

**The Procedure Followed to Identify/Prove CSA**

A majority of healthcare professionals are not sufficiently trained to evaluate or actually handle a case of CSA. It is important for them to acquire the required expertise. Physicians must also be aware of the prevention of CSA and the POCSO Act, which specifically addresses their responsibility in the management of CSA. Healthcare professionals (Registered Medical Practitioner) are in a specific position to recognize and work with child victims of sexual abuse. They must be able to accurately recognize a child who has been sexually assaulted even though the victim’s main complaint seems to be irrelevant to CSA. Introducing violence and abuse awareness programs will be an ideal way to improve the ability of healthcare professionals to handle CSA. The diagnosis of CSA is most frequently based on history, as compared to clinical examination, and so having a meticulous history of the child’s experience is important. The interview should be conducted in a friendly, nonjudgmental, and empathetic way and should not have an investigative tone, which is the domain of the police and the courts. Interviews are most often conducted by specially trained child forensic interviewers, law enforcement investigators, and child protective service workers. It is recommended the interview occurs in a neutral environment, whenever possible. The setting should be private, informal, and free from distractions. Children’s advocacy centers and other specialized interview rooms are advantageous because they are generally child-friendly and allow for observers as well as audio and video recording. If at all possible, law enforcement officers should arrive at the school in unmarked cars and wear plain clothes. If it is necessary to conduct an interview where abuse may have occurred, the interviewer should confirm the suspected offender is not in the vicinity and that there is a reasonable degree of privacy. Video recording is recommended to document the forensic interview, whenever possible.

Care should be taken in setting up the video recording equipment to ensure everything is accurately documented, including what both the interviewer and child say, as well as their facial expressions, movements, and positions. If video
The hospital is mandated to provide treatment and perform a medical examination with the written consent or assent of the child/parent/guardian, depending on the age of the child. For children between 12 and 18 years of age, written consent must be obtained. The legal age for giving valid consent in India is 18 years. A child below 12 years (minor) cannot give assent, and parents/guardians can consent for their medical/surgical procedures. A child between 12 and 18 years can give consent only for medical examination but not for any procedure. For children who are orphans or unknown or street children, the court is appointed as a guardian and any procedures/treatment requires court’s permission. In some instances despite the victimization, victim/parent/guardian does not want to file a complaint against the accused out of stigma or fear but needs medico-legal examination and treatment in the hospital. In such circumstances, it is the responsibility of the healthcare professional to motivate the victim to record or file her complaints. The healthcare professional needs to explain to the victim/parent/guardian that according to the law, they are obliged to notify the police about the crime (Section 19 of the POCSO Act, 2012). Section 21 of the same act states that any health care professional who has the knowledge that a child has been sexually abused is obliged to report the offense, failing which he may face legal punishment under subsection (1) of Section 19, imprisonment of either description that may extend to 6 months, or with a fine or with both.

Neither the court nor the police, however, can compel the victim to undertake a medico-legal examination without the child/parent/guardian’s informed assent/consent. A medico-legal case (MLC) must be made if the victim does not want to register a police case and an informed refusal must be recorded. The details of the MLC number and police station must be documented if the victim has reported with a police request or wants to register a complaint afterwards. In some situations, due to social stigma child’s parent/guardian may not agree to register a police case. It may be appropriate to spend time with the child alone, without the parent/guardian being present. This may make it easier for the child to not feel coerced by a parent/guardian, and share detailed information related to sexual abuse. Meanwhile, counseling is suggested for the child’s parent/guardian.

Medico-legal Aspects

(i) Obligatory reporting: An ethical dilemma:
Such a dilemma can arise when the victim and the family confidently provide the healthcare professional with a sexual history to obtain adequate treatment but do not want the incident to be reported to the police. There may be situations where out of interest, children or teenagers provide information on sexual exploration or participate in foreplay or perhaps even consensual sex with each other, and later on becoming pregnant. The POCSO Act, 2012 considers all pregnant minors (below 18 years of age) as survivors of sexual assault and allows healthcare professionals to inform the police of such pregnancies. The confidentiality clause under the Medical Termination of Pregnancy (MTP) Act, 2003 is in clear contravention with this. The MTP Act, 2003 makes it mandatory for healthcare professionals to keep all information on those seeking abortions confidential. According to POSCO Act, if a girl wants to undergo MTP on humanitarian grounds but does not want to file a police complaint (when pregnancy is an outcome of sexual assault), the healthcare professional must inform the police that the cause for pregnancy was rape. Healthcare professional’s attempts to interact and work with young people will be severely compromised by a violation of privacy if they are legally obligated to reveal any knowledge of consensual, although underage sex.

