"SAFE CHILDHOOD - RIGHT OF EVERY CHILD"

Child Rights, Safety & Child Protection

Editors
DR ASHOK KUMAR P., DR RAJEEV SETH, DR ABY DANY VARGHESE

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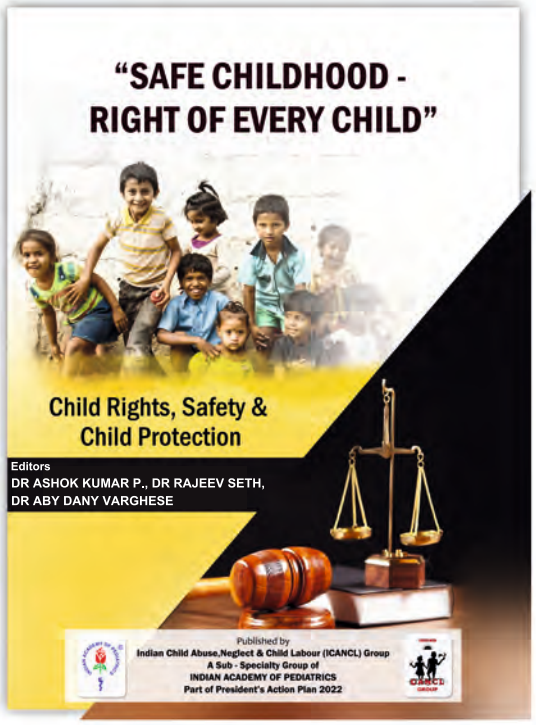

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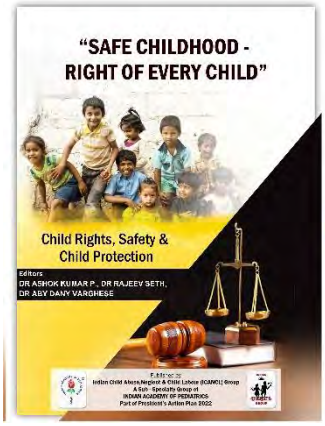

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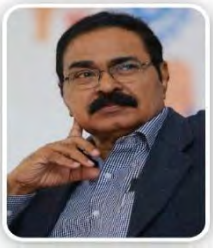

FOREWORD

I am honored to write foreword for this unique book on "SAFE CHILDHOOD - RIGHT OF EVERY CHILD" focusing on Child Rights, Safety & Child Protection ably edited by Dr. Ashok Kumar P, and colleagues. The book is published by the Indian Child Abuse, Neglect & Child Labour (ICANCL) Group – a sub-specialty group of Indian Academy of Pediatrics (IAP) as a part of IAP President's Action Plan-2022.

Child rights, safety and protection have been a priority of United Nation (UN) agencies and major international nonprofit organization for some time now. The Constitution of India have provided adequate provisions for the implementing the child rights, safety and protection. It is now the duty of every pediatrician to put their heart into it, without any reservation. Intention to do something, do not necessarily get translated to action and for this knowledge, adequate skills and right attitude are required.

As a parent each one of us are concerned about our children's safety and protection, but do not realize that we need to empower our children and adolescents first, then the parents and teachers, to optimally utilize the programs of Government agencies, ably supported by sensitized health & social justice personnel, NGO's, Police, Lawyers and finally the Judiciary. The eminent authors from different parts of India have made sure that the book provided a state of the art work on safe childhood.

I take this opportunity to congratulate Dr. Ramesh Kumar, President CIAP 2022, the Executive Board of Indian Academy of Pediatrics, the editors and eminent authors from all over India for their outstanding efforts.

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PREFACE

Over the years, during my work as a member of Indian Academy of Pediatrics, my concepts and thought processes revolved around clinical pediatrics only (primary health care, immunization, nutrition, developmental delay, disability, life skill training in Schools etc.), with limited idea of social pediatrics. As a member of ICANCL group, my exposure and interests turned over to Child rights, Exploitation, and Child Protection. Dr. Remesh Kumar, President IAP 2022 expressed a thought on developing a module on child rights for the pediatricians. Working together with many seniors in the ICANCL group helped me to conceptualize an idea on Child Right, Child Safety and Child Protection. This idea was further refined after a few focused group discussions with a small group of interested colleagues. Despite these were very wide topics, we did our best to compile these three big topics into a single module. The module was launched on 27th February 2022 on the dIAP Platform. Later zonal workshops were also conducted. During the course of preparing the materials for this module, there was a suggestion that we should bring out a book on these topics. And that is how this book has come about!

First of all, I wish to express my sincere gratitude to Dr. Remesh Kumar, President IAP 2022 and the team CIAP in giving us an opportunity to conduct workshops as a part of CIAP Presidents Action Plan 2022 and later publish this book. This book would not have been a success without the wholehearted support of my fellow contributors: Dr. Aby Dany Verghese, Dr. Gunjan Baweja, Dr. Sudershana Skanda, Dr. Chhaya Prasad, Dr. Preeti Galagali, Dr. Mousumi Sen, Dr. Jayesh Panot, Dr. Pradnya Jhadav, Dr. Thangavel and Dr Rajeev Seth. Along with Dr Aby Dany Verghese, Dr Rajeev Seth, my senior mentor joined hands with tremendous efforts in editing and bringing out this book. Special thanks go to Dr. Rajeev Seth & Dr Aby Dany Verghese who supported me in completing this work as my co-editors. They made my work quite easy. My teacher and guide throughout my career, Dr. M.K.C Nair readily accepted to write a forward to this book. I would always be grateful to him. My mentors in ICANCL group, Dr. Rajeev Seth, Dr. Jagdeesh Narayana Reddy, ICANCL Chairperson Dr. Sandhya Khadse, Secretary Dr. Uma Nayak and a whole lot of colleagues helped and supported in the completion of this task.

The aim of the present book to simplify the understanding and concepts of Child Rights, Child Safety and Child Protection. We anticipate this book will be useful to pediatricians, and allied medical professionals in helping them in their work to realise child rights and protection. Lastly, I thank Micro Labs for supporting us in the publication of this book.

Jai IAP
Dr. Ashok Kumar P.

From CIAP Presidents' Desk

As the President, Indian Academy of Pediatrics, 2022, I am extremely happy to pen down a few words as an Introduction I Forward to this book on Child Rights, Safety & Child Protection. IAP always stands for overall development and wellbeing of Children of the country. Childhood is often described as a 'golden age' that is full of innocence, freedom, joy and play; an age without responsibilities and stress. Most parents genuinely desire and attempt to fulfil this concept of childhood. The knowledge and certainty in their own safety is an important part of children's social and emotional development. A child that feels safe will be more able to explore and experience the world around them, and more able to learn. Paediatricians are the professional who interact with children and their families throughout the childhood and are the right persons to guide them. The Sustainable Developmental Goals by UN focus on all areas related to safety, children in particular. In this context, IAP Presidential action Plan 2022 has included this module on Child Rights, Safety & Child Protection. Dr. Ashok Kumar P. and his team has prepared a very useful module and conducted several zonal workshops with very good attendance. Compiling the materials of this module was presented to me and I was extremely happy to accept it, since we are short of good publications in the area of child rights and protection.

I wish to congradulate the team lead by Dr. Ashok Kumar P., Dr. Aby Dany Varghese, Dr. Gunjan Baweja, Dr. Chhaya Prasad, Dr. Preeti Galagali, Dr. Sudharsana Skanda, Dr. Mousumi Sen, Dr. Jayesh Panot, Dr Pradnya Jadav and Dr.A Thangavel. The team was ably guided by starwalts like Dr. M.K.C. Nair, Dr. S.S. Karnath, Dr. Rajeev Seth, Dr. Jagadeesh Narayan Reddy, Dr. Sandhya Khadse and Dr. Uma Nayak, which shows the credibility of this publication. I am sure that this book will be a useful guide for all pediatricians in the future.

Dr. R. REMESH KUMAR
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Dr Ashok Kumar P

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According to the World Health Organization, health is "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity".[1]

When we consider the health of a child, another dimension also exists, that he/she should be able to reach his/her full potential. We, Pediatricians as individuals and the Indian Academy of Pediatrics (IAP) as an organization, have a responsibility to see that children of our country get an opportunity to reach their full potential. Over the last 60 years, our efforts have focused more on physical and mental health to a certain extent. In the social and emotional well-being of the children, our involvement was very limited. The time has come that pediatricians and allied medical professionals have to think of involving themselves more in providing comprehensive health care, which includes addressing social determinants of health in order to achieve our national targets set aside under the UN Sustainable Development goals (SDG) (2).

All children deserve a happy childhood and the opportunity to lead a dignified life free from violence, exploitation, neglect, deprivation and discrimination. India is a young nation with more than 444 million children (3). Protection of children is not only a matter of their human rights, but also an investment towards building a developed nation. Children and childhood worldwide have broadly been construed as a 'golden age' synonymous with innocence, freedom, joy, play and the like. However, it is also true that children are vulnerable, especially when very young. Pediatricians are the first point of contact with the children and their families. Parents trust their pediatricians to help and guide them throughout their life since the parents will take our words in letter and spirit.

The aim of the present book is the following:

(a) To simplify the understanding of the following three areas of clinical importance; Child Rights, Child Safety and Child Protection;

(b) To provide a background and rationale about each one of the above three modules;

(c) To help practicing pediatricians, doctors & allied medical professionals in realizing child rights and protection.

Child Rights

The United Nations Convention on the Rights of the Child (UNCRC) is the most comprehensive international document on children's rights. India accepted & signed UNCRC in 1992 (4). According to UNCRC, every one under the age of 18 is referred to as a child.

The UN CRC is primarily concerned with the following four (4P) principles of children's rights:

- Provision of assistance to children for their basic needs.
- Prevention of harm to them;
- Protection of children against discrimination and all forms of neglect and exploitation
- Participation by children in decisions affecting them;

Child Safety

A safe and healthy environment for all children is vital for their healthy growth and development (5). Children are susceptible and vulnerable due to their age, difficulty in risk perceptions, impulsivity and risk-taking behaviors.

Typically, injuries are classified based on intent as:

1. Unintentional
2. Intentional.

Unintentional Injuries include road traffic injuries (RTIs), falls, burns, drowning, mechanical injuries, falls of objects and sports injuries, among others. Intentional injuries include those that are caused due to interpersonal conflict, violence against children, intimate partner violence (IPV), suicide, deliberated self-harm and child maltreatment among many others.

In 2017, unintentional injuries in the age group of 0-14 accounted for 652,664 deaths globally, accounting for nearly 10.6% of all deaths in that age group. In addition to the deaths, millions of children require hospital care for non-fatal injuries. The injury leaves many children with some form of disability; for some, it

has life long consequences. Nearly 36.23 million DALYs (disability-adjusted life year) were lost worldwide due to injuries among children aged 0-14; 17.6% were accounted for by India alone (6, 7). India accounted for 11.1% of all unintentional injury deaths globally. Unintentional injuries accounted for nearly 7.2% of all causes of deaths and nearly 6.3 million DALYs among children below 14 years of age.

Child injuries are a growing public health problem in India, with nearly 5,00,000 child deaths in the last decade. Three unintentional injury deaths are reported for every intentional injury death among children. Children account for 15% of total injury deaths. Everyday, about 165 children die in India due to unintentional injury. The proportion of child injury deaths at the site of injury in rural areas (58%) was higher than in urban areas (33%). Nearly 41% of all fatal injuries occurred on roads, followed by 31% at home. Road crashes/accidents are India's most common cause of child injury deaths. Road Traffic Injuries (RTI) accounted for 37-38% of deaths among 0-14 years and 62-64% among 14-18-year-old children. Burns and drowning accounted for 10-11% and 13-19% of all deaths respectively. Falls and poisoning injuries accounted for 5-6% of all deaths among children.Nearly 44% of all child injury deaths occurred at the site of injury, followed by 37% in the hospital and 18% during transit to the hospital. Half the child injury deaths can be prevented with efficient trauma care systems. Nearly 10% of injured children experience temporary functional limitations varying from one week to several months. About 2% of children are left with a permanent disability, and 12% live with long-term(>6 weeks) temporary disability

Children are particularly vulnerable to accidents, and their safety requires different approaches from those of adults. No one device or solution can prevent all types of accidental childhood injuries. Instead, child safety requires a multifaceted approach, which includes educating adults and children about risks, designing safe environments, conducting research, and advocating for effective laws. Education is one of the main pathways to improving child safety and requires the involvement of parents, caregivers, children, healthcare practitioners, policymakers, and other target groups to increase knowledge and change attitudes and behavior. Some areas in which education about risks is crucial include using seat belts in automobiles and helmets while bicycling and for other activities, the importance of not leaving young children unattended, and keeping plastic bags, choking hazards,and toxic materials out of the reach of children.

The massive number of traffic accidents during the 20th century inspired efforts to build safer cars and child restraints (e.g., car seats) to ensure children travel safely.The correct use of child safety seats in passenger cars can reduce the risk of death from car accidents by as much as 71% for children less than one year of age. Likewise, helmets can significantly reduce the risk of brain injury from bicycling accidents.

Certain everyday household objects can be hazardous to children. Small objects and plastic wrappings or bags left with children are choking hazards, and toxic products, such as cleansers can result in poisoning. Many injuries are also caused by falls, both outside and inside the house, and often these incidents can be prevented by using simple child safety devices such as safety gates for stairways. Child safety is just as important in the context of the Internet as in the physical world. The easy access to online communities and cases of children being bullied or pursued online by pedophiles have sparked much discussion about how best to monitor and keep children's interaction online safe?

Safety policies and programmes

Various policies and legislations to promote safety and prevent injuries among children are present in India, however, several challenges exist in their implementation challenges. The existing guidelines, legislations/standards need strict implementation calling for strengthening mechanisms at the local levels. These include the supreme court guidelines of safe travel to schools (1997), safety of school children in a school bus as per CBSE guidelines (2017), fire and life safety guidelines as per the national building code (2016), National Disaster Management Authority School Safety Policy Guidelines (2016), Guidelines for School Infrastructure and Strengthening (2014), Council for Indian School Certificate Examination (ICSE): School Safety Manual (2018), Manual on Safety and Security of Children by National Council for Protection. of Child Rights, Rashtriya Kishor Swasthya Karyakram (2014)by Ministry of Health and Family Welfare, POCSO Act (2012), and the recently amended Motor vehicles amendment bill (2019) and several state directives.

Child safety is the joint responsibility of governments and their various ministries/departments, industries, school managements, citizens and all others. Children need to be made safe in all places they are present. Implementing existing policies, programmes and legislations is the first step and key to reducing child injuries in India

Child Protection

What is Child Protection?

Child protection refers to strategies and structures to protect children from abuse, exploitation, neglect and violence. Such child maltreatment of children includes early marriage, child labour and other forms of exploitation and all forms of abuse including sexual abuse and physical violence against children in homes, schools and wider communities (4). It is closely linked to the better care of children, which involves ensuring that more children grow up in safe and caring families or when this is not possible; have a range of high-quality alternative care choices available to them (8).

Child Protection is embedded in Convention the Rights of the Child (UNCRC) and the Sustainable Development Goals (SDGs) (2). Over 1 billion children experience violence every year. The world has made significant progress in education, nutrition and child health in the past decade, yet, India has been ranked 112 in the Child Development Index. The Constitution of India and various Union and State Laws have provided a legal framework that ensures all children have a safe and nurturing context to enjoy their childhood.

What is a Child Protection System?

A child protection system aims to address all forms of abuse, exploitation and neglect in a coordinated manner. Child protection systems include: "the set of laws, policies, regulations and services needed across all social sectors–especially social welfare, education, health, security and justice–to support prevention and response protection related risk." (2, 8)

Key components of a successful child protection system include: a legal framework, national strategy and coordinating body; local protection services; a well-trained child welfare workforce; a strong focus on community and child participation; adequate resources and monitoring and data collection systems (8,9)

Legislations for Child Protection in India

1. Juvenile Justice JJ Act 2015

2. The Protection of Children from Sexual Offences Act 2012
3. Right of Children to Free and Compulsory Education Act, 2009
4. The Prohibition of Child Marriage Act,2006
5. Commission for Protection of Child Rights Act 2005
6. The Child Labour (Prohibition and Regulation) AmendmentAct,2016
7. Pre-Conception & Pre-Natal Diagnostic Techniques (PCPNDT)Act1994

The consequences of Child Protection Violations are Catastrophic–profound, enduring and often deadly for children – with economic costs of violence against children estimated at $7 trillion annually (10). We must understand that child protection violations are preventable: progress can be made through political will, societal change and the emerging science of prevention and treatment strategies. The primary focus of this strategy is prevention. Our ambition is to scale up evidence-based prevention approaches to the population level–not only in the core Child Protection Sectors of Social Welfare and Justice but also in Education, Health, Social Protection and other sectors with strong and clear accountabilities to deliver child protection outcomes. This includes universal access to justice, family and parenting support, safe schools and safety online, and universal adoption of transformative norms and values.

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OVERVIEW OF CHILD RIGHTS, LEGAL FRAMEWORK, VIOLATIONS AND THEIR EFFECTS ON CHILDREN

2

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WHO IS A CHILD?

As per the United Nations Convention on the Rights of the Child (UNCRC), a child is defined as anyone who has not attained 18 years of age (1)

WHAT ARE RIGHTS? WHAT IS THE DIFFERENCE BETWEEN RIGHTS VS NEEDS?

Children have basic needs to be fulfilled to survive and develop to their fullest potential. All children have every day needs irrespective of their socio-economic and cultural background. They require adequate food, health care, education, protection from abuse, and a safe and respectful growing environment.

These needs (e.g. need for education) become rights when they are put into legally binding human rights treaties/legislation. The need for education becomes a right through RTE Act 2009. The Right of Children to Free and Compulsory Education Act, 2009 (commonly known as the Right to Education Act or RTE) was enacted by the Parliament of India on August 4, 2009. This landmark legislation outlines the modalities for providing free and compulsory education to all children between the ages of six and fourteen years in India, as mandated by Article 21A of the Indian Constitution (2).

Needs and 'rights' are mutually interdependent. All child rights are based on three core principles - dignity, equality and respect. **All rights are dependent on each other and are indivisible**

'Right' recognizes a child's entitlement to fulfill their' needs'. This put obligations on state/adults at all levels to take the necessary action to ensure that those rights are implemented for every child. UNICEF says **- "Every right, for every child."** (1)

There is a misconception that 'Rights' are a 'Western' concept and that 'Children's Rights' encourage children to be too individualistic, always 'getting what they want, without regard for their families or communities. This thought process has to

change!

The approach based on child 'rights' rather than as a favor or charity is grounded in obligations and accountability, working with children, not just for them but also respecting their human dignity. It is more universal, holistic, respectful and sustainable rather than addressing them as needs only

A' child-focused' or 'child- centered' is not the same as a child rights approach. A child is not an object, 'beneficiary' or 'victim' for whom decisions are made, but a child is the holder of rights. Rights are the entitlements and freedom that should be accorded to all below 18 years of age regardless of race, color, gender, language, religion, opinions, wealth, birth status or ability.

