SPECIAL ARTICLE

Child Sexual Abuse: Management and Prevention, and Protection of Children from Sexual Offences (POCSO) Act

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Child Sexual Abuse is an alarming reality and is being increasingly reportedin India as well as globally. Pediatricians and allied medical professionals are often the first point of contact with abused children and their families. They have a key role in detecting Child Sexual Abuse, providing immediate and long-term care and support to the victims and their families. India has adopted the Protection of Children from Sexual Offences Act (POCSO) in 2012. It is a comprehensive law on sexual abuse, which expands the scope and range of forms of sexual offences, makes reporting of abuse mandatory and defines guidelines for the examination of victims. Pediatricians and health care professionals need to acquire necessary expertise for clinical evaluation of child sexual abuse, and its prevention, management and reporting.

Keywords:*Child Abuse, Legislation, Management, Prevention.*

Child sexual abuse (CSA) includes all types of sexual victimization of children – penetrative or non-penetrative sexual intercourse, pornography, sexual harassment, commercial sexual exploitation, sex tourism and online exploitation [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 offences [2]. In recent years, CSA has assumed global concern [3,4]. Whereas CSA has been mostly reported from economically affluent countries, it may be more common in developing countries. A recent epidemiological study mentions that the prevalence rates of CSA in Europe, America and Asia were 9.2%, 10.1% and 23.9%, respectively [4]. CSA is influenced by socio-cultural practices and frequently goes unreported, as a culture of secrecy, fear of indignity and social embarrassment prevents disclosure of such offences. Moreover, minor forms of CSA are mostly ignored.

Sexual violence takes place in all settings: at home, schools, child care institutions, places of work and in the community. Information on the prevalence and forms of CSA is very scarce and difficult to obtain. In a study carried out under the aegis of the Ministry of Women and Child Development (2007) interviewing 1,25,000 children in 13 Indian states, it was found that sexual abuse had taken place in about half of them [5]. Boys were equally affected and more than 20% were subjected to severe forms of abuse. 10,854 cases of child rape were reported from India in 2015, according to National Crime Records Bureau. Several reports indicate that neighbours, friends, close relatives, and acquaintances and employers at workplaces are the most common abusers. The Delhi High Court observed that in 2014, of the 1704 cases of rape registered in the Capital, 215 cases were instances of incestuous rape. Acts of CSA are usually repeated over varying periods and may cause serious short- and long- term adverse effects [6].

A majority of health care professionals are not trained to examine and manage a case of CSA. It isimportant that they acquire the necessary expertise. This communication describes the management of CSA, focusing on medical history, physical examination and forensic aspects. Physicians also need to be aware of prevention of CSA and the POCSO Act, which clearly mentions their responsibility in the management of CSA.

INITIAL MANAGEMENT OF CHILD SEXUAL ABUSE

Every case of sexual assault is a medical emergency for which free treatment is mandatory at government or private medical facilities, and no document or precondition is necessary for providing emergency medical care.

A victim of CSA may approach a health facility directly for treatment, with a police requisition after police complaint, or with a court directive. The hospital is bound to provide treatment and conduct a medical examination with consent of the child/parent/guardian, depending upon the age of the child. The victim may or may not want to lodge a complaint, but requires medical examination and treatment. In such cases, the doctor is bound to inform the police as per law. However, neither court nor the police can force the survivor to undergo medical examination without an informed consent of the child/parent/guardian. If the victim does not want to pursue a police case, a medico-legal case (MLC) must be made and an informed refusal documented.If the victim has reported with a police requisition or wishes to lodge a complaint later, the information about MLC number and police station must be recorded.

MEDICAL EVALUATION OF A CHILD SUBJECTED TO SEXUAL ABUSE

An informed consent must be obtained, which is required for examination, collection of samples for forensic examination, treatment and police intimation. If the child is over 12 years of age, consent should be sought from the child. For those below the age of 12 years, a parent or the guardian is required to providing it. Such consent should be informed and the person providing the consent should be clearly explained the purpose, expected risks, benefits and any adverse effects of the examination, and the amount of time it will consume. This information should be provided before the examination is conducted [7-9].

Medical History

The diagnosis of CSA is most often based on the history, as opposed to physical findings; and thus obtaining a meticulous history of the child's experience is crucial. The interview should be conducted in a facilitative, non-judgmental and empathetic manner and should not have an investigative tone, which is the domain of the police and courts. The history includes the family's psychosocial background. The child's developmental level is assessed. The questions and the child's responses are recorded verbatim. The body language, demeanor and emotional responses are noted. The likelihood of behavioral complaints and physical findings that may suggest sexual abuse should be considered. Past medical history, incidents of abuse or suspicious injuries, and menstrual history should be documented. Information is obtained about the child's behavior, specially sexualized behaviors and in young children, the names the child uses for body parts (breasts, vagina, penis,anus). Leading and suggestive questions are avoided and expression of strong emotional responses such as shock or disbelief is resisted. A review of systems is done focusing on any anal and genital complaints such as bleeding, discharge, pain, or past genital injury. The history of sexual abuse is ideally obtained without the presence of the parent or caregiver. The child and the parents should be informed and reassured that the pediatric forensic examination is not invasive or painful and that internal instrumentation or speculum insertion is carried out only when considered essential.