(ii) Lack of medical evidence:
Reporting of sexual violence is sometimes delayed for weeks or months, and any direct evidence could be lost by that time. The observed unusual findings may be due to acute injury sustained during the recent episode or to lingering effects after frequent sexual encounters in the past. Delay in reporting of cases and medico-legal examination causes loss of essential biological trace evidence.

(iii) Ruling out accidental genital trauma:
The concerns are intensified in pediatric patients, where genital trauma can be caused by accidental injury and most significantly, where the injury will cause parents anticipatory anxiety regarding their potential gynecological issues, sexual growth and not to forget causing humiliation by defamatory questions asked by the police. The examination of female genitalia requires different techniques and methods than those used in adults, and the examination should be comprehensive and detailed, and it is important to differentiate between those physical findings which resemble signs of trauma or sexual abuse. Therefore, careful examination findings are of importance in this group of patients.

Long-Term Effects on Child

Preadolescent sexually abused children meet full criteria between 30% and 50% for a posttraumatic stress disorder diagnosis, 30–40% for depression, 27% for conduct disorders, 14.3% for attention deficit hyperactivity disorder, and 5–8% for obsessive-compulsive disorder.

In adolescent children, the experience of CSA has a strong association with feelings of hopelessness, suicidal ideation, and suicidal attempt. Children most often do not reveal their shameful truth and stay silent. However, CSA typically triggers strong emotions, including fear, uncertainty, shame, guilt, rage, helplessness, depression, and distress. Survivors
of CSA may consider themselves different, disgusting, and harmed.\(^{[99]}\)

Owing to various emotional, social, and cultural factors, CSA survivors may not be able to express their feelings and experiences. The main rationale for this is that children are traumatized and are unsure of the proper words to express their encounter. CSA has long-lasting negative effects on mental health. Effects can be immediate, intermediate, and long-term. Reference should be made to the psychologist and psychiatrist in all cases needed for the assessment and treatment of acute stress reactions and, consequently, to posttraumatic stress disorder. Also, another reference should be made to other specialists like District Child Protection Units, child developmental experts, medical social workers as needed for both medical care and legal aid. Coordination and convergence between all key experts can support the child and help reduce the emotional stress of trauma. Appropriate steps must be taken to avoid further violence, trauma, and revictimization.

The Ministry of Women and Child Development (MWCD), Govt. of India, since 1\(^{st}\) April 2015, is establishing Sakhi: One Stop Centers (OSC) preferably within a hospital/medical facility to provide support and assistance to victims of gender violence.\(^{[50]}\) So far 683 OSCs have been started operations in different state/Union territories in India.\(^{[31]}\) The holistic facilities, including medical, police, psychosocial counseling, legal assistance, shelter, referral, and video-conferencing are therefore given “under one roof.” The scheme is centrally funded with complete financial assistance.

Prevention of CSA

CSA is a major public health concern and as such, needs public health initiatives. The preventive factors must be targeted at the population and must discuss the most common and significant factors affecting CSA. Knowledge on its prevalence, the incidence in all communities and in particular, the common perpetrators, the legal implications, and the means of its prevention should be widely publicized. Brochures, visual explanations, and parenting manuals are available to support them. Parents should ask the child to report any suspicious behavior by adults or older children. Children’s accounts must not be neglected, and the child should be assured not to feel guilty. The child aged between 3 and 5 years can be told what is “good” touch or “okay touch,” and “bad touch,” and places over the body where nobody except the mother can touch or clean. Children between 10 and 13 years age group should be informed about body parts, differences between boys and girls, what privacy and private parts mean. Adolescents need more detailed knowledge of body physiology, sexual intercourse, pregnancy, healthy relationships, and sexual violence, which is best provided at schools by trained teachers. In schools in India, under the “Health and Wellness Curriculum”, teachers use creative ways to teach children about adolescent health, including puberty.

To conclude, healthcare professionals are often the first contact for CSA victims and thus need to have the expertise for its adequate clinical evaluation and treatment and be knowledgeable of the legal aspects. A multidisciplinary response is required for comprehensive management that includes psychological support to the victim and the family. Parents, school teachers, and the civil society at large must overcome the traditional inimical attitudes of silence and shame and take appropriate educative measures to prevent CSA.

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