CONCEPT OF EVOLVING CAPACITIES OF A CHILD

- As children grow older, they become more able to understand their lives and make decisions that affect them.
- This happens gradually and at different speeds, and it depends on a child's experiences, education, maturity, environment etc.
- A child's ability – or capacity – to make a reasoned decision will depend on the decision being made. Thus, evolving capacity is a term used to refer to the increasing ability to make reasoned decisions in different parts of a child's life. The various legal frameworks are based on this concept.
- This concept appears in UNCRC- Articles 5 and 12 (1)
- Taking into consideration of the evolving capacities of a child, we can say that Child is NOT an object of protection and introduces the prospect of the child as a rights-holder
- This also recognizes that as children grow and develop, their capacities evolve, and parents must adjust their direction and guidance to enable their children to exercise their rights
- There is a change in the traditional parent-child relationship, in which parents were the primary rights-holders, and the child was a passive recipient of protection and care.
- Now there is a Direct relationship between State and the child, and parents must adjust their direction and guidance to enable their children to exercise their rights

CHILD RIGHTS VIOLATIONS AND THEIR EFFECTS

- Child rights violation is a broad term that encompasses violence, exploitation, abuse, and neglect against children
- It can even be stretched to include poverty, discrimination against girls, orphans,

migrants, refugee children

- Violation can occur in any setting, e.g., home, school, community, childcare institutions
- Examples of child rights violations are: Child labour, child marriage, sexual abuse, lack of access to primary education, lack of access to healthcare or clean water or food
- Children are the most vulnerable group in society and are prone to rights violations directly or indirectly
- It has been documented that anxiety and depression tend to arise more frequently among abused children, physically or psychologically (Norman et al) .
- The most tragic and extreme consequence of child abuse and neglect is that which results in death. The World Health Organization (WHO) estimated 31,000 homicide deaths of children aged 15 or younger around the world occur every year (3). The possibility of deaths caused by abuse and neglect go unreported due to being misattributed to other causes such as falls or insufficient investigations and a failure to run post-mortem examinations.
- It has been found that students who are victims of physical or psychological abuse tend to have worse educational outcomes
- "Toxic stress" in the early years in response to abuse, the hormones associated with the fight-or-flight response (e.g. cortisol) can inhibit physical growth and the children's susceptibility to illness (4).
- These can impair the development of neural connections in parts of the brain that are critical for learning
- Gilbert et al. found that children exposed to abuse and neglect are at increased risk of inflicting pain on others and developing aggressive and violent behaviors in adolescence, and these are among the most consistent predictors (5).
- Miller et al. found that all forms of maltreatment were associated with adolescent suicidal ideation and suicide attempts (6).
- Meta-analyses of 21 studies of child sexual abuse reported that this form of abuse more than doubled the risk of adolescent pregnancy (7).
- Child labour- no access to education- not aware of rights- forms a cycle that continues
- Young people who are removed from the care of their parents because of abuse or neglect may also face homelessness and unemployment soon after leaving out-of-home care. Evidence suggests that all types of child maltreatment are significantly related to higher levels of substance use (tobacco, alcohol and illicit drugs)

FRAMEWORK OVERVIEW OF THE RIGHT TO EDUCATION

This section will attempt to summarize various international and national instruments that deal with the right to education.

a) International Framework for Education

1. United Nations Convention on Rights of the Child (UNRC), 1989

UNRC is a legally binding international instrument to incorporate human rights, civil, cultural, economic, political and social rights (1). Protection of child's rights as laid down in the convention is pursued worldwide, setting standards in health care, education, and legal, civil and social services. The core principles of the convention are the right to life, survival and development, non-discrimination and the child's best interest. India ratified the UNCRC in 1992. **Articles 28 and 29 are relevant to education.**

Article 28 deals with

- Free compulsory primary education for all
- Development of secondary education
- Accessibility of higher education
- Regular attendance in school and reduce dropout

Article 29 deals with the purpose of education of the child, such as

- development of personality, talents and mental and physical abilities
- development of respect for human rights and fundamental freedoms
- development of respect for a child's parents, their own cultural identity, language and values, for the national values of the country child is living, the country from which they may originate and for civilisations different from their own, preparation of the child for responsible life in a free society
- in the spirit of understanding peace, tolerance, equality of sexes and friendship among all people.

2. United Nations Convention on the rights of Persons with Disabilities (UNCRPD), 2006.

This deals with education concerning a person with a disability (8). The disabilities can be physical, intellectual, mental or disabilities caused by chronic conditions. Article 24 lays down the parameters for the education of persons with disabilities, such as

- The inclusive education system at all levels and lifelong learning are directed to the full development of human potential, dignity and self-worth, talents, and creativity enables participation in a free society.

- People with disabilities are not excluded from the general education system based on disability; they receive support within the public education system to facilitate their effective education.
- Enable people with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. Measures like braille learning, alternate script, augmentative and alternative models, sign language, and promotion of linguist identity of the deaf community.
- Employment of teachers, teachers with disabilities who are qualified in sign language or braille
- Access to general tertiary education, vocational training, adult education
- This is fulfilled in India through the The Rights of Persons with disabilities Act 2016.

b) Indian Legal Framework for Education

The Right of Children to Free and Compulsory Education Act, 2009 (commonly known as the Right to Education Act or RTE) was enacted by the Parliament of India. The following below are the background commitments that led to enactment of RTE:

1. The Constitution of India

The demand for free and compulsory education (FCE) echoed throughout the freedom struggle as one of the most important demands. Still, it did not translate into a fundamental right in the Constitution when drafting the Constitution of India (10)

Realizing any of the rights is not possible with a sound education. The State has ensured education to enjoy the rights entitled to everyone.

To sum up, in brief, the parts in the Constitution that mean/stand for the right to education

- Preamble- the core principle of the Preamble stands for social justice and equality
- Article 14- Equality before the law
- Article 15- Prohibition of discrimination
- Article 16- equality of opportunities
- Article 21- right to a dignified life
- Article 21A- right to education 6-14 years (86th Amendment)
- Article 23- prohibition of human trafficking
- Article 24- Abolition of child labour
- Article 37- the State is duty-bound to apply principles in making laws

- Article 39 (e) & (f) – protection of children
- Article 41- the State, within the limits of its economic capacity, makes provision for education
- Article 45- provision of early childhood care and education, i.e. below six years (86th Amendment)
- Article 46- promotion of the educational interest of SC/ST and other weaker sections of society
- Article 51A- parent or guardian to provide education to his child or, as the case may be, ward between ages 6-14 years. (86th Amendment)

2. National Education Policy 2020

The National Education Policy (NEP) will play a critical role in transforming the Indian education system and is expected to help India reap its demographic dividend (11).

Salient features of NEP:

- The policy aims to universalize pre-primary education by 2025 and provide foundational literacy/numeracy for all by 2025
- It proposes a new Curricular and Pedagogical Structure, with a 5+3+3+4 design covering children aged 3-18. Under this, Pre-Primary & Grades 1-2 are considered the foundational Stage; Grades 3-5 as Preparatory Stage; Grades 6-8 as Middle Stage and Grades 9-12 as the Secondary Stage. This is an academic restructuring; there will be no physical restructuring of schools.
- Universal Access & Retention with 100% Gross Enrolment Ratio for all school education by 2030.
- Children learn languages most quickly between 2 and 8 years, and multilingualism has excellent cognitive benefits for students. Therefore a three-language formula has been proposed
- It proposes the teaching of other classical languages and literature, including Tamil, Telugu, Kannada, Malayalam, Odia, Pali, Persian, and Prakrit, in schools
- It aims to consolidate 800 universities & 40,000 colleges into around 15,000 large, multidisciplinary institutions
- The policy proposes three types of Higher Educational Institutions (HEIs): Research Universities, Teaching Universities and Autonomous degree-granting colleges
- It aims to provide autonomy to all higher education institutions. Higher education institutions are to be governed by Independent Boards with complete academic and administrative autonomy
- An autonomous body called the National Research Foundation (NRF) is to be

established through an Act of the Parliament

- To be constituted, Rashtriya Shiksha Aayog or the National Education Commission is - the apex body. It will be chaired by the Prime Minister and will comprise eminent educationists, researchers, Union Ministers, representation of Chief Ministers of States, eminent professionals from various fields
- Ministry of Human Resource Development (MHDRD) to be re-designated as the Ministry of Education (MoE)
- Increase in public investment by the Central and State Governments to 20% of overall public expenditure over ten years

3. Right to Education Act, 2009

The Right of Children to Free and Compulsory Education (RTE) Act, 2009, which represents the consequential legislation under Article 21-A, means that every child has a right to full-time elementary education of satisfactory and equitable quality in a formal school with certain essential norms and standards.

The title of the RTE Act incorporates the words 'free and compulsory'. 'Free education' means that no child, other than a child whose parents have admitted to a school that the appropriate Government does not support, shall be liable to pay any fee or charges or expenses that may prevent them from pursuing and completing elementary education. 'Compulsory education' casts an obligation on the appropriate Government and local authorities to provide and ensure admission, attendance and completion of elementary education by all children in the 6-14 age group. With this, India has moved forward to a rights-based framework that casts a legal obligation on the Central and State Governments to implement this fundamental child right as enshrined in the Article 21A of the Constitution under the provisions of the RTE Act

Main Features of the Right to Education (RTE) Act, 2009

- Section 3: Free and compulsory education to all children of India in the 6 to 14 age group in a neighborhood school till completion of elementary education.
- Section 4: If a child above six years of age has not been admitted to any school or could not complete their elementary education, they shall be admitted to a class appropriate to their age. However, if a case may be where a child is directly admitted to the class appropriate to their age, then, to be at par with others, they shall have a right to receive special training within such time limits. Provided further that a child admitted to elementary education shall be entitled to free education until the completion of elementary education, even after 14 years.
- Section 6: imposed an obligation on the appropriate Government and local authority to establish a school within such areas or limits of the neighborhood as may be

prescribed

- Section 12(1)(c) read with Section (2): Twenty-five per cent reservation for economically disadvantaged communities in admission to Class I in all schools is to be done even if it is unaided, not receiving any grant or aid to meet its expenses from the appropriate Government or local authority
- Section 14: Proof of age for admission: For admission to elementary education, a child's age shall be determined based on the birth certificate issued under the Provisions of Birth. Deaths and Marriages Registration Act 1856, or based on other documents as may be prescribed. No child shall be denied admission to a school for lack of age proof.
- Section 16 and 17: No child shall be held back, expelled or required to pass a board examination until the completion of elementary education. No child will be subjected to physical (Corporal) punishment.
- Section 18: private schools to obtain recognition from the prescribed authority after the commencement of the RTE act 2009 to continue functioning
- Section 22: School Management Committee constituted under section 21 shall prepare a school development plan in a prescribed manner
- Section 23: School teachers will need an adequate professional degree within five years, or they will lose their job.
- Section 25: A call must be made for a fixed student-teacher ratio.
- Section 28: No teacher shall engage themselves in private tuition
- Section 30: A child who completes elementary education shall be awarded a certificate
- Section 31: Monitoring child's right to education

Amendments to RTE Act, 2009

- Section 2/3: Child with disability and severe disability was included in Section 3(Amendment of section 2)
- Section 21/22: Regarding the school management committee.
- The right of children to free and compulsory education was subjected to provisions of articles 29 and 30 of the Constitution of India
- RTE Act will not apply to Madrasas, Vedic Pathshalas and educational institutions primarily imparting religious education
- Section 16/38: There shall be a regular examination in the fifth and eighth classes at the end of every academic year. The appropriate Government may allow schools to hold back a child in the fifth class or the eighth class, or both classes in such manner and subject to such conditions as may be prescribed if he fails in the re-examination referred to in sub-section

4. National Programmes for Educational Development

a) District Primary Education Programme (DPEP), 1994

The World Bank, and European Commission, assist DPEP. The programme takes a holistic view of primary education development. It seeks to operationalize the strategy of UPE through district-specific planning with emphasis on decentralized management, participatory processes, empowerment and capacity building at all levels. The programme is implemented through the State level registered societies. DPEP is a centrally sponsored scheme. 85% of the project cost is shared by the Government of India and 15% by the concerned State government

b) Sarva Shiksha Abhiyan (SSA), 2001-02

Sarva Shiksha Abhiyan was launched in 2001-02. The Sarva Shiksha Abhiyan is known as the Education for All movement or 'Each One Teach One'. It was introduced in 2000-2001 as the flagship programme run by the Government of India. This scheme is framed to provide valuable and relevant elementary education for all children aged six to fourteen by 2010. It aimed to ensure that by 2015 all children in India receive eight years of basic education of acceptable quality, regardless of sex, caste, creed, family income or location. It combines a dual thrust on enrolment and equity with an emphasis on quality. The programme seeks to open new schools in those habitations which do not have schooling facilities within one kilometer (three kilometers in the case of upper primary and strengthen existing school infrastructure through the provision of a classroom for every teacher, a teacher for every 40 pupils, toilets, drinking water, free textbooks, school grants, maintenance grant and school improvement grants.

c) National Programme of Nutritional support to primary Education (Mid-Day Meal Scheme – MDMS), 1995

To give a better Universalisation of primary education (UPE by increasing enrolment, retention and attendance and simultaneously impacting the nutritional level of students in introductory classes. Mid-Day Meal (MDM) is vital in improving children's nutritional status or eliminating classroom hunger. MDM can also play beneficial socialization roles, especially in India's class and caste-ridden society. Sharing meals with children from diverse castes and class backgrounds can help overcome traditional social prejudices.

d) National Programme for Education of Girls at the Elementary Level (NPEGEL), 2003

It was an amendment to the existing Sarva Shiksha Abhiyan (SSA scheme for

providing additional support for the education of underprivileged girls at the elementary level.

e) Navodaya Vidyalaya Samitis (NVS)

NVS is an autonomous organization functioning under the administrative and financial control of the MHRD, the Government of India, which has its headquarters in New Delhi. It was set up to establish and manage co-educational residential schools (courses VI to XII known as Jawahar Navodaya Vidyalayaas per the recommendation of the National Policy on Education, 1986 in each district of the country; Education in these Vidyalayas is free for all enrolled students, including lodging, boarding, textbooks, uniform etc., The primary objective of this Vidyalaya is to promote and develop talented, bright and gifted children predominantly from rural areas, irrespective of their socio-economic conditions, who may otherwise be denied good educational opportunities. These Vidyalayas' are affiliated with the Central Board of Secondary Education (CBSE and impart the CBSE Curriculum.

FRAMEWORK OVERVIEW OF THE RIGHT TO HEALTH

The right to health does not mean only healthcare access and building hospitals. The right to health encompasses all factors that are essential to leading healthy life such as:

- free from non-consensual medical treatment
- access to basic health services and essential medicines
- ensuring the prevention, treatment and control of diseases
- provision of maternal and child and reproductive health
- access to a system of health protection
- provision of health education
- providing a safe and healthy environment
- safe and nutritious food
- adequate housing and sanitation services
- free from torture

a) International Legal Framework for Child Health

The essence of the international legal framework is that these contents are to be recognized and ensured by the State (countries) that sign/accept it.

1. United Nations Convention on the Rights of the Child (UNCRC), 1989

Article 23 and Article 24 are about a child's right to health

Article 23- Children with disabilities have the right to special care and support and all the rights in the convention so that they can live whole and independent lives

Article 24 – Children have the right to good quality health care- the best health care possible- to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this

2. United Nations Convention on the rights of person with disabilities (UNCRPD) 2006

Article 1 mentions that persons with disabilities include long-term physical, mental, intellectual or sensory impairments that may hinder their full and effective social participation on an equal basis in interaction with various barriers.

Article 25 requires the state parties to recognise and implement measures to ensure access for persons with disabilities to health services, including gender-sensitive health-related rehabilitation.

UNCPRD stress the need to design and provide services for prevention and minimizing further disabilities in children through early identification and intervention.

3. World Health Organisation (WHO)

WHO Constitution advocates all its states to ensure measures to improve health. The primary role is to direct international health within the UN system and lead partners in global health responses. The Constitution of WHO states that the attainment by all people of the highest possible level of health is one of the fundamental rights of every human being without distinction of sex, religion, political belief, economic or social condition. The Constitution stresses that the health of all people is fundamental to attaining peace and security, and unequal development in different countries in the promotion of health and control of diseases, especially communicable ones, is a common danger.

b) **Indian Legal Framework for Health**

Along with Constitutional obligations, the Central Government and States have enacted various healthcare policies and laws to ensure a secure healthcare status for children (10,12).

1. The Constitution of India

The framers of the Indian Constitution have made provisions to create and provide

environments that ensure their steady maturing into adulthood (10). Specific provisions directly related to child development in the Fundamental Rights and the Directive Principles of State Policy.

Directive principles of state policy in the Indian Constitution specifically refer to the State's responsibilities towards public health. The duty of Protection includes the level of nutrition and standard of living of its people, improvement of public health, and prohibition of the consumption of intoxicating drinks and drugs.

Among the various provisions in the Constitution (fundamental rights/directive principles of state policy), the following articles can be read specifically in view of the right to health

- The Preamble reflects the terms socialist, secular, democratic and republic are inclusive of health impliedly, as health is such an essential part of human life without which other rights cannot be enjoyed at al
- Article 14- equality before the law
- Article 15- prohibition of discrimination
- Article 15(3)- enables the State to make special provisions for children
- Though article 21 concerns the right to a dignified life, it is understood that the right to life is impossible without adequate avenues for attaining the highest physical and mental health standards.
- Article 23-prohibition of human trafficking
- Article 24-abolition of child labour
- Article 38- securing social order for the promotion of the welfare of the people
- Article 39- Protection of children
- Articles 41, 45, and 46- deal with the right to education and childhood care. It is important that note that unless a child is given proper education, the child will not be able to utilize his rights and entitlements as per the Constitution and legislation
- Article 42- powers the State to make provisions for securing just and humane conditions of work and maternity relief, i.e. maternity benefits, and to ensure to protect of the health of the infant
- Article 47- improvement of public health a primary duty of the State
- Article 48A/51A(g)- protection and impose pollution-free environment for good health
- Article 243-G - the state government may confer on the panchayats power and authority to enable them to prepare plans for drinking water, health and sanitation, including hospitals, primary health centers and dispensaries, family welfare, women and child development
- Article 243- W - empowering the municipalities concerning similar matters

mentioned in 243- G

- Article 253 - Centre government to take steps to achieve the goals set by international human rights instruments and make laws for their implementation.

2. Medical Termination of Pregnancy Act (MTP) 1971 and its Amendment

This Act is relevant to a child as it is directly related to the pregnant woman's physical and mental health. This Act is also applicable to sexual abuse against a girl child.