Examination

Doctors are legally bound to examine and provide treatment to survivors of sexual violence. Timely reporting, documentation and collection of forensic evidence are important toward investigation of the crime. Police personnel should not be present during any part of the examination.Where the victim is a girl, the medical examination has to be conducted by a woman doctor in the presence of the parent of the child or any other person in whom the child reposes trust or confidence. If such a person cannot be present, the examination is conducted in the presence of a woman nominated by the head of the medical institution.The elements of physical examination include particular attention to the following

- calming the child during examination
- positioning for optimal exposure of prepubertal genital structures: frog-leg supine position, knee-chest or left lateral decubitus position
- general observation and inspection of the anogenital area, looking for signs of injury or infection and noting the child's emotional status.
- examination of mons pubis, labia majora and minora, clitoris, urethral meatus, hymen, posterior fourchette, and fossa navicularis.
- visualization of the more recessed genital structures, using handheld magnification or colposcopy as necessary.
- collection of specimens for sexually transmitted disease (STD) screening and forensic evidence collection.

It is important realize that physical examination in CSA is very likely to be within normal limits in most cases. The absence of abnormal findings can be explained by several factors. Many forms of sexual abuse do not cause physical injury. Thus, sexual abuse may be non-penetrating contact and may involve fondling, oral-genital, genital or anal contact, as well as genital-genital contact without penetration. Mucosal tissue is elastic and may be stretched without injury, and superficial abrasions and fissures can heal within a few days. The perpetrators are very often known to the child and family and the use of physical force is rarely a major component in CSA as in adult sexual assaults. Disclosure of abuse is often delayed for weeks or months, and by that time any physical evidence may be absent. The abnormal findings observed may be attributable to acute injury incurred during the recent episode or indicative of residual effects following repeated episodes of genital contact in the past.

Investigations

The following investigations are routinely carried out:

- Gram stain of vaginal or anal discharge
- Genital, anal, and pharyngeal culture for Gonorrhea
- Genital and anal culture for *Chlamydia*.
- Serology for syphilis
- Wet preparation of vaginal discharge for *Trichomonas vaginalis*
- Culture of lesions for herpes virus
- Serology for HIV (based on suspected risk)

Collection of forensic evidence employing the Rape Kit and Urine toxicology screen (if the abuse or assault was likely to be substance-facilitated) may be required.

FORENSIC EXAMINATION

Forensic evidence includes blood, semen, sperm, hair or skin fragments that could link the assault to an individual person, as well as debris (*e.g.,* carpet fibers) that could help to identify the location. Collection of specimens and material should be done if sexual contact has occurred within 96 hours of the physical examination. The purpose of a forensic examination is to ascertain the following:

- whether a sexual act has been attempted or completed. Sexual acts include the slightest genital, anal or oral penetration by the penis, fingers or other objects as well as any form of sexual touching. The absence of injuries does not imply consent of the victim for the act.
- whether the sexual act is recent and if any injury has been caused to the child's body.
- the age of the survivor in cases involving of adolescents.
- whether alcohol or any other intoxicating substances have been administered to the child.

MANAGEMENT

Emergency medical care must be provided in a case of CSA. Police or magisterial requisition is not required for that purpose. The management of CSA includes the following:

- Treatment of sexually transmitted diseases (STDs) is carried out with appropriate medications.
- In post-menarchal girls, the likelihood of pregnancy and the need for emergency contraception is considered.
- Emotional support is provided.
- CSA, whether confirmed or strongly suspected, must be reported to the appropriate authorities.
- Detailed, well-documented medical records must be kept, since these are crucial in legal proceedings, which may take place after a lapse of long periods.
- Referral to a mental health specialist should be made in all cases, which is required for evaluation and treatment of acute stress reaction, and subsequently posttraumatic stress disorder (PTSD). Referral to other specialists should be made as required.

Proper collection of material, depending upon the history of sexual violence, is of utmost importance for medicolegal purposes. Such assault can be peno-vaginal, peno-anal, peno-oral, masturbation and use objects for penetration. Thus the material can be semen, fecal matter, lubricant, saliva and hairs. Detailed instructions about collecting forensic evidence are provided by the Ministry of Health & Family Welfare, Government of India [9,10]. The material should be properly packed, sealed, labeled and sent to the police.

One Stop Centers (OSC)

The Ministry of Women & Child Development, Govt. of India is establishing One Stop Centers (OSC) to provide support and assistance to victims of gender violence [11]. Thus, comprehensive services, including medical, police, psychosocial counseling, legal aid, shelter, referral and facilities for video-conferencing are provided 'under one roof.' For those below 18 years, these are undertaken in coordination with authorities under the Juvenile Justice Act, 2011 and the POCSO Act, 2012. The scheme is centrally sponsored with 100% financial assistance.