3. The Child Labour (Prohibition and Regulation) Act, 1986 and its Amendment in 2016

The Indian Government recognised child labour as a necessary evil and had to stop the employment of children, at least in specific work areas. This Act aimed at prohibiting children from working in some hazardous work regions and regulating the conditions of employment for children in different work areas. It defines a child **"as a person under the age of fourteen years** "and prohibits his employment in transport, foundries, the handloom industry, mines, restaurants, circuses, and other hazardous processes. This Act supplements the provision of the Factories Act 1948, Plantations Labour Act 1951 and Mines Act 1952

4. The Consumer Protection Act 2019

It protects the marketing of goods and services which are hazardous to life and property

5. The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 and Amendment Act 2003

This legislation contains provisions regulating the production, supply and distribution of Infant milk substitutes, feeding bottles and infant foods. Also, it ensures awareness and promotion of breastfeeding, the correct usage of infant foods, and matters connected in addition to that or incidental. The Act prohibits advertisements and promotion of infant milk substitutes, feeding bottles and infant foods. It states that no one shall make advertisements or involve himself in any public or commercial for the distribution, sale, or supply of infant milk substitutes or feeding bottles and give a reason to believe for others that the use of infant milk substitutes is equivalent to or better than, mother's milk. It also prohibits the offer of incentives for promoting the use or sale of infant milk substitutes or feeding bottles or any indictments. Section 6 of the Act makes it mandatory to mention on infant milk substitutes or infant food that 'mother's milk is best for your baby' in capital letters

6. Pre Conception and Pre-natal Diagnostic Act (PCPNDT), 1996 (Amended)

This Act prohibited the ways and means of knowing the gender of an unborn child as it disturbs the typical ecosystem. This Act provides access to all female children's fundamental right to equality. The action plan of the Act is to ensure efficient implementation of the Act through the Reproductive and Child Health (RCH)Program and to reduce preconception and prenatal mortality of girl children so that there can be an improvement in the sex ratio at birth.

7. Prohibition of Child Marriage Act, 2006 8. Food safety and standard act (FSSA), 2006

This focuses on health hazards emanating from unsafe food. The principles included are to achieve an appropriate level of protection of human life and health, protection of consumer interests and fair practices in the food trade and food safety standards and procedures.

9. Protection Of Children From Sexual Offences Act (POSCO), 2012

This is directly related to the physical and mental health of the child. The offenses under the POCSO act may require emergency medical care and other services for the child

10. The Juvenile Justice (Care And Protection Of Children) Act 2015

This Act envisages that the State is responsible for the care, protection, treatment and rehabilitation of children who do not have the support of their families. Providing health care to the child is with the State when the child is in the State's custody. The responsibility shifts when the child is given to adoption or foster care. The foster family provides health and nutrition, education, and the child's overall well-being.

11. Mental Health Act (MHCA), 2017

This repeals the mental health act 1987. This Act mentions the right to access mental health care, the right to equality and non-discrimination in treatment, the right to adequate and appropriate information, confidentiality, access to medical records and the right to keep contact and communication.

12. Schemes and Programmes

The Government of India has implemented several schemes and programmes. These programmes focus on the health of mother and child, financial assistance, health insurance, or delivery of services.

a) National health mission (NHM) was launched in 2013, subsuming the National Rural Health Mission and National Urban Health Mission. The main programmatic components of NHM are health system strengthening in rural and urban areas, reproductive-maternal- neonatal-child and adolescent health and communicable/non-communicable diseases.

b) Schemes providing financial assistance and other facilities to families: These plans aim to ensure families' right to health. The plans such as:

ESIS (Employment State Insurance Scheme), CGHS (Central Government Health Scheme), UHIS (Universal Health Insurance Scheme), AABY (Aam Aadmi Bima Yojana) & RSBY (Rastriya Swasthya Bima Yojana)

c) Schemes aimed at specific groups:

- JSY (Janani Suraksha Yojana) is a modified National Maternity Benefit scheme intervention under NRHM that ensures safe motherhood and is being implemented to reduce maternal and infant mortality by promoting institutional deliveries among pregnant women.
- JSSK (Janani Shishu Suraksha Karyakram) is entitlement such as free drugs and consumables, free diet for up to 3-7 days depending on the type of delivery, free diagnostics, free transport from home to hospital for all pregnant women who access government facilities for delivery. This has been expanded to cover sick infants
- Mission Indradhanush aims to cover all children by 2020 who are either unvaccinated or partially vaccinated against vaccine-preventable diseases

FRAMEWORK OVERVIEW OF THE CHILD IN NEED OF CARE AND PROTECTION

UNICEF uses the term 'Child protection' to prevent and respond to violence, exploitation, and abuse against children, including commercial sexual exploitation, child labour, and harmful traditional practices such as child marriages (1).

WHO IS A CHILD IN NEED AND PROTECTION?

It is pertinent to know that the Juvenile Justice (Care & Protection of Children) Act 2015 (JJ Act), Government of India has two sections

a) Children in need of care and protection (CINCP)

b) Children in conflict with the law (CIL)

a) According to Section 2 (14) of the Juvenile Justice (Care & Protection of Children) Act 2015, (13) **A child in need of care and protection means:**

I. A child who is found without any home or settled place of abode and any ostensible means of subsistence; or

II. A child who is found working in contravention of labor laws for the time being in force or is found begging or living on the street; or

III. A child who resides with a person, whether a guardian of the child or not, and such person-has injured, exploited, abused or neglected the child or has violated any other law for the time being in force meant for the protection of a child; or has threatened to kill, injure, exploit or abuse the child, and there is a reasonable likelihood of the threat being carried out; or has killed, abused, neglected or exploited some other child or children, and there is a good likelihood of the child in question being killed, used, exploited or neglected by that person; or

IV. who is mentally ill or mentally or physically challenged or suffering from terminal or incurable disease, having no one to support or look after or having parents or guardians unfit to take care, if found so by the Board or the Committee; or

V. who has a parent or guardian and such parent or guardian is found to be unfit or incapacitated, by the Committee or the Board, to care for and protect the safety and well- being of the child; or

VI. who does not have parents and no one is willing to take care of them, or whose parents have abandoned or surrendered him; or

VII. who is missing or runaway child, or whose parents cannot be found after making reasonable inquiry in such manner as may be prescribed; or

VIII. who has been or is being or is likely to be abused, tortured or exploited for sexual abuse or illegal acts; or

IX. who is found vulnerable and is expected to be inducted into drug abuse or trafficking; or

X. who is being or is likely to be abused for unconscionable gain; or

XI. who is a victim of or affected by an armed conflict, civil unrest or natural calamity; or

XII. who is at imminent risk of marriage before attaining the age of marriage and whose parents, family members, guardians and any other persons are likely

responsible for solemnizing such marriage.

Abandoned Children

Under the JJ Act, a child deserted by his biological or adoptive parents or guardians is declared abandoned by the Child Welfare Committee (CWC) after due inquiry. The reasons common for abandonment are poverty or disability, or gender discrimination.

Section 75 JJ Act, 2015: "Whoever, having the actual charge of, or control over, a child, assaults, abandons, abuses, exposes or wilfully neglects the child or causes or procures the child to be assaulted, abandoned, abused, exposed or neglected in a manner likely to cause such child unnecessary mental or physical suffering, shall be punishable with imprisonment for a term which may extend to three years or with fine of one lakh rupees or with both:

Provided that if it is found that such abandonment of the child by the biological parents is due to circumstances beyond their control, it shall be presumed that such abandonment is not willful. The penal provisions of this section shall not apply in such cases."

Orphaned children

Under the JJ Act Section 2(42), orphan" means a child—

- who is without biological or adoptive parents or legal guardian; or
- whose legal guardian is not willing to take or capable of taking care of the child;

b) **Children in conflict with the law (CIL**)

A child in conflict with law' is a child who is alleged or found to have committed an offense and who has not completed eighteen years of age on the date of commission of a such offense

International Framework for Child Protection

1. United Nations Convention on the rights of the child (UNCRC), 1989

The Convention on the Rights of the Child (CRC is the most comprehensive document on children's rights. Based purely on the number of substantive rights it sets forth, as distinct from implementation measures, it is the longest U.N. human rights treaty in force and unusual in that it addresses not only the granting and implementation of rights in peacetime but also the treatment of children in situations of armed conflict. The CRC is also significant because it enshrines, "for the first time in binding international law, the principles upon which adoption is based, viewed from the child's perspective(19).

The CRC is primarily concerned with four aspects of children's rights

- participation by children in decisions affecting them;
- protection of children against discrimination and all forms of neglect and exploitation
- prevention of harm to them;
- provision of assistance to children for their basic needs The following are a few relating to this chapter:

  a) Article 3

  1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the child's best interests shall be a primary consideration.
  2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and to this end, shall take all appropriate legislative and administrative measures.

  b) Article 5

  States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention.

  c) Article 9

  States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine that such separation is necessary for the child's best interests under applicable law and procedures.

  d) Article 19

  1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
  2. Such protective measures should, as appropriate, include effective procedures for establishing social programmes to provide the necessary support for the child and those who care for the child.

e) Article 20

A child temporarily or permanently deprived of his or her family environment or in whose best interests cannot remain in that environment shall be entitled to special protection and assistance the State provides.

f) Article 25

States Parties recognise the right of a child placed by the competent authorities for care, protection or treatment of his or her physical or mental health to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her or her placement.

g) Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse

h) Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

2. Optional Protocols to the CRC on Sex Trafficking, Armed Conflict, 2000

The United Nations adopted two protocols to the CRC on May 25, 2000, the Optional Protocol to the CRC on the Sale of Children, Child Prostitution, and Child Pornography 2000 (Sex Trafficking Protocol and the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (Child Soldiers Protocol.

Few other international and regional instruments

- Universal Declaration of Human Rights, 1948
- European Convention on Human Rights, 1950
- International Covenant on Economic, Social and Cultural Rights, 1966
- International Covenant on Civil and Political Rights, 1966
- Hague Convention on the Civil Aspects of International Child Abduction, 1980
- Hague Convention on the Protection of Children in Intercountry Adoption, 1993
- European Convention on the Exercise of Children's Rights. 1996

Indian Legal Framework for Child Protection

It is important to note that multiple legislations or provisions can directly or indirectly be interpreted concerning child protection (14,15) . This section

concentrates on a few of the domestic laws, legislations, and provisions offered for child protection (17,18).

1. **Indian Penal Code (IPC), 1860**

This contains provisions for various offenses, and the following are a few related to this topic

- Section 21: Prohibition of publication of the name, etc., of the juvenile involved in any proceeding under the act.
- Section 23: Punishment for cruelty to juvenile or child.
- Section 24: Employment of juvenile or child for begging.
- Section 25: Penalty for giving intoxicating liquor or narcotic drug for a psychotropic substance to a juvenile or child.
- Section 26: Exploitation of juvenile or child employees. In dealing with crime against children, along with the section of JJA,
- Section 82: Nothing is an offense that a child does under seven years of age.
- Section 302: Murder
- Section 315 & 316: Foeticide
- Section 315: Infanticide – 0 to 1 year of age
- Section 305: Abetment to suicide
- Section 317: Exposure and abandonment All degrees of hurt or abuse
- Section 319: hurt
- Section 320: Grievous hurt
- Section 321: Voluntarily causing hurt
- Section 322: Voluntarily causing grievous hurt
- Section 324: Voluntarily causing hurt by dangerous weapons or means
- Section 339: Wrongful restraint
- Section 340: Wrongful confinement Kidnapping and Abduction
- Section 354, 354A,354B,354C,354D- Sexual offenses
- Section 360: Kidnapping for exporting
- Section 361: Kidnapping for lawful guardianship
- Section 384: Kidnapping for ransom
- Section 363-A: Kidnapping for begging
- Section 366: Kidnapping to compel marriage
- Section 367: Kidnapping for slavery
- Section 369: Kidnapping child for stealing from its person" child under ten years of age only
- Section 366-A: Procuration of minor girls
- Section 366-B: Importation of girls
- Section 370- Trafficking for exploitation

- Section 372: Selling of girls for prostitution
- Section 373: Buying of girls for prostitution
- Section 376: Rape
- Section 377: Unnatural offenses

2. Immoral Traffic (Prevention) Act, 1956

This act was passed to prevent any form of trafficking of human beings, specifically for sex. The "child" under ITPA means a person who has not completed the age of sixteen years, and "prostitution" means the sexual exploitation or abuse of persons for commercial purposes. The ITPA Amendment Bill, 2006, attempts to change the child definition from 16 to 18.

- Section 3: Stringent action and punishment for keeping a brothel or allowing premises to be used as a brothel
- Section 4: Living on the earnings of prostitution
- Section 5: Procuring, including taking a person for the sake of prostitution
- Section 6: If any person is found with a child in a brothel, it shall be presumed, unless the contrary is proved, that he has committed an offense of detaining a person on premises where prostitution is carried on. The punishment consists of imprisonment of either description for a term which shall not be less than seven years
- Section 21: Establishment of protective homes by the State Government
- Under this act, the quantum of punishment is higher if a minor is trafficked and a repeat offender is imprisoned for the remainder of their life.

3. Child Labour (Prohibition and Regulation) Act, 1986 and Amendment Act 2016

The act provides punishments and penalties for employing children below 14 years in certain occupations and processes. It provides for the regulation of work conditions, including fixing hours of work, weekly holidays, notices to inspectors, provisions for resolving disputes regarding age, maintenance of registers, etc. The amendment has included adolescent labor (14-18 years) for the first time.

4. Prohibition of Child Marriage Act, 2006

Child marriage is a blatant violation of the right to care and protection, developing and growing into a complete individual, regardless of the social and economic situation. Child marriage denies children their fundamental rights to good health, nutrition, education, and freedom from violence, abuse and exploitation.

Few provisions of this law

- The solemnization of child marriages is a cognisable and non-bailable offense.
- Child Marriage Prohibition Officers (CMPOs) are appointed in every state.
- The law lays down penal provisions for those who solemnize child marriages
- The law makes child marriages voidable by giving a choice to the children in the marriage to seek annulment of marriage.
- It provides for the maintenance and residence of the female contracting party.
- It gives legal status to all children born from child marriages and provisions for custody and maintenance.
- It also lays down punishment for those performing/conducting/ abetting a child marriage.
- It prescribes punishment for promoting or permitting the solemnisation of child marriage, including for parents, guardians or any other person/association/organisation23.
- The law clearly states that women offenders in any of the above categories cannot be punished with imprisonment. However, they can be penalized by way of imposition of a fine
- Karnataka Amendment 2017- Child marriage void from the beginning

5. Commission for Protection of Child Rights Act (CPCR), 2005

The Commission for Protection of Child Rights (CPCRS belong to the general category of human rights institutions. The Act's objective is to provide for the constitution of a National Commission and State Commissions for the Protection of Child Rights (16). The Act also establishes Children's Courts to ensure speedy trial of offenses against children or violations of child rights.

In this act, a Child is defined as a person in the 0 to 18 age group. The Commission visualizes a rights-based perspective flowing into National Policies and Programmes, along with nuanced responses at the State, District and Block levels, taking care of the specificity and strengths of each region.

6. Information Technology Act, 2000

A rapid increase in computers and the internet has led to new crimes like publishing sexually explicit materials in electronic form, video voyeurism and breach of confidentiality. A section relevant to this topic is Section 67 B: Punishment for posting or transmitting material depicting children in the sexually explicit act, etc., in electronic form.

7. Juvenile Justice (Care and protection of Children) Act 2015

The Act seeks to achieve the objectives of the United Nations Convention on the Rights of Children (13). The Act has placed special emphasis on the rehabilitation and social integration of children and has provided institutional and non-institutional measures for the care and protection of children. The non-institutional alternatives include adoption, foster care, sponsorship, and aftercare.

Key provisions

- A child means every person who has not completed 18 years of age.
- Change in terminology from 'juvenile' to 'child' or 'child in conflict with law' across the Act to remove the negative connotation associated with the word "juvenile
- Children have been categorized into two categories under Act, 2015

  a. Children in need of care and protection

  b. Children in conflict with the law

- Inclusion of several new definitions such as orphaned, abandoned and surrendered children; and petty, serious and heinous offenses committed by children
- Under Section 15, special provisions have been made to tackle child offenders committing heinous offenses in the age group of 16-18 years
- "Place of Safety" means any place or institution, not being a police lockup or jail, established separately attached to an observation home or a special home, as the case may be, the person in charge of which is willing to receive and take care of the children alleged or found to conflict with the law, by order of the Board or the Children's Court, both during the inquiry and ongoing rehabilitation after having been found guilty for a period and purpose as specified in the order.
- "Special Juvenile Police Unit" means a unit of the police force of a district or city or, as the case may be, any other police unit like railway police, dealing with children and designated as such to exclusively deal with children either as victims or perpetrators in coordination with the voluntary and non-governmental organizations.
- "Child Welfare Committee" is the sole authority to deal with matters concerning children in need of care and protection
- "Juvenile Justice Board" shall be established by the State Government for every district, one or more Juvenile Justice Boards for exercising the powers and discharging its functions relating to children in conflict with law under this Act
- Any police officer, SJPU, public servant, CHILDLINE, voluntary organization, social worker, or a spirited public citizen or the child can contact the CWC and

produce the child before it.

- Every child is entitled to be legally represented and avail of free legal aid
- Competent authority means concerning children in need of care and protection by a Committee and relation to juveniles in conflict with the law.
- Childline is the country's first toll-free tele-helpline for children in need of care and protection, and the number is 1098

DISCLAIMER

The framework mentioned in the chapter is not exhaustive. It is important to note that multiple legislations, provisions, or programmes can directly or indirectly be interpreted concerning different individual rights, and this is a sincere attempt at summarizing a few of them. I apologize for the errors made inadvertently.

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VIOLENCE AGAINST CHILDREN & ADVERSE CHILDHOOD EXPERIENCES: LONG TERM EFFECTS ON HEALTH

3

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Introduction

Violence against children (VAC) includes all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers. The World Health Organization (WHO) estimated that up to 1 billion children aged 2–17 years, have experienced physical, sexual, or emotional violence or neglect in the past year globally (1). VAC is both a human-rights violation and a personal and public health problem that incurs huge costs for both individuals and society. All forms of VAC are violations of the United Nations Child Rights Convention (UN CRC) (2). Providing global impetus to this issue, the elimination of VAC is also called for in the 2030 Agenda for Sustainable Development, most explicitly in Target 16.2: "end abuse, exploitation, trafficking and all forms of violence against and torture of children" (3)

Figure1. Sustainable Development Goals (SDG) 2030

The term VAC was traditionally framed for child abuse, neglect, maltreatment and

exploitation, terms often used interchangeably. Recently, an innovative collaboration between global agencies, led by the International Society for Social Pediatrics and Child Health (ISSOP), the International Society for Prevention of Child Abuse and Neglect (ISPCAN), and the International Pediatric Association (IPA), galvanized to respond to VAC using a child-rights and public health lens. These global societies explored violence categories according to the context in which it is committed: i.e., interpersonal, community, collective, practices based on tradition, culture, religion and superstition, and gender dimensions (4).

Specific typologies of VAC:

(a) **Interpersonal violence which includes Child maltreatment (CM),** which is one of the most recognized forms of VAC worldwide. Most definitions of CM found in the literature include four main types of maltreatment: physical abuse, sexual abuse, neglect and emotional abuse, which may occur in combination.

(b) **Domestic/family violence**: The term 'domestic violence' or family violence is used in many countries to refer to intimate partner violence (IPV), but the term can also encompass other forms of violence including child or elder abuse, or abuse by any member of a household. The overwhelming global burden of IPV is borne by women, and different forms of family violence co-occur. Children's exposure to IPV is now recognized as a type of CM with levels of impairment similar to other types of maltreatment

(c) **Community violence:** Schools: bullying, corporal punishment: Bullying is repeated aggression via physical, verbal, relational or cyber forms in which the targets cannot defend themselves. Corporal punishment is the most common form of VAC. While over 53 states prohibit all corporal punishment of children, and over 125 states have prohibited corporal punishment in all schools. (Global Initiative to End All Corporal Punishment of Children, 2017) (5)

(d) **Institutional violence**: Children living in residential facilities are more likely to experience violence and sexual abuse than children living in family-based. There has been a dramatic increase in the number of children and youth in institutional care, including those displaced by violence and war and those in juvenile detention (6)

(e) **Child labor** is so ubiquitous that it is ignored; but it is one of the most serious

forms of VAC and is underpinned by poverty and deprivation of education. Globally, over 168 million children work, with more than half of them doing hazardous work (7). A particularly heinous form of child labor results from trafficking, with estimates suggesting that half of trafficked victims worldwide are children. Exploitative practices involving children include labor, domestic work, sexual exploitation, marriage, illicit adoption, begging and organ harvesting.

(f) **Collective violence:** Armed conflict in which millions of children live in areas affected by conflict, and nearly one in three children living outside their country of birth is a refugee (8). Children are affected by armed conflict in a myriad of ways—caught in the crossfire, or directly targeted by combatants resulting in injury, illness, disability, psychological trauma and mortality.

(g) **Practices based on tradition, culture, religion or superstition** the common characteristic of the violations here are that they are based on tradition, culture, religion or superstition and are perpetrated and actively condoned by the child's parents or the child's community The report from the International NGO Council on Violence against Children (9) lists exhaustively practices from acid attacks, breast flattening, child marriage, dowry, to male circumcision, female genital mutilation (FGM) and honor killing.

(h) **Gender dimensions**: There are certainly specific types of violence that disproportionately affects girls, particularly in low- and middle-income countries (10), including — female infanticide/feticide due to son preference early and forced marriage, honor killings, neglect of the girl child, domestic labor and FGM.

Indian Perspective of Violence against Children (VAC)

India is home to the largest child population (440 million) under the age of 18 years in the world. The Constitution of India guarantees fundamental rights to all children and empowers the States through directive principles of state policy. In the year 1992, India accepted the obligations of the United Nations Convention on the Rights of the Child (UNCRC) (2). The policies for children in India have been formulated in consonance with the UNCRC. They adhere to the constitutional mandate and guiding principles of UNCRC and recognize rights of children under four key priority areas, namely: survival, development, protection and participation. In 2007, a Study conducted by the Ministry of Women and Child Development of the Government of India study revealed high prevalence of all

forms of interpersonal VAC such as child physical abuse (66%), sexual abuse (50%) and emotional abuse (50%). 70.57% of girls reported having been neglected by family members, and 48.4% of girls wished they were born as boys (11).

In the last two decades, the Government of India has taken several positive steps towards overtly advancing children's rights to protection (12). These include the formation of the National Commission for Protection of Child Rights (2005), National Policy for Children (2013), National Plan of Action for Children (2016); legislations such as Right to Education Bill (2009), Protection of Children from Sexual offenses (POCSO) Act 2012 and amendment to Juvenile Justice Act (2015) to protect, promote and defend child rights (13). The Child Labour Prohibition and Regulation Act were amended in 2016.Despite the above Government initiatives, a large number of children living amidst adverse socio-economic circumstances in India, poor resources and lack of access to health and child protection services in backward districts have led to considerable adverse childhood experiences (ACE), particularly for younger children during their early formative years.

Pediatricians, doctors and allied health professionals are often the first point of contact for abused and neglected children. They play a key role in detecting abuse, and provide immediate and long term support to the survivors. The Indian Academy of Pediatrics (IAP) recognizes that pediatricians and allied medical professionals should support, reassure, treat, and ensure rehabilitation of victims of child abuse, keeping the best interest of the child as their primary goal. However, pediatricians and allied medical professionals have limited knowledge in the early recognition and response to various forms of VAC. The training to prevent and respond to VAC has not been imparted previously in medical colleges. The Indian Child Abuse Neglect & Child Labour (ICANCL) group, a subspeciality group of IAP has been working relentlessly in this field for past 25 years (14-16). To support the urgent need to impart training to pediatricians and allied medical professionals to prevent VAC, recently, the IAP has started a series of training of trainers (TOT) to prevent and respond to VAC (17).

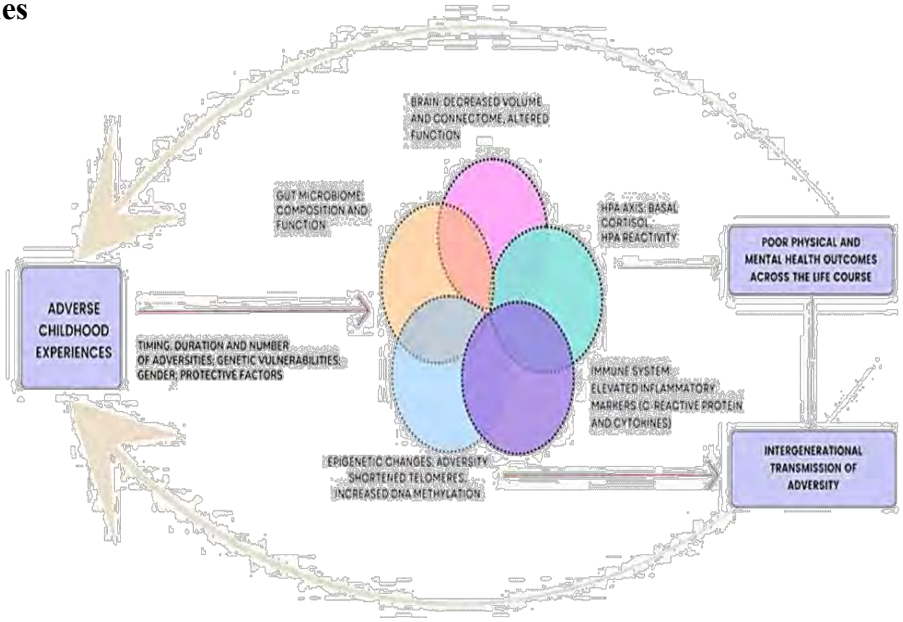
ADVERSE CHILDHOOD EXPERIENCES(ACEs)

The VAC exerts a multitude of short and long term health consequences on children, including serious and often lifelong adverse consequences on mental and physical health, reproductive health, academic performance, and social functioning. According to a major American epidemiologic Adverse Childhood Experience

(ACE) research study, a powerful relationship has been established between VAC and child maltreatment & to adverse health effects in adult life, including development of adult onset high-risk health behaviors such as smoking, alcohol and drug abuse, and severe obesity, and correlated with ill-health including depression, heart disease, cancer, chronic lung disease and shortened lifespan (18).

A recent paper by Zulfikar Bhutta et al (19) on ACEs and lifelong health, linked the key mechanism linking ACEs to health outcomes and suggested promising strategies to prevent and mitigate their effects, highlighting programs from Low income and high income countries (Figure 2).

Figure 2: Mechanisms by which ACEs impact Neurodevelopment and health outcomes

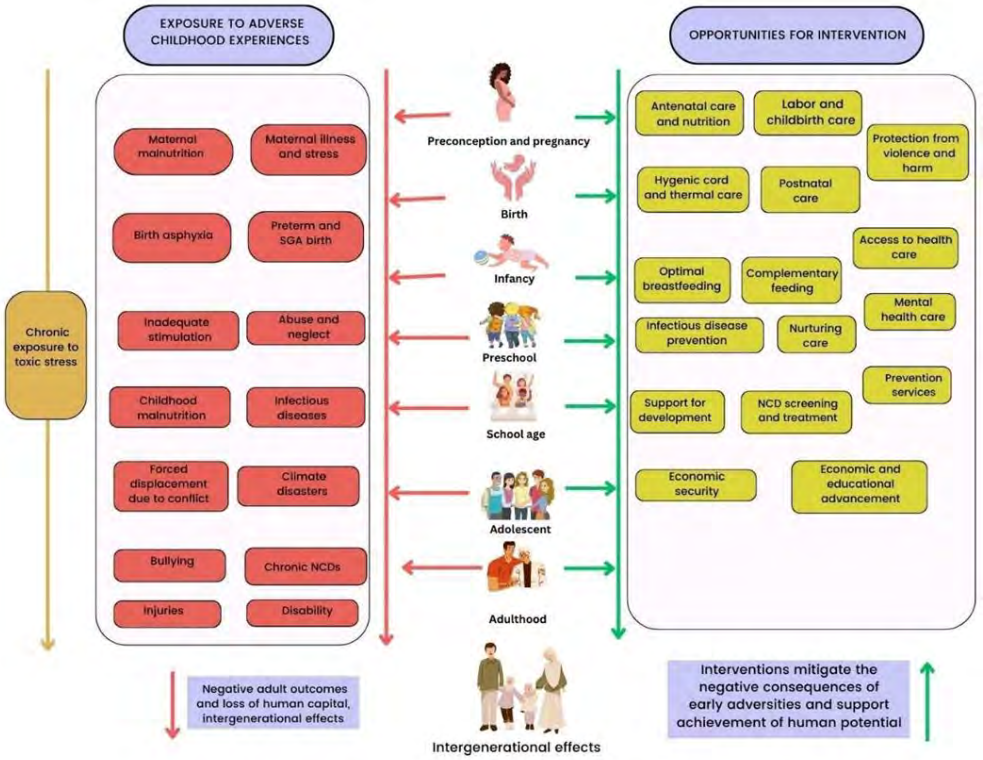


Adverse childhood experiences (ACEs) and opportunities for intervention across the life course.

Harmful social environments that typically define ACEs can begin prenatally and opportunities for intervention exist throughout the life course. Chronic exposure to toxic stress can continue through infancy and into adulthood and can include financial insecurity (often associated with abject poverty), violence and conflict, untreated chronic disease or disability, as well as hazardous environmental conditions such as unsafe drinking water, inadequate sanitation and air pollution. Interventions can help to prevent and mitigate the negative consequences of ACEs, reducing the number of preterm or small for gestational age (SGA) births, supporting the achievement of human potential (indicated by physical and mental health, adult stature, social behavior and relationships, academic achievement and

socioeconomic status) and reducing the burden of non-communicable diseases (NCDs)

Figure 3. ACEs and opportunities for interventions (19)



Adverse childhood experiences and opportunities for intervention across the life course.

Prevention and response

Violence against children can be prevented. Preventing and responding to violence against children requires that efforts systematically address risk and protective factors at all four interrelated levels of risk (individual, relationship, community, society) (20).

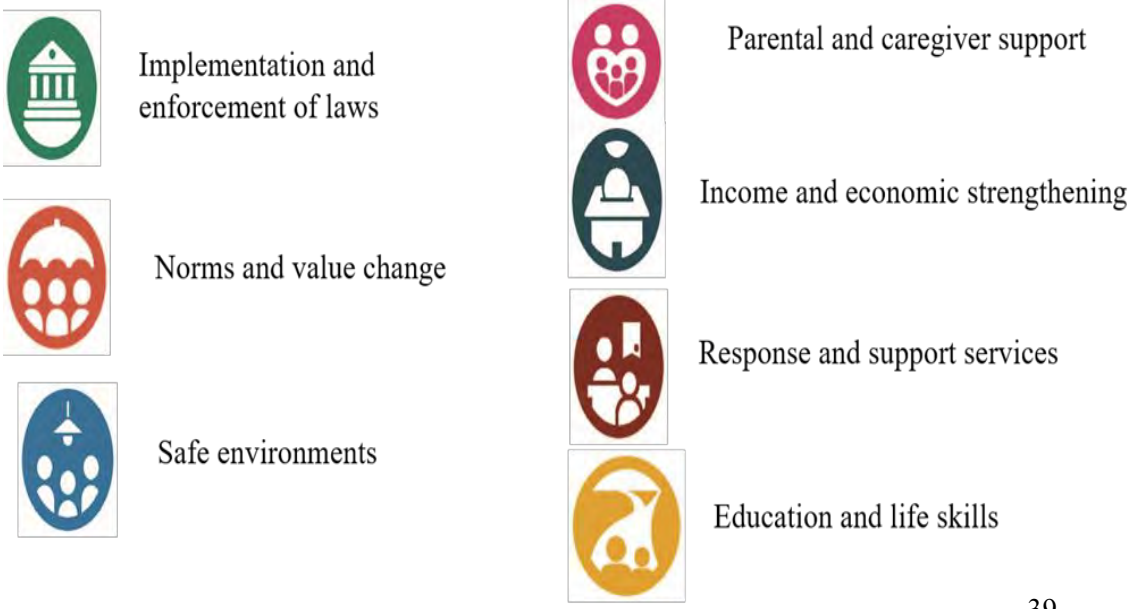
Under the leadership of WHO, a group of 10 international agencies have developed and endorsed an evidence-based technical package called *INSPIRE: Seven strategies for ending violence against children*. The package aims to help countries and communities achieve SDG Target 16.2 on ending violence against children.

Each letter of the word INSPIRE stands for one of the strategies, and most have been shown to have preventive effects across several different types of violence, as well as benefits in areas such as mental health, education and crime reduction.

INSPIRE: Seven strategies for ending violence against children are:

- **I**mplementation and enforcement of laws (for example, banning violent discipline and restricting access to alcohol and firearms);
- **N**orms and values change (for example, altering norms that condone the sexual abuse of girls or aggressive behaviour among boys);
- **S**afe environments (such as identifying neighborhood "hot spots" for violence and then addressing the local causes through problem-oriented policing and other interventions);
- **P**arental and caregiver support (for example, providing parent training to young, first time parents);
- **I**ncome and economic strengthening (such as microfinance and gender equity training);
- **R**esponse services provision (for example, ensuring that children who are exposed to violence can access effective emergency care and receive appropriate psychosocial support); and
- **E**ducation and life skills (such as ensuring that children attend school, and providing life and social skills training).

Figure 4: INSPIRE: Seven Strategies to end violence against children



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CHILD PROTECTION SYSTEMS IN INDIA

4

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Child protection systems and agencies aim to protect children's rights and provide children freedom from violence, exploitation, abuse and neglect. The revised National Children Policy (2013), and the National Plan of Action for Children, 2016 laid down the policy framework for child welfare and protection. The Indian Parliament has passed several landmark legislations in favor of children like the Juvenile Justice (Care and Protection of Children) Act 2015, the Protection of Children from Sexual Offences Act 2012, the Commissions for Protection of Child Rights Act, 2005, the Prohibition of Child Marriage Act, 2006 and the Right to Education Act 2009. India is also a signatory to important international treaties i.e., the United Nations Convention on Rights of Child and the Hague convention on Adoption of children which mandate systemic development and strengthening of the juvenile justice system in the country.

NATIONAL COMMISSION FOR PROTECTION OF CHILD RIGHTS

National Commission for Protection of Child Rights (NCPCR) (1) was established in March 2007 under an Act of Parliament (December 2005) under the Commission for Protection of Child Rights Act, 2005 with the vision of the Child's rights as enunciated with Constitution of India and the United Nations Convention on the Rights of the Child (2).

The Commission envisages a rights-based perspective, which flows into national policies and programmes. It also envisages an indispensable role for the State to ensure children and their wellbeing, strong institution-building processes, respect for local bodies and decentralization at the community level and greater social concern in this direction.

The Commission consists of the following members, namely: -

1. A chairperson who is a person of eminence and has done outstanding work for promoting the welfare of children; and
2. Six members, among them two are woman, to be appointed by the Central Government from amongst person of eminence, ability, integrity, standing and experience in -

- Education;
- Child health, care, welfare or child development;

- Juvenile justice or care of neglected or marginalized and disabled children;
- Elimination of child labour or children in distress;
- Child psychology or sociology; and
- Laws relating to children.

Functions

The Functions of the National are based on Protection of Child Rights (CPCR) Act,2005, and there are a number of them, some of them are as follows:

a) Examine and review the safeguards provided by or under any law for the time being in force for the protection of child rights and recommend measures for their effective implementation;
b) Inquire into violation of child rights and recommend initiation of proceedings in such cases;
c) Examine all factors that inhibit the enjoyment of rights of children affected by terrorism, communal violence, riots, natural disaster, domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation, pornography and prostitution and recommend appropriate remedial measures.
d) Look into the matters relating to the children in distress, marginalized and disadvantaged children, children in conflict with the law, children in conflict with the law without family and children of prisoners and recommend appropriate remedial measures;
e) Inquire into complaints and take suo moto notice of matter relating to :
   - Deprivation and violation of child rights;
   - Non-implementation of laws providing for the protection and development of children;
   - Non-compliance with policy decisions, guidelines or instructions aimed at mitigating hardships and ensuring the welfare of the children and providing relief to them;
   - Alternatively, take up the issues to appropriate authorities.
f) Produce and disseminate information about child rights.
g) Compile and analyze data on children.
h) Promote the incorporation of child rights into the school curriculum training of teachers or personnel dealing with children.

INTEGRATED CHILD PROTECTION SCHEME

Integrated Child Protection Scheme (ICPS) (3) is a centrally sponsored umbrella scheme under which various schemes for children in need of care and protection, and children in conflict with law are covered. The children in need of care and protection are being provided Institutional as well as Non Institutional Care under the scheme. For providing non Institutional Care State Adoption Resource Agency (SARA) has been set up at State level. At the district level the District Child Protection Unit (DCPU) and District Child Protection Committee under the chairmanship of Deputy Commissioner has been constituted. The Integrated Child Protection Scheme (ICPS) is mainly an instrument to implement the provisions of J.J. Act, 2000 which has been amended as Juvenile Justice Act, 2015 and came into force w.e.f. 15.01.20106. The States have to create a Juvenile Justice Fund for providing facilities to the juveniles. Child Welfare Committees (CWC) and Juvenile Justice Board (JBB) have been set up in all the districts for the effective implementation of Juvenile Justice (Care & Protection of Children) Act 2015.