Role of Mental Health Professionals

Mental health professionals have an important role in assisting the child and the family during examination and for comprehensive management of CSA. Victims of CSA are vulnerable topsychoemotional distress and may have a tendency to self-harming behavior. Experts can counsel the child and help to reduce the emotional burden of trauma. Appropriate measures must be taken to prevent further abuse, trauma and re-victimization.

PREVENTION OF CHILD SEXUAL ABUSE

CSA should be considered a preventable crime. The society must shed old traditions of silence, shame and embarrassment and act against this most reprehensible violation of child right and dignity. Whereas the parents have the chief responsibility of protecting their children, they must be supported by the civil society. Information about the prevalence of CSA, its occurrence in all societies and particularly who are the common perpetrators, legal aspects and the ways for its prevention should be widely disseminated.The parents should know the facts about CSA and take every care to watch over the child and never leave them unsupervised. The child aged between 3-5 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. Older children should be informed about body parts, differences between boys and girls, and issues of privacy. Such communication may appear difficult, particularly when using expressions for body parts and 'how babies are born', but most parents find their own ways once they understand the importance of empowering the child. Brochures, graphic descriptions and parental guides are available to help them [10].

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. This information can be packaged as health and family life education, thus avoiding the term 'sex education'. The parents should ask the child to report any unusual behavior by adults or older children. Their accounts must not be ignored and the child never made to feel guilty.

CSA is frequently reported from Children's Homes, work places and schools. Institutions must be closely supervised by independent agencies and records of their inspections maintained. The staff at these homes should be carefully selected. School authorities and teachers should be informed about CSA and strict vigilance needs to be maintained. Improper use of internet and mobile phones may put the children at the risk of sexual misconduct.

CHILDLINE 1098: This is an emergency telephonic helpline, which can link children in situations of abuse and neglect with sociolegal services. It is operational in more than 400 cities and districts across the country (India) and has proven to be of great help. Medical professionals and others should be aware of this telephone helpline, and call it to refer cases of known or suspected child abuse or neglect. Clinics and hospitals should prominently display the Childline telephone number (1098).

THE LAW ON CHILD SEXUAL ABUSE

In November 2012, India adopted The Protection of Children from Sexual Offences Act (POCSO) meant to provide for protection of children from the offences of sexual assault and safeguarding the interest and well being of children [2]. It clearly describes various forms of sexual misconducts including actual or attempted sexual intercourse, oral sex, fondling sexual parts, pornography and inappropriately photographing. POCSO is a comprehensive law, which besides expanding the scope and range of forms of CSA, makes its reporting mandatory and gives guidelines for various actions by the police and at courts. Physicians are made responsible for ensuring prompt and adequate response to child victims.

The Act includes child-friendly mechanisms for reporting, recording of evidence, investigation and speedy trial of offences through designated Special Courts. It deems a sexual assault to be 'aggravated' when abuse is committed by a person in a position of trust or authority *vis-a-vis* the child, such as a family member, police officer, teacher, or doctor [1,2]. Different levels of punishment are included, which are more stringent in cases of aggravated assault.

Mandatory Reporting

The Act calls for mandatory reporting of sexual offences so that the doctor or any other health care professional who has the knowledge that a child has been sexually abused is obliged to report the offence, failing which he may face legal punishment (6 months imprisonment and/ or fine (Sections 19 and 21 of the POCSO Act).It does not lay down that the mandatory reporter has an obligation to inform the child or his parents or guardian about his duty to report. While making the mandatory report, the doctor or other health professional should describe the nature of the abuse and all involved parties. The reporter is not expected to investigate the matter, or even know the identity of the perpetrator, which are left to the police and other investigative agencies.

Multidisciplinary Approach

The POCSO Act envisages a multidisciplinary approach that will be conducive to medical care and justice delivery for a sexually abused child. This can be achieved through coordination and convergence between all key stakeholders such as Juvenile Police Units, Child Welfare Committees, District Child Protection Units, health professionals, mental health professionals including psychiatrist, psychologist and counsellors, child developmental experts, medical social workers, advocates, magistrates and members of legal profession. The components of comprehensive health care response to sexual violence, as per Guidelines & Protocols of the Ministry of Health and Family Welfare [8], include first aid, informed consent, history and examination, collection of forensic material and its further handling. Appropriate treatment of injuries is carried out along with management of sexually transmitted infections, HIV testing and prophylaxis, and emergency contraception if indicated. Referral to other specialists is made if required.

WHO GUIDELINES

The World Health Organization has recently published guidelines providing evidence-based, quality, trauma-informed care to children and adolescents who have been sexually abused [12]. Their observations and recommendations are particularly aimed to assist front-line healthworkers in low-resource settings.

CONCLUSIONS

CSA is a particularly reprehensible criminal act. The practice is globally prevalent and occurs in all societies. Pediatricians and other health care 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 multi-disciplinary response is necessary for comprehensive management that includes psychological support to the victim and the family. The Government of India's Act for Prevention of Children from Sexual offences Act (POCSO, 2012) defines CSA and lays down responsibilities of physicians and gives management guidelines and legal procedures. 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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