The Integrated Child Protection Scheme (ICPS) has significantly contributed to the realisation of Government/State responsibility for protecting children. Based on the cardinal principles of "protection of child rights" and "best interest of the child". The scheme was then renamed as “Child Protection Services” Scheme in 2017. The CPS Scheme has been now subsumed under Mission Vatsalya from 2021-22 onwards.

MISSION VATSALYA

Mission Vatsalya (4) is a road-map to achieve development and child protection priorities aligned with the Sustainable Development Goals (SDGs).It lays emphasis on child rights, advocacy and awareness along with strengthening of the juvenile justice care and protection system with the motto to 'leave no child behind'. The Juvenile Justice (Care and Protection of Children) Act, 2015 provisions and the Protection of Children from Sexual Offences Act, 2012 form the basic framework for implementation of the Mission.

Mission Vatsalya promotes family based non-institutional care of children in difficult circumstances based on the principle of institutionalization of children as a measure of last resort.

The Mission aims to:

i) Support and sustain Children in difficult circumstances;

ii) Develop context-based solutions for holistic development of children from varied backgrounds;

iii) Provide scope for encouraging innovative solutions; iv) Cement convergent action.

The key objectives of Mission Vatsalya are:

i) Prioritization of children in the scheme of Administration keeping Centrality of the Child during all the activities and actions taken under the Mission.

ii) Best interest of the Child while designing or delivering projects and programmes and to take affirmative action to ensure the right to grow in a happy family environment with strong social safety net to support families.

iii) Ensuring Children's right to Survival, Development, Protection and Participation.

iv) To establish essential services and strengthen emergency outreach, noninstitutional care within the family and community, and institutional care counseling and support services at the national, regional, state and district levels.

v) To ensure appropriate inter-sector response at all levels, coordinate and network with all allied systems to promote convergent efforts for seamless service delivery to children.

vi) To strengthen child protection at family and community level, equip families and communities to identify risks and vulnerabilities affecting children, create and promote preventive measures to protect children from situations of vulnerability, risk and abuse.

vii) Encourage private sector partnerships and interventions to support children within the framework of law. Mission Vatsalya Guidelines 3

viii) Raise public awareness, educate public about child rights, vulnerabilities and measures for protection sponsored by government and engage community at all levels as stakeholder in ensuring the best interest of children.

ix) To build capacities of duty holders & service providers at all levels.

x) Monitor progress on objective parameters against well-defined Outputs and Outcomes,

xi) Participation of Panchayats and Municipal Local Bodies at the village level and at the ward and the urban cluster level within the urban municipal ward, for

sustained assessment of the issues deserving attention, implementation of appropriate interventions, regular monitoring to develop a robust social safety net for children.

The Mission Vatsalya scheme envisages a defined institutional arrangement to implement which will be monitored at different levels by the center, state, and district. The Mission Vatsalya Project Approval Board (PAB) under the Chairpersonship of the Secretary, Ministry of Women and Child Development (MWCD) will scrutinize and approve the annual plans and financial proposals received from the States and UTs for release of grants under the scheme. The Mission Vatsalya Central Project Monitoring Unit (CPMU) will provide necessary secretarial assistance to the Board and will do coordination and monitoring with the State Governments in the Ministry. It will be based at Delhi and would function as the Mission Directorate headed by Joint Secretary level officer as Mission Director.

At the State level, there shall be a committee headed by the Chief Secretary to monitor, review and promote convergence in the implementation of the scheme. The Chairperson may co-opt any other domain expert/statutory body/departments in the Committee. The state level institutional arrangement for implementation, monitoring and coordination will consist of statutory and service delivery structures as follows:

State Level Monitoring and Review Committee

Statutory Arrangement	**Service Delivery System**
State Child Protection Society	State level Monitoring Committee
State Adoption Resource Agency (SARA)	State Child Welfare & Protection Committee
District Child Protection Unit (DPCU)	District Child Welfare & Protection Committee
Child Welfare Committee	Local Child Welfare & Protection Committee
Juvenile Justice Board	
Special Juvenile Police Unit	

State Child Protection Society

The State Child Protection Society (SCPS) as established under the Juvenile Justice (Care and Protection of Children) Act, 2015, shall ensure the implementation including mapping, planning of Mission Vatsalya scheme. The SCPS shall assist the State Child Welfare and Protection Committee, for coordinating and ensuring effective implementation of legislations, policies, and schemes for child welfare & protection in the State viz. the Juvenile Justice (Care and Protection of Children) Act, 2015; Protection of children from Sexual Offence Act, 2012;The Prohibition of Child Marriage Act, 2006;Commissions for Protection of Child Rights Act, 2005 (CPCR Act) along with Rules and Regulations made there under; Hindu Adoption and Maintenance Act (HAMA) 1956; Guardians and Wards Act (GAWA) 1890; the Child Labour (Prohibition and Regulation) Act 1986; and the Immoral Traffic Prevention Act 1986; Pre Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 1994,and any other Act, Rule, Regulation and policy that comes into force for protecting child rights.

State Adoption Resource Agency (SARA)

In order to support the Central Adoption Resource Authority (CARA) in promoting in-country adoption and regulating inter-country adoption, Mission Vatsalya provides for supporting the State Adoption Resource Agency (SARA) in every State/UT. The SARA shall coordinate, monitor and develop the work related to non-institutional care including adoption in the state. SARA shall be headed by the Additional Chief Secretary/Principal Secretary/Secretary of the Department of Women and Child Development/Social Justice Empowerment of the State identified to implement the Mission Vatsalya as State Mission Director. The Director/ Commissioner of the Department of Women and Child Development/Social Justice Empowerment of State shall assist the Mission Director.

State Child Welfare and Protection Committee

There shall be a State Child Welfare and Protection Committee under the Chairpersonship of the Principal Secretary/Secretary WCD/DSJE to supervise implementation of Mission Vatsalya with the help of the State Child Protection Society (SCPS). This Committee shall closely monitor and review the working of structures, services and progress under various components of Mission Vatsalya and hold quarterly review meetings with District Child Welfare and Protection

Committees for effective implementation of the scheme. The State Committee shall take needful measures for advocacy, awareness generation, capacity building, of all stakeholders on child rights and child welfare, and address road-blocks, issues, complaints received regarding care and protection of children in the State. The State Committee shall make special efforts for convergence so as to ensure benefits under all possible government welfare schemes for the children. The State Committee shall ensure that all institutions are set up under the Juvenile Justice (Care and Protection of Children) Act, 2015, and Rules thereof.

District Child Protection Unit:

The District Magistrate shall be responsible for the implementation of the Mission in the district. The District Child Protection Unit will function under the overall supervision of District Magistrate in ensuring service delivery and care and protection of children in the district. The District Magistrate shall facilitate effective implementation of the Juvenile Justice (Care and Protection of Children) Act, 2015; and all other legislations, Rules and regulations for ensuring child welfare, child rights and child protection in the district, viz. Protection of children from Sexual Offence Act, 2012; the prohibition of Child Marriage Act 2006; the Hindu Adoption and Maintenance Act (HAMA) 1956; Guardians and Wards Act (GAWA) 1890; the Child Labour (Prohibition and Regulation) Act 1986; the Commissions for Protection of Child Rights Act, 2005; the Immoral Traffic Prevention Act 1986; the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, etc. and any other Act that comes into force for protecting child rights.

District Child Welfare and Protection Committee

The District Magistrate shall chair the District Child Welfare and Protection Committee in every District. It shall be responsible for the effective implementation of Mission Vatsalya. The District Child Welfare and Protection Committee shall be assisted by District Child Protection Unit (DCPU), to supervise and monitor the activities as well as Mission Vatsalya Guidelines.

Juvenile Justice Board

The Juvenile Justice (Care and Protection of Children) Act, 2015; makes it mandatory to establish at least one Juvenile Justice Board (JJB) in each district as the authority to dispose of matters related to Children in conflict with law. The composition and functioning of the JJB shall be in accordance with the Juvenile Justice (Care and Protection of Children) Act, 2015. Mission Vatsalya shall provide infrastructure and financial support to the States/UTs for facilitating setting up of

JJB in every district and to ensure their effective functioning. The Juvenile Justice Board shall perform functions and Roles as laid down in Juvenile Justice Act/Rules as amended from time to time.

Child Welfare Committee

The Juvenile Justice (Care and Protection of Children) Act, 2015; makes it mandatory to establish at least one Child Welfare Committee (CWC) in each district as the authority to dispose of cases for the care, protection, treatment, development and rehabilitation of children in need of care & protection and to provide for their basic needs and protection of human rights. The Composition and functioning of the CWC shall be in accordance with the Juvenile Justice (Care and Protection of Children) Act, 2015; and Rules thereof. Mission Vatsalya shall provide infrastructure and financial support to the States/UTs for facilitating setting up of CWC in every district and to ensure their effective functioning. The Child Welfare Committee shall perform functions and Roles as laid down in Juvenile Justice Act/Rules as amended from time to time.

Special Juvenile Police Unit (SJPU)

The Juvenile Justice Act, 2015, provides for setting up of Special Juvenile Police Units in every district and city to coordinate and upgrade the police interface with children. The police officers, designated as Child Welfare Officers in the district or city by the Home Department, and social workers are members of the SJPU.

Child Welfare and Protection Committees

Mission Vatsalya envisages a robust ecosystem through the network of state and local governments to ensure the safety and security of children in the country. These local bodies must be able to reach out to children, engage with communities and encourage them to take ownership of the wellbeing of Children in their areas. Hence, under the existing Standing/Sub-Committee system of the local bodies, the function of child welfare and protection issues may be assigned to the existing committee of the urban local body/Panchayati Raj Institution/Gram Panchayat which deals with issues of social justice/welfare of women and children.

Mission Vatsalya Portal The Mission Vatsalya portal will provide a unified Digital Platform for various MIS related to children in difficult circumstances which include missing, orphaned, abandoned, and surrendered children

A series of new initiatives have been undertaken to complement the existing system for child welfare and child protection in the country. Approximately 2% of the total

cost has been provided to take up essential activities such as SAMVAD, Grading of CCIs, National Resources Centre at NIPCCD, Child Survey, Child Index, Capacity Building exercises etc.

CHILDLINE

CHILDLINE 1098 Service is a national 24/7, emergency helpline and outreach service for children in need of care and protection. Initiated by CHILDLINE India Foundation (CHILDINE India Foundation) in 1996, it has been supported by the Central Government to expand across the nation. The service was implemented for 27 years by CHILDLINE India Foundation and partner network with the support of Ministry of Women and Child Development, Govt. of India and in close coordination with the respective State/UT Govt. The service focuses on the needs of children living alone on the streets, child laborers, domestic workers, run away children, Children of sex workers and sexually abused children. (7) The basic objective of the CHILD HELPLINE Service was to respond to children in emergency situations and refer them to relevant Governmental and Non-Governmental Organizations and link them to long term rehabilitation. Till now, the CHILDLINE INDIA FOUNDATION has been rendering Childline services in 568 districts, 135 railway stations and 11 bus stands through its network of over 1,000 units.

The Government of India has taken a policy decision that the Child Helpline under Mission Vatsalya (earlier CPS) shall be run in coordination with State and District functionaries and integrated with the Emergency Response Support System 112 (ERSS-112) helpline of MHA." (Sec 2.14). (8) As per the new program, States will ensure a dedicated 24x7 WCD (Women and Child Development) Control Room to be integrated with the ERSS 112. At the district level, a Child Help Line (CHL) would be available round the clock at the District Child Protection Unit (DCPU) to link children in crises to emergency as well as long-term care and rehabilitation services. Help desks or kiosks or booths will be maintained for children in distress at select railway stations and bus stands.

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ESSENTIALS PROTECTION OF CHILDREN FROM SEXUAL OFFENSES (POCSO) ACT & JUVENILE JUSTICE ACT (JJ Act)

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ESSENTIALS OF PROTECTION OF CHILDREN FROM SEXUAL OFFENSES (POCSO) Act

The POCSO Act, 2012 is a comprehensive law to provide for the protection of children from the offences of sexual assault, sexual harassment and pornography while safeguarding the interests of the child at every stage of the judicial process by incorporating child-friendly mechanisms for reporting, recording of evidence, investigation and speedy trial of offences through designated Special Courts.

- Until 2012, provisions of the Indian Penal Code, 1860 (IPC), Immoral Traffic (Prevention) Act, 1956 (ITPA), and Juvenile Justice (Care and Protection of Children) Act 2000 (JJ Act), The Goa Children's Act, 2003 and rules, 2004 were some of the laws applied to sexual offenses against children.
- Ministry of Women and Child Development, POCSO Act, 2012 was enforced on 14 November 2012
- A child under the Act includes any person below the age of eighteen years.
- The Act is gender neutral, i.e., boys and girls can be victims/survivors of rape and/ or sexual assault under the POCSO Act. The IPC is gender specific; only a woman or a girl can file a complaint of rape or sexual assault against a man.
- The definition of sexual offences is not restricted to rape. The Act protects children from offences of sexual assault, sexual harassment, and pornography- for example, penetration by an object touching with sexual intent or showing pornography to the Child
- Both men and women can be offenders under the Act
- The burden of proof regarding the sexual offense has been shifted onto the accused- Section 29-30
- Under the Act, sexual offenses are divided into two- Penetrative and Non-penetrative sexual offenses
- Under the Act, certain acts of penetrative sexual assault are listed as aggravated,

and stricter punishment is accorded to these offences

- A sexual assault is considered "aggravated" under certain circumstances, such as when the abused child is mentally ill or when a person commits the abuse is in a position of trust or authority vis-à-vis the Child, like a family member, police officer, teacher, or doctor.
- Abetment and attempt to Child sexual abuse are punishable- Section16,17,18
- Section 23 of the POCSO Act provides for the procedure of media and imposes the duty to maintain the child victim's identity unless the Special Court has allowed the disclosure
- Section 19 and Section20-The Act provide for mandatory reporting. Any person (including the Child who has apprehension that an offense is likely to be committed, or knows that an offense is likely to be committed, or knows that an offense has been committed shall complain to the Special Juvenile Police Unite or the local Police.
- Not reporting information on sexual offenses is punishable.
- False complaints to humiliate, extort, threaten, or defame someone are punishable under the Act.
- The Act establishes special procedures for reporting cases, special procedures for recording statements of the child victim, and Special Courts for the trial of such offenses.
- Recording statements & functions of Police and Magistrate

➢ The Child's statement shall be recorded at the Child's residence as far as practicable by a woman police officer, not below the rank of sub-inspector.

➢ The police officer, while recording the statement of the Child, shall NOT BE in UNIFORM

➢ The police officer has to ensure that at no point in time does the Child come in contact in any way with the accused

➢ The police officer shall ensure that the Child's identity is protected.

➢ The magistrate/police officer shall record the statement as spoken by the Children in the presence of the parents of the Child or any other person in whom the Child has trust or confidence

➢ In the case of a child having a mental/physical disability, they can take assistance from a special educator or any person familiar with the manner of communication of the Child.

➢ Where sexual abuse has been committed by a person living in the same or

shared household/child care institution, or where there is no parental support, to produce the Child within 24 hours before the CWC with reasons stating whether the Child is in need of care or protection.

➢ The Child or the Child's parent or any person whom the child trusts should be kept updated by the Police about the investigation of the crime from time to time

● Medical examination of the Child must be conducted irrespective of FIR or complaint of the offense. The child is to be taken to the hospital for medical examination in accordance- Section 27

● If the victim is a GIRL CHILD, a woman doctor shall conduct the medical examination. The medical examination shall be conducted in the presence of the Child's parent or any confidant of the Child.

● The evidence of the Child has to be recorded within 30 days of the SpecialCourt taking cognizance of the case, and the trial is to be completed within one year from the date of taking cognizance of the offense- Section 35

● NCPCR & SCPCR shall, in addition to the functions assigned to them under the CPCR Act, ensures and monitors the implementation of the provisions of the POCSO Act

● Child-friendly trial

➔ All trials before the Special Court must be conducted on camera and in the presence of the parents of the child or any other person the child trusts.

➔ At the time of recording evidence, the Special Court will have to ensure that the Child is not exposed to the accused and also that the accused is in a position to hear the statement of the Child and communicate with his advocate

➔ Permit frequent breaks for the Child during the trial

➔ Ensure that the Child is not called repeatedly to testify in court

➔ Not allow aggressive questioning

➔ Child witness awaiting her turn to depose before the special court can wait In the children's waiting room with attached bathroom and play materials

➔ Ensure adequate security outside the waiting room.

Punishments under the Act (in brief)

Name of the offense	Sections	Punishment
Penetrative sexual assault on a child of 16 to 18 years of age	Section 4	Minimum imprisonment of 10 years, which may extend to imprisonment for life plus fine
Penetrative sexual assault on a child below 16 years of age	Section 4	Minimum imprisonment of 20 years, which may extend to imprisonment for the remainder of natural life plus fine
Aggravated penetrative sexual assault	Section 6	Minimum rigorous imprisonment of 20 years, which may extend to imprisonment for the remainder of natural life plus fine or death
Sexual assault	Section 8	Imprisonment of 3 to 5 years plus fine
Aggravated sexual assault	Section 10	Imprisonment of 5 to 7 years plus fine
Sexual harassment	Section 12	Imprisonment can extend up to three years plus a fine.
Use of a child for pornography	Section 14 (1)	First conviction- imprisonment extending up to 5 years. Second or further convictions- imprisonment extending up to 7 years plus fine
Use of a child for pornography while committing an offense under - Section 3	Section 14 (2)	Minimum imprisonment of 10 years extending up to imprisonment for life plus fine
Use of a child for pornography while committing an offense - Section 5	Section 14(3)	Rigorous imprisonment for life plus fine

❖ **Points to ponder in the POCSO Act, 2012**

Use of a child for pornographic purposes while committing an offense - Section 7	Section 14 (4)	Imprisonment of 6 to 8 years plus fine
Use of a child for pornographic purposes while committing an offense -Section 9.	Section 14 (5)	Imprisonment of 8 to 10 years and fine

❖ Consensual sexual activities-In case of sexual intercourse with consent, one of which is minor, the partner who is not minor can be prosecuted under the POCSO Act as the consent of a minor is not considered relevant under this Act.

❖ The improper investigation, i.e. investigation not as per the POCSO act

❖ Application of the last seen theory

❖ Trial within one year- pending cases are rising

❖ Judicial Precedents in India for further reading

❖ Shyamal Ghosh v. State of West Bengal (2012)

❖ Shankar KisanraoKhade v. State of Maharashtra (2013)

❖ Subhankar Sarkar v. State of West Bengal (2015)

❖ M. Loganathan v. State (2016)

❖ Nar Bahadur v. State of Sikkim (2016)

❖ Kanha v. State of Maharashtra (2017)

❖ S. Suresh v. State of Tamil Nadu (2017)

❖ Bijoy Guddu Das v. The State of West Bengal (2017)

❖ Sofyan v. State (2017)

❖ Shubham Vilas Tayade v. The State of Maharashtra (2018)

❖ Imran Shamim Khan v. State of Maharashtra (2019)

❖ Fatima A.S. v. State of Kerala (2020)

ESSENTIALS OF JUVENILE JUSTICE (CARE AND PROTECTION) ACT 2015

This is an Act to consolidate and amend the law relating to children alleged and found to conflict with the law and children in need of care and protection by catering to their basic needs through proper care, protection, development, treatment, and social re-integration by adopting a child-friendly approach in the adjudication and disposal of matters in the best interest of children.

- It came into force on 15 January 2016
- The Juvenile Justice Act 2015 replaced the Juvenile Justice (Care and Protection of Children) 2000, so children below 18 in conflict with the law and involved in heinous offenses can be tried as adults.
- The Act, amended in 2015, changed the nomenclature of 'juvenile' to 'child' and 'Child in conflict with the law.
- The Act defines orphaned, surrendered and abandoned children
- The juvenile/child has been defined as anyone who has not completed the age of 18 years
- There is a separation between children in need of care and protection and those in conflict with the law.
- This Act defines -
- A heinous offense attracts a maximum punishment of 7 years imprisonment under any existing law.
- A serious offense attracts imprisonment of 3 to 7 years.
- A petty offense attracts a maximum of 3 years imprisonment.
- In this Act, children in conflict with the law are put under two classes or groups
- Those below 18 years of age in case of petty or serious offenses and those below 16 years of age in case of heinous offenses. This group is to be dealt with by the Juvenile Justice Board constituted under this Act.
- Those who have completed 16 years of age but are below 18 in case of heinous offenses and such offenders can be treated as adults. They are to be kept in a place of safety until age 21 and may be sent to an adult jail to complete the remainder of the sentence.

❖ Under the Act, the Child Protection Committee must investigate any child produced before it. Orphaned and delivered children are also included in the

procedure.

- ❖ Section 3- states the principles of care and protection of children
- ❖ The Act describes the functions and powers of the Juvenile Justice Board and the Child Welfare Commission.
- ❖ Juvenile Justice Board:
- ❖ It is a judiciary body before which children detained or accused of a crime are brought.
- ❖ It acts as a separate court for juveniles since they are not to be taken to a regular criminal court.
- ❖ The Board comprises a judicial magistrate of the first class and two social workers, one of whom should be a woman.
- ❖ The Board is meant to be a child-friendly
- ❖ Child Welfare Committee:
- ❖ The State Governments set up these committees in districts following the provisions of the Act.
- ❖ The Committees have the power to dispose of cases for the care, protection, treatment, development and rehabilitation of children in need of care and protection and to provide for their basic needs and protection.
- ❖ Points to ponder in Jac
- ❖ Treating minors between 16 and 18 years differently violates Article 14, which guarantees every citizen the right to equality.
- ❖ According to this UNCRC, any individual below the age of 18 is to be treated like a child
- ❖ Section 15- trial like an adult
- ❖ A psychological assessment is to be made to assess whether the minor can be treated as an adult or not- this can be subjective and not entirely scientific

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CHILD ABUSE: RECOGNITION, RESPONSE AND COUNSELING

6

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Child abuse is a misuse of power by adults over children that endangers or impairs a child's physical or emotional health and development. The most common belief about child abuse is that it is a problem of lower socio-economic class and happens to vulnerable children staying in unsafe places is not valid. Most of the abuse occurs to normal children in regular homes. Child abuse can happen everywhere, in streets, institutions, public places, homes, schools, workplaces, etc. Children at risk are both **normal children** and the **vulnerable group,** which includes destitute children, orphans, abandoned children, street children, neglected children, parents who lack economic means, parents with a physical, mental or terminal illness, single parents, children of refugees, migrants, construction workers, victimized children, child beggars, children of prostitutes, rape victims, child sex workers, HIV/AIDS affected children, substance/drug abuse, child labourers, etc. The abusers can be parents, caregivers, teachers, neighbors, family members, frequent visitors, strangers…almost anyone. In most cases, there is a likelihood of recurrent abuse and also of siblings or other children in similar situations.

The forms of child abuse are:

- Physical abuse,
- Sexual abuse,
- Emotional abuse and
- Neglect.

RECOGNITION

Potential Indicators of Sexual and/or Physical Abuse

Nonspecific Signs/Symptoms of Traumatic Stress Sudden changes in behavior, e.g. regression of milestones like thumb sucking, bed wetting, temper tantrums, clinginess

Chronic pain without obvious source; Change in eating patterns

Recurrent urinary tract infection, nocturnal enuresis,

Sleep problems; Interpersonal problems (e.g., withdrawal, aggression; avoidance) Decrease in academic performance.
Anxiety, poor concentration, Dissociative symptoms.
Problematic sexual behavior Depression, self-harm behavior, Difficulty controlling emotions.
Sexual Abuse; Symptoms/signs of sexually transmitted infection, Anogenital trauma, Pregnancy (in specific contexts)

Physical Abuse; Injuries in ordinarily protected areas of the body (e.g., ears, neck, torso, upper arms, upper, medial, or posterior thighs, genitalia, buttocks, feet) Patterned injuries (reproduce the shape of impacting object)
Explanation of injury that is:

- Inconsistent with the child's developmental capabilities
- Inconsistent with the mechanism or appearance of injury
- Changing over time or between caregivers

History

Detailed **medical** and social history, including presenting symptoms, is mandatory. A high index of **suspicion** should be maintained.

1. Any history of fall, fracture or injury (including head injury), poor growth and stunting, recurrent UTIs or abdominal pain, unexplained bruises, redness, bleeding or pain at the genitals, anus or mouth, genital sores or discharge in genital area et should be noted.

2. Behavioral History includes

a. fear of certain people or places, nightmares, trouble sleeping, or other extreme fears without an obvious explanation,

b. loss of appetite, trouble eating or swallowing or sudden changes in eating habits,

c. sudden mood swings: rage, fear, anger, insecurity or withdrawal, abdominal pain all of the time with no identifiable reason,

d. an older child behaving like a younger child, such as bed-wetting or thumb sucking, adult-like sexual activities with toys or other children, new words for private body parts, resistance to bathing, toileting, or removing clothes,

e. talking about a new older friend, suddenly having money, toys or other gifts for no apparent reason,

f. cutting, burning or otherwise intentionally harming herself or himself, i.e. drug

use, alcohol abuse, sexual promiscuity, running away from home, negative body image, etc.

3. Inconsistency in history, poor corroboration with physical findings, psychosomatic symptomatology, previous or repeated similar injuries, delay in seeking medical help, and circumstantial evidence should be noted.

Examination

Detailed **general** and **systemic** examination of the child with **local** examination for determining size, shape, site and nature of injury should be carried out.

Differential Diagnosis includes Bleeding disorder, hemangiomas, urticarias, skin lesions, meningococcal disease, birthmarks, etc., and these conditions should be ruled out.

Fabricated illnesses include repeated presentations or persistent symptoms, unusual symptoms, family history of similar or unusual patterns, sudden death etc. It is usually seen in families with medical knowledge or training.

In cases of Sexual Abuse, the presenting complaints could be inappropriate sexual behaviour or tendency, vaginal discharge or bleeding, vulvovaginitis, rectal bleeding, bites, bruises around genitals, anus, oral, breast or thighs, lacerations or tears around these areas, mutilation of genitals in extreme cases etc. Hence, a detailed **genital** examination is mandatory.

Emotional Abuse and Neglect present as feeding problems, poor growth and stunting, developmental delay, behavioral problems, poor school performance, substance abuse, etc. These children are also prone to other forms of abuse.

Investigations as per the type of abuse and physical findings should be obtained. Multiple references should be obtained from a gynecologist, psychiatrist, counselor, etc.

Effect of Abuse on Children:

Children suffering from abuse develop a range of **maladaptive, anti-social and self-destructive behaviors and thoughts** by trying to cope with the abuse. They are forced to handle the stress of coping single-handedly without getting to confide with any family member about the trauma that has accrued to them as a result of the abuse. This creates a feeling of **alienation** among the child from his immediate family, creating a situation detrimental to his normal physical and mental development.

Another disturbing aspect of abuse is the **experiential restraint** it puts on children.

If a child fear doing anything new because of the chance that it will lead to a violent attack or because an abusive parent keeps extremely tight control over children, the child will lose his or her sense of curiosity and wonder at the world and will stop trying new things and exercising his or her mind. That child will never achieve his or her intellectual potential.

A series of **emotional reactions** result from abuse, including denial, shock, anger, frustration, guilt, blame, shame, sadness, revulsion, horror, disgust, revenge or desire for punishment and post-traumatic stress disorder. **Behavioral manifestations** include externalizing and internalizing behavior patterns. **Personal and social adjustment problems** include weak interpersonal relations, poor social interactions, criminal behavioral tendencies and unconventional sexual behavior.

Long-Term Consequences of Child Sexual Abuse

To understand the long-term consequences of child sexual abuse, it is essential to understand a few key points regarding Finkelhor's conceptualization of the traumatogenic effect of child sexual abuse and the latest neurobiology research on the effect of toxic stress on the brain.

Finkelhor's Conceptualization of Traumatogenic Effect of Child Sexual Abuse

Finkelhor has divided the sequelae of child sexual abuse into four categories, i.e. betrayal, powerlessness, stigmatization and traumatic sexualization. As the perpetrator is usually a known, trustworthy figure, the child feels betrayed when he/ she fails to protect. This leads to a lifelong feeling of distrust and poor interpersonal relationships. The child may feel weak and powerless to stop the abuse, resulting in either despair and depression or aggression later in life. Due to stigmatization, the child feels 'dirty', guilty and responsible for the abuse. This leads to poor self-esteem, drug use and self-harm. Traumatic sexualization is aversive feelings about sex, overvaluing sex and sexual identity problems. Child sexual abuse can lead to sexual aversion or promiscuity later in life.

Effect of Toxic Stress on the Brain

Long-term toxic stress on the developing brain in the form of child sexual abuse can impact learning, behaviour and physical health by disrupting the neural pathways in the hippocampus, orbitofrontal tracts and prefrontal cortex. Due to changes in the hippocampus, linguistic, cognitive, and social-emotional skills are impaired. Disruption of the orbitofrontal tracts leads to maladaptive responses to stress, and changes in the prefrontal cortex led to a hyperresponsive or chronically

activated stress response. This can cause physiologic disruptions that result in higher stress-related lifestyle chronic diseases of the cardiovascular and immune systems. These changes may be potentially permanent and can be transmitted from one generation to another.

Physical Health Consequences

Prospective longitudinal research studies have reported strong associations between child sexual abuse and obesity. Middle-aged women who were sexually abused as children were twice as likely to be obese compared to their non-abused peers. Large cross-sectional studies indicate relations between child sexual abuse and ischemic heart disease, cancer, chronic lung disease, skeletal fractures, liver disease, irritable bowel syndrome, fibromyalgia and chronic pain in adulthood.

Impact on Mental Health

Child sexual abuse can lead to childhood depression, post-traumatic disorder, aggression and criminal behaviour. It can also lead to high-risk behavior like gambling, sexual promiscuity, runaway behavior and drug abuse. Adult survivors have 2-3 times more chances of developing depression, suicide ideation, criminal behaviour, personality disorders, drug addiction and even psychosis than those who had not been sexually abused. They have problems in maintaining intimate relationships and in parenting. Children who have been sexually abused are at increased risk of 'revictimization' in childhood and adolescence. Most victims do not go on to offend others in adulthood, although the chance compared to non-victims is higher. Sexually abused boys experience more internalizing symptoms, including guilt and shame, than girls. Prospective studies have identified that sexually abused children do poorly in schools and, as adults, have lower rates of skilled employment.

Impact on Sexual Health

A few retrospective studies have reported a strong association between sexual abuse and sex trading in adolescence and adulthood. Few other studies have noted an increase in teen pregnancy rates, abortions, early onset of sexual activity, a greater number of sexual partners and increased risk of sexually transmitted diseases. Male sexual abuse survivors have twice the HIV infection rate of non-abused males.

Protective Factors

Research has demonstrated family support, stability and positive parental relationships as important factors that can reduce the adverse consequences of child sexual abuse. Positive peer and intimate partner affiliations in adolescence and adulthood are also protective influences. A few studies have shown that living in communities with strong social cohesion also has a protective effect. Empathetic, non-judgmental and caring response of the health care providers and parents towards the abused child results in a positive outcome.

Role of the Pediatrician & Allied Professionals

As child sexual abuse may affect the individual's entire life span, pediatricians must respond appropriately to a case in a medical setting. Secondly, it is important to break contact with the abuser to keep the child safe and closely follow up on the child's physical and psychological health. Increasing awareness and sensitization among pediatricians for child abuse are necessary. A high index of suspicion should be maintained while evaluating a child with suspected abuse or where some pointers of abuse are found.

The role of pediatricians is critical as Pediatricians are involved with the care of the child from birth to adolescence. Counseling of parents and informed consent becomes the responsibility of pediatricians after evaluation. Relevant authorities must be notified. Treatment and Rehabilitation of these children are of utmost importance; all care should be taken to prevent ongoing abuse. The pediatrician needs to work with a multidisciplinary team consisting of a gynecologist, psychiatrist, psychologist, social worker, child protection agencies, and the police. The paediatrician has to play the main role of a collaborator between various disciplines to ensure the physical, psychological, emotional and spiritual well-being of the victim of child sexual abuse.

RESPONSE OF THE PEDIATRICIAN / MEDICAL PRACTITIONER TO CHILD ABUSE

A pediatrician’s response to a child abuse case in outpatient and inpatient settings should follow three cardinal principles. It should be:

1. Child-centered and child friendly**:** It should keep the best interest of a child in mind. The safety of the child is to be considered paramount.

2. Family supportive: Response should provide adequate support to the family as, generally, family forms the backbone of the child protection system. Keeping the

child permanently in an institution is the last option for child protection.

3. According to the law of the land and 'safe' for the pediatrician, the case's management and documentation should be impeccable to avoid professional litigation later.

When a pediatrician is confronted with a suspected child abuse case, it is important not to respond in a knee-jerk fashion and jump to the abuse diagnosis. **The golden rules to be followed include:**

1. To **consult widely** with people who know the child well, like relatives, teachers apart from parents.

2. To **gather information** from other professionals like the child's regular pediatrician, and the parents' physician, especially if the parent has a mental disease, drug abuse, or other chronic diseases.

3. To **check past medical records** for any hospital admissions (for child safety concerns) and developmental history.

4. To **document child safety concerns** after a comprehensive medical assessment.

5. To conclude, **after discussing** the case with seniors, peers, psychologists, NGOs and social workers.

6. To follow **mandatory reporting of cases of child sexual abuse** to police

The responses of a pediatrician to a child abuse case can be broadly classified into the following:

1. **Urgent response** is needed if the child is brought dead, has a life-threatening injury, or has acute sexual assault (reports within 24-72 hours of the abuse). The child will need emergency care, and the police will require immediate forensic samples to book a strong case against the abuser. Such cases are best managed in a hospital setting. All cases of CSA have to be reported to the police.

2. **Admission to the hospital** is needed in all cases of serious injuries. A child may be admitted if it is felt that there is an immediate threat to his safety at home.

3. **Social Services like Child Welfare Committee (CWC) and Child Helpline (#1098)** or local NGOs may be contacted if the parents refuse to follow the treatment plan or if there is an immediate threat to the safety of other siblings. CWC and Child Helpline can also be contacted in cases where child rights are violated, like neglect, child labour, corporal punishment at school, child marriage etc.

4. **A planned response** is the best. Here a planned interview and examination are performed in a child-friendly atmosphere with the appropriate equipment and

health personnel (social worker, psychologist, and gynecologist if needed). A child-friendly atmosphere is sensitive to the child's needs, where he feels comfortable, relaxed and comfortable confiding his problems.

The long-term after-effects of abuse on physical and mental health are well known, but some children suffer no adverse consequences. The following factors influence the outcome:

- Nature, extent and type of abuse
- Age of child, temperament and resilience of the child, relationship of abuser to the child
- Family's response to abuse and medical management

A single episode of non-contact sexual abuse by a stranger may need reassurance and letting out feelings in one or two counselling sessions with a good outcome. But prolonged abuse by a close family member will require longer and multiple counseling sessions to heal completely

The following form essential goals of a pediatrician's response, along with impeccable documentation and record keeping:

1. **The immediate goal** is to ensure safety, provide emergency care if needed and reassure the child and the family regarding the availability of help.

2. **Comprehensive medical assessment** includes history taking, examination, investigations and forensic sampling in cases of acute sexual assault.

3. Short-term goals include providing trauma-informed care, socio-emotional support to the family, mandatory reporting of CSA cases to police, treating physical problems like injuries, providing immunization, STI and HIV prophylaxis, emergency contraception and multidisciplinary referrals and collaborative care with child welfare agencies, if required.

4. Long-term goals include the complete physical and psychosocial well-being of the child and ensuring his/her reintegration into the family and social system. In cases of CSA, the child may need preparation to attend court

Comprehensive Medical Assessment

A chaperone, preferably a nurse, is a must during the assessment. The assessment should be recorded in a special performa.

History taken from the parent or caretaker should be documented separately from the child's. If possible, interview the child separately. The interviewer must be sensitive to the child's possible fears and apprehension when discussing the home situation and should tailor the interview to the child's developmental level.

Children above the developmental age of 6 years would be verbally able to narrate the abuse. For children between 3.5 to 5 years, toys and art may have to be used to facilitate disclosure. To avoid re-traumatisation, repeated interviews are to be avoided.

- Treating the child and the parents with respect and dignity without making accusations is important.
- Listen carefully and have a sensitive, empathic and nonjudgmental attitude.
- Ask open-ended and non-leading questions.
- Nonverbal cues such as 'watchful frozenness', sad mood, avoiding eye contact, etc., should be recorded. Exact questions and answers need to be recorded verbatim.
- Points to be covered in history include place, time, witness, present and past history, noticeable behavior change, and developmental and immunization history. Family history, pedigree charts and social history are extremely important. A psycho-social history known by the acronym **HEEADSSS** can be taken directly from an adolescent patient. This includes details regarding the home, education, eating behaviour, activities and peers, drugs, depression, suicide, sexual history and sleep pattern.

Examination

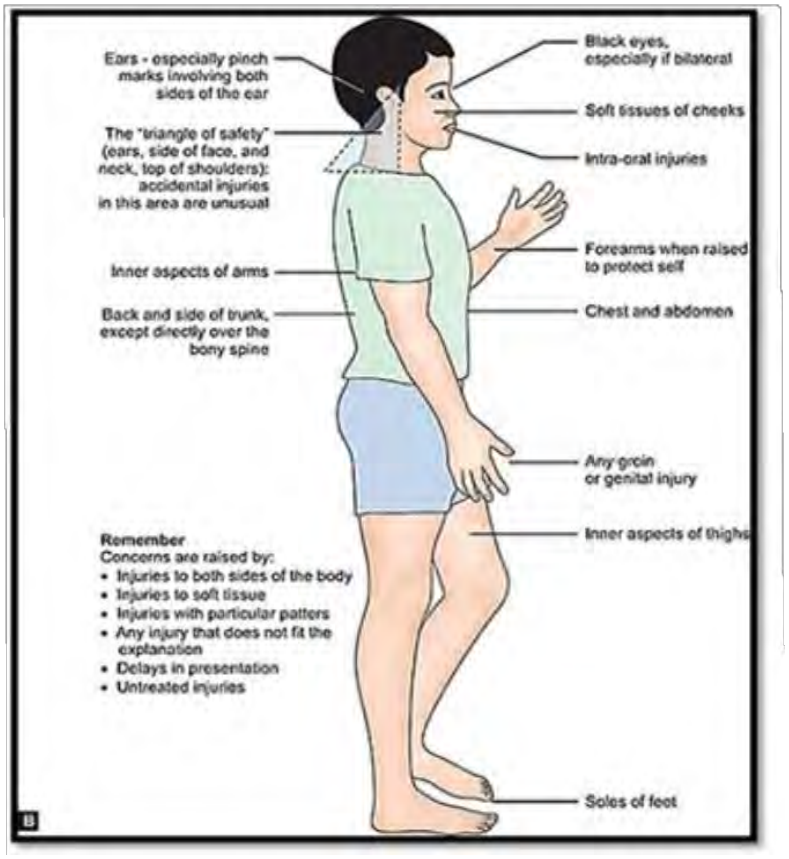
Parental and the child's consent if aged above 12 years and assent if below 12 years are essential for a medical examination. The child may prefer to get examined by a doctor of the same sex. He/she may also choose to have a trustworthy adult with him/her during the procedure. The pediatrician may seek the expertise of a forensic physician and a gynecologist while examining a case of sexual abuse. The following should be recorded:

- General demeanor (like unkempt appearance in neglect)
- Vitals and tip-to-toe general physical examination, especially noting pallor, bruises, vitamin deficiencies
- Fundoscopy may reveal multiple retinal hemorrhages in cases of abusive head trauma
- Height, weight and head circumference are to be plotted on the growth chart
- Sexual Maturity Rating for adolescents
- All injuries are to be marked on anatomical diagrams. Special sites to look for injuries include ears, inside the mouth, soles, genitalia and anus.
- Systemic examination and any evidence of injuries are recorded(figure1)
- Examination of genitalia in girls should be done in supine frog leg, knee-chest prone and left lateral position. Details of hymen and injuries are to be noted.

Anal dilatation on a rectal examination indicates sodomy. The presence of discharge, genital ulcers, warts and inguinal lymphadenopathy are to be noted.

It is seen that in 70-85% of documented sexual abuse cases, the physical examination is normal

Figure: 1 Injuries that indicate Physical Abuse



Investigations

The following investigations need to be done:

Child sexual abuse

STD screening, including low and high vaginal (in post-pubertal girls) swabs and urethral swabs in boys, and serology for HIV, Hepatitis B and Syphilis are done in cases of:

- Acute sexual assault
- Penetrative abuse

- Vaginal/ urethral discharge
- STD in abuser
- Pregnancy test in an adolescent girl

Forensic samples maintaining the chain of evidence include skin, hair, nail clippings, clothing, saliva, and oral and genitourinary secretions in acute sexual assault.

Physical abuse

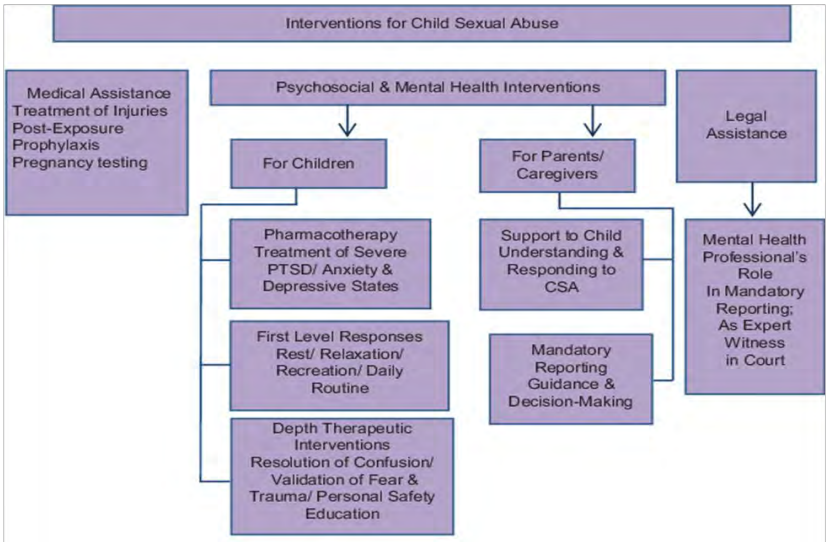
- A skeletal survey is done in case of multiple injuries and if a child is below two years old.
- Multiple bruising entails a detailed hematological profile, including bleeding and coagulation profile.
- Neuroimaging and Ultrasonography of the abdomen are indicated in case of head and abdominal injury, respectively.

Management

Management should be child friendly and aim to achieve short-term and long-term goals. The current and future action plans should be discussed with the non-offending family members. The need for breaking immediate contact with the abuser if he/she is known should be emphasized. All children of the family should be screened for abuse if the abuser is close to the family.

Multiple types of abuse may coexist in the same patient and should be looked for. The physical injuries should be treated. Hepatitis B, DPT/Td/ TdaP and HPV vaccination should be considered if the child is not vaccinated. STI and HIV prophylaxis and emergency contraception are to be given to adolescents with acute sexual assault. Referrals to appropriate specialties and childcare agencies should be made according to the needs of the child. These include psychologists, psychiatrists, orthopedic surgeons, surgeons, social services, and police.

Figure -2 Child Sexual Abuse Interventions



Counseling of the child and family forms the cornerstone of management. In the immediate counseling session following medical management, the pediatrician should focus on the following:

1. Believe the child, reassure and absolve feelings of guilt/ blame
2. Explain the existence of a medical, family and social support system.
3. Listen carefully to all fears and concerns associated with disclosure and mandatory reporting in cases of CSA.

Mandatory Reporting is a process, and the steps should be documented. Pediatricians should partner with parents and the child. Although not always easy, maintaining a professional approach with the family can facilitate the reporting process. Explaining the reporting process and what the parents can expect to happen is often helpful. A non-accusatory statement such as "I am required by law to make a report to the child protective agency whenever I see a child with an injury (a condition) like this one" should be used. Pediatricians should share information about POCSO, elicit queries and concerns, and negotiate. Pediatricians should familiarize themselves with legal procedures, e.g. police statements, magistrate statements, forensic interviewing, examination and sampling, and court cases. Inform them about 'child-appropriate/ friendly' legal procedures like special court for CSA cases, no contact with perpetrator during judicial proceedings and about the child's identity not being revealed by the media. Finally, they should elicit consent/ assent from parents and the child for mandatory reporting. The parents and child should be reassured about the availability of help from support persons and health professionals during the judicial proceedings.

Counseling Family Members

The family members would need counseling regarding the following:

- To deal with guilt
- To normalize family life: encourage family task sharing and caring, routines
- Increase communication between child and parents:, reassure regarding safety measures, do not blame, be open to listening to the concerns
- To respond to the child's emotional issues calmly: avoid fights, reactive discussions, overprotection
- To ensure follow-up appointments
- Referral for individual or family therapy in cases of intense grief, stress, economic distress, divorce, mental disorder

- Guidance regarding mandatory reporting

Child Sexual Abuse (CSA) Survivor Counseling

A trauma-informed approach is followed using age and developmentally-appropriate communication techniques that include the following

- Rapport building: introduction, explaining what you do, establishing context, asking permission, confidentiality, getting to know activities, art, toys
- Active listening
- Acceptance and non-judgmental approach
- Recognising and acknowledging emotions- listen to the inner voice
- Open-ended questioning and summarizing

First-level responses are for the containment of anxiety and include the following:

- Ensure child safety- in concurrence with the child
- Assess the need for pharmacotherapy
- Rest and recreation- music, drawing, play
- Respond to initial questions and confusion
- Relaxation techniques- deep breathing, guided imagery
- Daily routine and developmental activities
- Identity exercises to build self-esteem

Follow up

Follow-up after two weeks is essential to reassess the child. In the acute sexual assault of an adolescent girl, a repeat pregnancy test is warranted. A repeat serology for syphilis at 4-6 weeks and HIV at 3-6 months is required.

Regular follow up of the abused children should include the following:

1. To verify if the abuse has stopped.
2. To monitor physical and mental health.
3. To evaluate the development and ensure that it is normal.
4. To refer for therapy (counseling, cognitive behavior therapy or medication) for delayed presentation of symptoms

Long-term interventions include the following:

- Inquiry: Helping the child detail/provide a narrative on sexual abuse experience in a gentle, non-threatening manner.
- Healing & Recovery: Enabling children to overcome abuse trauma and move from confusion to clarity; empowering children to develop coping and survival skills.
- Personal Safety and Abuse Prevention: Identifying ways to cope/respond in case

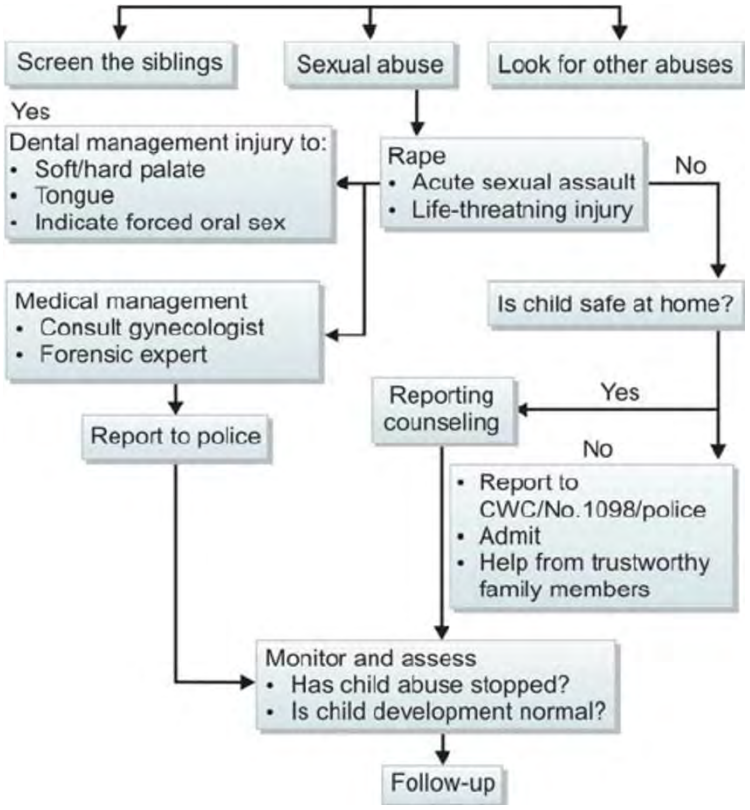
abuse is imminent or after the abuse has occurred (for children); acquire life skills such as decision-making, assertiveness, and negotiation (for adolescents)

- Vision for the future: Who am I? What do I want to be?
- Trauma-focused Cognitive Behavior Therapy includes psychoeducation, normalization of routine, building self-esteem, cognitive restructuring, coping with emotions, coping with stress, sexuality education, parental support, joint sessions with parents, exposure therapy

Suggested Protocol of Pediatrician's Response

The flow chart details suggest protocols for pediatricians to respond to child abuse. Forming a local Child Protection Group at the hospital level is recommended to respond appropriately to child abuse (Figure 3). Such a group could easily be formed in the local medical college, as all the health personnel are available under one roof. The social worker could lead the networking between different professionals and parents. The team members should include the following:

- Social worker - General and Orthopedic Surgeons
- Police - Psychologist and Psychiatrist
- Lawyer - Forensic experts
- Pediatrician - Gynecologists



The group should form a common networking protocol. Each professional group should also form a separate protocol to respond to a case of child abuse at their level.

The key points to be kept in mind while making decisions in the existing framework of child protection services include:

1. **The seriousness of abuse:** Serious abuse requires urgent intervention and long term follow up
2. **Safety of the child:** If the child is not safe at home, help from non-offending family members for a change in residence is sought. CWC, Child Helpline and local NGOs may also help in this situation. If the home continues to be unsafe, safer options like foster care and adoption of the child need to be considered. Sexual abuse needs to be reported to the police.
3. **The importance of counseling and follow-up** of the child is essential issues. Counseling the parents if they are abusers is also necessary. All pediatricians should assess suspected harm with the same thoroughness and attention as they would with a life-threatening condition. Poor management after disclosure can increase psychological damage. A pediatrician should believe, support, reassure, treat and ensure the rehabilitation of victims of child abuse. The existing child social, legal and police services towards child protection are not adequate and child friendly. Hence the pediatrician remains in a dilemma in reporting and seeking help. However, the pediatrician's response must follow the country's existing law. The appropriate response to child abuse by the pediatrician is the need of the hour.

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CHILD SAFETY IN DIFFERENT SETTINGS

7

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Introduction

Child safety concerns child supervision, providing a safe environment, limiting children's exposure to hazards, and teaching them about what is safe and what is not.

Child protection is safeguarding children from violence, exploitation, abuse and neglect.

Two generations ago, our streets were filled with children, running here and there like a swarm of butterflies. Most of the time, they were unsupervised, with the older children looking out for the younger ones.

Alas! Times have changed.

We increasingly hear about reports of child abuse, where the perpetrator is invariably an individual known to the family and trusted by the child and the parents. Is this because of increased crime against children, or is it due to increased reporting?

Why is there a need for increased awareness of child safety, child abuse and reporting? Is a child's safety the sole responsibility of the family, or do healthcare professionals have a role to play?

The National Policy for children in 1974 stated that children are the nation's supremely important asset.

The **Government of India, in 2013, adopted a new National Policy for children to reiterate its commitment to rights based approach to children** which stated that -

1. Every child has universal, inalienable and indivisible human rights.

2. Right to life, survival and development goes beyond the physical existence of the child.

3. The child's best interest is a primary concern in all decisions and actions affecting the child.

These are some of the abuses that children are exposed to – Accidents and injuries,

Bullying, Physical abuse, psychological abuse, Sexual abuse, Abduction, Mental trauma, Teen pregnancy and Death

Magnitude of the Problem

A Study by the by the Ministry of Women and Child Development, Government of India, 2007 revealed that 53% of children had faced one or more forms of sexual abuse. Most children did not report the matter to anyone.

The National Crime Records Bureau has reported that 109 children were sexually abused every day in India in 2018.In its report in 2021, the NCRB reported that the number of cases of crime against children in the preceding three years was 4,18,365. Of these, 1,34,383 cases were of child sexual abuse offences under POCSO.In 96 % of cases, the offender is known to the child. In 51% of cases, the offender is a family member.

The latest report of the National Crime Records Bureau (NCRB) revealed 149,404 crimes against children, according to a quick analysis by non-profit Child Rights and You (CRY). Every hour, there were 17 crimes against children in India — translating to a whopping 409 crimes every day.

There is a worrying rise in crimes against children compared with the year before. In 2020, 128,531 cases were recorded, according to the NCRB data. In 2021, the number saw a 16.2 percent increase. A close look at the decadal scenario also pointed to an alarming upward trend. Crimes against children increased sharply by 351 percent between 2011 and 2021.

A child at risk is said to be a person under 18 years of age who experiences an intense or chronic risk factor or a combination of risk factors in personal, environmental or relational domains that leads to undesirable actions where the victim is the child.

Risk Factors

FAMILY RELATED FACTORS that put a child at risk of abuse-

- Poverty
- Low parental education level
- Parental mental illness
- Single parenthood
- Parental substance abuse
- Family discord

COMMUNITY risk factors

- Low-income community
- Low high school graduation rate
- High crime rate

CHILD VULNERABLE AT HOME; Situations that leave the child vulnerable include;

- Parents away at work, a child with a caregiver
- Large house, extended family, demanding to keep track of every event
- Intimate partner Violence (IPV) & Conflict between parents
- Left home alone without supervision
- Abusive first-degree relative

MISCELLANEOUS FACTORS; A child is more at risk of being abused if any of these are present –

- A previously abused child
- Low self-esteem
- Disabled child
- A child left with caregivers
- Unsupervised time with members inside/outside the family

Child safety in Schools

1. Screening all teaching and non-teaching staff before the appointment (mental health/criminal record)

2. Installation of CCTV cameras in isolated areas on the campus

3. Identification and close follow-up of drug abuse among students

4. Counselor to follow up on the mental health of students

5. Conduct awareness programs for parents on child safety and child sexual abuse

6. Have a school child protection policy in place for handling and reporting child sexual abuse.

7. By overcoming the fear of stigma and the temptation to suppress facts, if the school acts swiftly on the complaint of a single child being abused, many more children will be saved.

One should remember that NO CHILD IS SAFE FROM THE RISK OF BEING SEXUALLY ABUSED. Boys are also sexually abused.

Role of Pediatricians

Our role as pediatricians does not end with monitoring growth and development, vaccination, identifying illness early and giving appropriate treatment.

As pediatricians, we are in a unique position

1. We have gained the family's trust
2. There is a high possibility of complete disclosure
3. It is possible to have a long-term follow-up, especially since the psychological consequences of abuse on the child and the family need time to be addressed fully

4. Any change in the child's behavior, growth or deterioration in school performance is reported to us. All we need to have is a degree of suspicion.

It is time to step out of our comfort zones.

- We, the pediatricians, have a definite role to play in child safety.
- We must learn to suspect, identify, manage and report cases of child sexual abuse.
- As in any disease management, primordial prevention plays a significant role. We should create awareness in our place of work and the community about child abuse.
- Posters, booklets, handouts and videos can be used in the clinics to raise awareness among parents about child safety, sexual abuse and how to contact us to seek help.
- We can periodically deliver awareness talks in schools, addressing parents, teachers and students separately.
- Our role in child protection goes a long way in nourishing an abused child's mental health for life.
- Our anticipatory guidance goes a long way in prevention and early identification.
- Articles on child sexual abuse and management must be shared in our local pediatrician's groups, and the protocol for the approach and management of an abused child must be given as much importance as the protocol for other pediatric problems.

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PERSONAL SAFETY EDUCATION OF CHILDREN 8

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The concept of Personal Safety Education works to allow every child the right to feel safe all the time, using a methodology that promotes the safety of self against abuse. Personal Safety empowers children to take part in their own protection by giving them age-appropriate information, skills, and self-esteem. Personal Safety teaches children that their body belongs only to them and nobody has the right to touch them in a way they don't like or understand. Learning about personal safety help children to go a long way in preventing sexual abuse and violence against them. Every child has the right to be safe, and parents, teachers, and Pediatricians have a considerable role to play.

The **aims and objectives of this chapter** are to prevent violence against adolescents & school going children, through understanding personal safety.

1. How to teach children about personal safety.
2. Prevention of Child Sexual abuse, by knowing personal safety principles.
3. Dealing with difficult situations, like when you are alone at home, facing strangers,
4. Bullying in School-going children and Teenagers.

THE IMPORTANCE OF PERSONAL SAFETY

Research shows that teaching children about personal safety reduces the likelihood of a child entering into an unsafe situation.

- Clearly demonstrates how to respond to an unsafe situation.
- Increases a child's sense of confidence and in doing so increases their resiliency.
- Increases a child's knowledge of their personal rights i.e. "*I have the right to feel safe with people*".
- Increases the likelihood that the child will speak out if they feel unsafe and tell someone they trust.
- Can interrupt or prevent grooming.

IT'S NEVER TOO EARLY TO TEACH PERSONAL SAFETY

It's never too early to sow the seeds of personal safety and children can begin learning about keeping safe as young as three. As parents, we need to teach our children five basic principles, which form the basis of our personal safety education program for young children. These principles are:

- To trust their feelings and to distinguish between 'yes' and 'no' feelings
- To say 'no' to adults if they feel unsafe and unsure
- That they own their own bodies
- That nothing is so yucky that they can't tell someone about it
- That if they feel unsafe or unsure to run and tell someone they trust.

YOUR AWARENESS IS THE ONLY WAY FORWARD

Children should be taught from the start that they should stand up for their rights, learn to speak for themselves, learn to say NO, and learn to communicate.

Children should know about **safe and unsafe touch**.

What is unsafe touch?

1. Any touch which makes you uncomfortable
2. Any touch on the private parts
3. Any touch for a longer time than a handshake
4. Any touch from strangers
5. Any touch where the person asks you to hide

Children can communicate and convey only when they are aware and clear about these.

The next important thing to know is how to talk to strangers alone. Children should be taught the below-mentioned things clearly

1. Talk to people you know well
2. Avoid talking to strangers when alone
3. No personal information should be given to anyone unknown
4. Avoid talking about family to people unknown
5. Always inform parents if someone asks you something
6. A list of safe adults should be known to children (save the password for 8+ years)

7. Your choice of how to greet people/say goodbye
8. Be aware of regular outsiders (Delivery people, volunteers, etc.)
9. Whom to call when alone
10. Push the person away if required

Safety rules for school-going children should be known to them and reminded repeatedly.

1. I AM THE BOSS OF MY BODY! I have the right to say no when I am not sure.
2. I know my NAME, ADDRESS, & PHONE NUMBER, and my parents' names.
3. Safe Grownups will never put the child's life in DANGER. A well-wisher adult will never ask the child to go somewhere alone at night.
4. I never go ANYWHERE or take ANYTHING from someone I do not know.
5. I must "CHECK FIRST" with my safe grownup for permission: before I go anywhere, change my plans, or get into a car, even if it is with someone I know.
6. Everybody's swimming suit areas are PRIVATE and should not be exposed in front of anyone.
7. I do not have to be POLITE if someone makes me feel scared or uncomfortable. If I have to, it is okay to say NO… even to a grownup.
8. I do not keep SECRETS… especially if they make me feel scared or uneasy.
9. If I ever get LOST in public, I can FREEZE & YELL or go to a Mom with Kids and ask for help.
10. I will always pay attention to my Special Inner Voice, especially if I get an "uh oh" feeling.

Additional Rules for teenagers

1. DO NOT GO OUT ALONE. There is safety in numbers, and more kids together are always better. This rule is not just for little kids; it applies to teens, too.
2. ALWAYS TELL AN ADULT WHERE YOU ARE GOING. Letting someone know where you will be at all times is smart. If you are faced with a risky situation or get into trouble, your family and friends will know where to find you.
3. SAY NO IF YOU FEEL THREATENED. If someone touches you in a way that makes you uncomfortable, you have the right to say no. Whether it is pressure

about sex, drugs, or doing something you know is wrong, be strong and stand your ground.

Home Alone Tips to be told to children -

1. Check out the house before entering. Go to a safe place to call for help if something does not seem right.
2. Lock the door.
3. Call your mom or dad when you get home to tell them you are safe.
4. Never tell callers that your parents are not home. Just say that he or she cannot come to the phone and offer to take a message.
5. Do not open the door for or talk to anyone who comes to your home unless that person is a trusted family friend or relative and your mom or dad has said it is okay

How to Deal with Domestic Issues

- Talk to someone you trust
- Try talking to your parents
- Maybe a sibling, teacher, friend, cousin
- Always remember, its not your fault
- Do not blame yourself
- Be positive
- Escape from the issues

BULLYING

Bullying is a common form of aggression among girls and boys, mostly in schools and colleges, and may occur to you anywhere – playgrounds, classes, tuitions, etc. Always remember that bullying is not your fault, and there is nothing to be ashamed of. Do not be afraid to tell your parents or teachers. Always take help when needed

There are three crucial components of bullying -

1. A**ggressive behavior** that involves **unwanted adverse** action.
2. Happens **repetitively** over time.
3. It occurs in **asymmetric unequal power relationships** where the victim is seen as defenseless and unprotected.

There are several methods to cope with bullying -

1. **Identify real from perceived harassment –**Sometimes, it may not be what you think. You should identify and discuss these with your friends and family, especially if in doubt.

2. **Assertiveness –**Being frank and open about how we feel and conveying this firmly and boldly (not aggressively) to the other person.
3. **Self-awareness –** Knowing our pitfalls, shortcomings, limitations, etc., and strengths bring down our expectations from ourselves and others to a manageable level.
4. **Effective communication –** Nonverbal tools such as smiling, eye contact, facial expressions showing interest in another person, body language, etc., are crucial to human interaction. Choose carefully the words you speak, and the tone and pitch of voice must be non-hurting and clear. Many times humour may ease out tense moments.
5. **Special talent –**Having a hobby and inculcating in a sport right from the beginning is always helpful. This compensates for some of the weaknesses which we have. It also enhances self-esteem and self-confidence. Choose for yourself, e.g. sports, painting, culinary skills, music, etc.
6. **Making alternate plans –** If expelled or separated from the previous one, be prepared to join another group or create your group. Temporary pain and stress are better than permanent compromises
7. **Handling emotions –**Understanding and addressing our feelings of anguish, anger, loneliness, and being hurt is crucial. Venting out these emotions with some trustworthy listener helps us to manage the crisis
8. **Resilience** – The ability to bounce back from adversity and be futuristic helps us to take life's challenges effectively
9. **Monitoring self-talk** shapes how we feel, think and behave. What you tell yourself is more important than what others tell you.
10. **Cyber skills and ethics –**Posting revealing pictures, videos, and personal information to known or unknown people on the Internet can cause cyberbullying

Important Resilience and coping skills -

- Make connections make good friends, and bond with them
- Helping others may help
- Maintain a daily routine
- Take a break
- Move towards your goal
- Life Skill Education
- Keep a Positive self-view
- Look for opportunities for self-discovery
- Accept Change

Life Educative skills

Adaptive and Positive behavior enable individuals to deal effectively with the demands and challenges of everyday life. Core life skills for the **promotion of Child and Adolescent mental health include:**

- Decision-making
- Creative thinking
- Effective communication
- Self-awareness
- Coping with stress and emotions
- Problem-solving
- Critical thinking
- Interpersonal relationship skills
- Empathy

Visit the website https://www.nimhanschildproject.in for more information.

Whom to contact when needed -

1. National Commission for Protection of Child Rights (NCPCR), www.ncpcr.gov.in

2. Child Welfare Committee (CWC) in every district takes care of children in need of care & protection. CWC should be reached in case of need.

3. As per the POCSO act all cases of Child sexual Abuses should be reported to the nearest police station. This is a mandatory requirement as per law of the land.

4. Child helpline number -1098 / 112

Always remember that when nothing else is available, this will help. Easy to remember 10-9-8

Just remember the 3 Golden words always.

CAUTION COMMUNICATION CONFIDENCE

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2. Hofferth, Sandra L. (2009) Media use vs work and play in middle childhood. Social Indicators Research, 93(1), 127-129

3. National Center for Missing and Exploited Children (NCMEC) http://www.missingkids.com

4. NCMEC's website to teach children about dangers on the Internet http://www.netsmartz.org

5. McGruff the Crime Dog Information for child safety, identification, abduction, fingerprinting, and crime prevention http://mcgruff-safe-kids.com/

CYBER SAFETY IN CHILDREN

9

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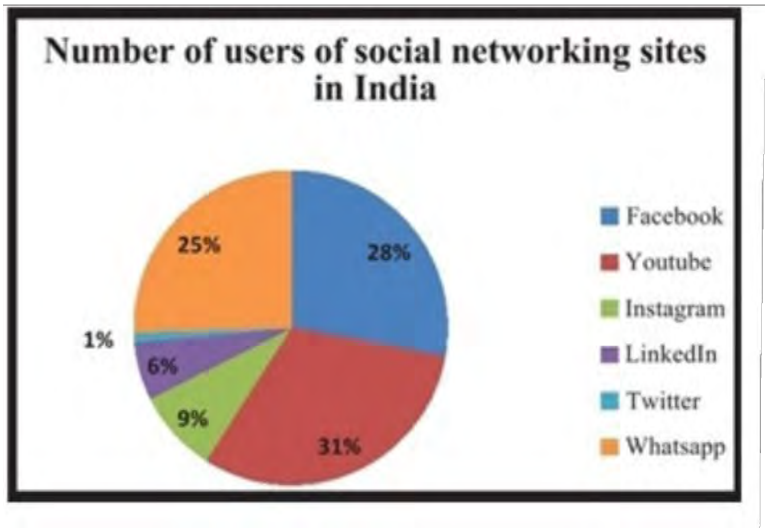
INTRODUCTION

Reports from 2012 indicate that 95% of American teenagers use the internet, and 81% use social media. A poll done in 2009 showed that more than half of adolescents were logging on to a social media website more than once per day and that 22% logged on to a preferred website more than ten times per day. Such websites provide an environment where users can meet, socialize, access information, and enhance learning opportunities.



An Indian study of 984 undergraduate students reported that 35.4% had poor sleep quality and internet addiction (1). A study done among 719 adolescents in Hong Kong observed high comorbidity between internet addiction and insomnia; 51.7% of these student's internet addicts were insomniacs. Studies have also suggested that adolescents with internet addiction may have personalities vulnerable to any other addiction and are at increased risk of substance abuse. Neuropsychological explanation proposes that nicotine and alcohol shares a common reward pathway

Over the years, a consistent relationship has been found between Cyberbullying and Mental health conditions such as depression and anxiety. Children & Adolescents lack awareness of coping Strategies to cope with cyberbullying; therefore, efforts should be made to increase education regarding how to address it and whom to tell, focusing on recipients and bystanders.

The rise in internet use in a child's life since the pandemic. The internet is a powerful tool for learning and communicating with people. However, there are many dangers that one must watch out for. Children and adolescents access the internet unsupervised and engage in discussions and, at times, pictures of a sexual nature. They would be highly susceptible to targeting by pedophiles and child pornographers. They can be victims of cyber grooming/Cyberbullying.

CYBER GROOMING

Cyber grooming is 'befriending' a young person online "to facilitate online sexual contact and/or a physical meeting with them to commit sexual abuse". Cyber grooming is when someone (often an adult) befriends a child online and builds an emotional connection with future intentions of sexual abuse, sexual exploitation or trafficking.

The main goals of cyber grooming are

- to gain the trust of the child
- to obtain intimate data from the child (primarily sexual)

The child who is a victim of cyber grooming feels violated and betrayed, and a child who has been groomed may feel responsible for or deserving of the abuse, leading to self-blame and low self-esteem.

Prevention and Protection from Cyber Grooming Children should be taught to:

- Avoid interacting with online strangers or people.
- Do not accept friend requests from people not known.
- Do not share private and confidential information publicly.
- Check and set privacy settings on websites and platforms regularly accessed.
- Do not accept gifts or offers from strangers met online.
- Block and report anyone who tries to abuse them online.
- Tell parents, guardians or trusted adult/s about any bad experiences they have online
- Do not visit untrusted sites or use anonymous video chat and live streaming apps.
- Know where to report online abuse and exploitation

Parents and Guardians

- Spend time with children and help them to use the internet safely.
- Teach children about online dangers.
- Monitor children's online activities and whom they are communicating with.
- Be alert to signs of distress.
- Listen to children without judgment and guide them towards a better solution rather than blaming them.
- Report online abuse cases to the police.

CYBERBULLYING

Cyberbullying is a form of intentional, repeated aggression using electronic forms of contact, such as text messaging and social media. The increase in cyberbullying cases is believed to correlate with the increased time spent online during COVID-19 lockdowns. As of January 2020, 44% of all internet users experienced online harassment. The most prevalent type of online harassment was offensive name-calling, making up 37% of all instances.

Cyberbullying harassment includes following the use of technology to antagonize the victim to harm:

- Social networks (Facebook, Twitter, Instagram, etc.)
- Cell Phone texting
- Picture messages
- Chat rooms
- Blogs
- Phone calls, text messages, videos etc.

Why is it done?

- Defamatory rumours to ruin the cyber victim's reputation
- Teasing
- Taunting
- Humiliating
- Threat

According to cyberbullying statistics from the i-safe foundation

- 38% of teen girls and 26% of teen boys are cyberbullied
- 25% of teens are bullied repeatedly through cell phones and the internet, and 20% of teens are repeatedly threatened online
- 1 in 10 teens has had embarrassing or damaging pictures taken without permission
- 1 in 5 teens is engaged in sexting
- Increase in the likelihood of being cyberbullied if a social networking site is used

Types of cyberbullies

a) **Vengeful angels**

- They do not see themselves as a bully at all
- They see themselves righting wrongs or protecting themselves or others from the "bad guy" they are cyber bullying
- They are teaching the new victim (initial bully) a lesson
- They are getting revenge on the new victim

b) **Power-Hungry and revenge of nerds**

- They want to exert their authority and show that they are powerful enough to make others do what they want
- They also want to control others with fear
- They want an audience so they can brag
- This type of bully is usually a victim of offline bullying
- They may be physically smaller and usually picked on for not being popular or cool
- The intention is to frighten and embarrass others
- Act tough online but not in real life

c) **Inadvertent Cyberbully**

- They do not see themselves as a bully at all
- Maybe pretending to be tough online, like role-playing for fun
- They may be reacting to hateful messages they received and feel hurt or angry from what was sent
- They do not lash out intentionally like revenge for the nerd's cyberbullies
- They respond without thinking of the consequences of their action
- Respond out of anger and frustration - they do not think before clicking "send."

d). Mean Boys & Girls

- They are bored and looking for entertainment
- Ego-based cyberbullying requires an audience
- They want others to know who they are and that they have the power to cyberbully others
- Group admiration, cliques and silence of bystanders encourage cyber bullying
- It will quickly die if they do not get the attention they are seeking

Consequences of cyberbullying

- Increased anxiety
- Distress, Stress
- Irritability, Fear
- Suicidal tendencies
- Depression, Low self-esteem
- Loneliness, Loss of interest
- Post Traumatic Stress Disorder

How to identify a cyber victim?

- Unexpectedly stops using their computer or cell phone
- Appears nervous or jumpy when an instant message or email appears
- Uneasy about going to school
- Appears to be angry, depressed, or frustrated after using the computer or cell phone
- Becomes withdrawn

Challenges today make it difficult to prevent cyberbullying:

1. Children and Adolescents cannot see the harm associated with it. They dismiss it because there are "more serious forms of aggression to worry about."
2. Parents say they do not have the technical skills to keep
3. Teachers are afraid to intervene in off-campus behaviours up.
4. Law enforcement is hesitant to get involved unless there is clear evidence of a crime or a significant threat to the victim's physical safety

What can we do?

As parents of the victim

- Believe the child and help the child feel safe and secure with unconditional support- Parenting Concepts
- Listen to the child
- Help the child seek help: school administrators and, if necessary, law enforcement

officers

As parents of a child who is doing cyber bullying

- Address the problem head-on and not wait for it to go away. Talk to the child firmly about his/her actions and explains the adverse effects it has on the victims
- Let the child know of the consequences of their actions both at home and at school
- Inform the child that there are Cyber Laws to protect the Rights of Children and Adolescents

- Restrict the privilege of using cell phones and computers
- Refer their child to a counselor

As teachers

- Educate students that it is wrong, and if found doing so, they will be subject to discipline
- Review their harassment and bullying policy to see if cyberbullying is included
- Educate parents and students about cyberbullying and its effects
- Incorporate cyberbullying lessons in the school counseling program
- Make students aware that sexting can label them as "Sex offenders."
- Pseudonyms cannot protect them, and they can be tracked (IP address and phone companies
- Tell students that the posts they put on social media reflect negatively towards them and may affect their future college and job applications

The following can be displayed in schools/public places (NCPCR)

ONLINE PORNOGRAPHY- IS IT A CRIME?

- "Pornography" can be broadly said to portray sexual actions to produce sexual excitement through books, films, pornographic websites etc. One of the most common uses of the internet is to download and transmit pornographic films, texts, photographs, and photos.
- The laws specify the events and situations that trigger punishment but do not define "pornography" or "obscenity" precisely and specifically, causing uncertainty because not all pornographic material is obscene and hence receives a varied penalty.
- The Supreme Court of India (2015) stated that an adult viewing porn in a private room may fall under the Constitution's right to personal liberty and is, therefore, legal. Watching pornography in a group or a public location is prohibited. It is noted that if a person privately watches a porn video and then shares it or stores it, it is an offense under Indian Laws.
- Every act relating to child pornography is punishable; therefore, even watching child pornography is illegal.
- Sex stories, by the definition of law, unless a text is for the public good of creating awareness, sex education etc., sex stories textual fall under the ambit of pornography and its rules.

Legal provisions

Article 21

- Any material that violates a person's privacy is consequently a violation of Article 21. Justice K. S. Puttaswamy (Retd.) and Anr. v. Union of India and Ors (2018) deal in this regard.
- An adult privately watching porn in a private room may fall under the constitution's Right to Personal Liberty

Information and Technology Act 2000

- Section 66-The transmission of photographs of "a private part of any person without his or her agreement is punishable
- Section 67A- Anyone who "publishes or transmits or causes to be published or transmitted in the electronic form" any obscene material can be punished
- Section 67B- Deals with child pornography as an offense

Indian Penal Code

- Section 292-'something' can be considered obscene if it is lewd or lustful or tends

to degrade and corrupt another person.

- Section 293- sells, distributes, exhibits, or circulates such content to any person under 20 years shall be punished. The punishment is higher if convicted for a second time. (7 years imprisonment and a fine)
- Section 471-making digital changes to an image is an offense, i.e. morphing.

POCSO Act 2012

- Section 14 -It is a criminal offense to use a child or children for pornographic purposes.
- Section 15 - prohibits storing or possessing child pornography "for transmitting or propagating or displaying or distributing" it in any manner.

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CHILD SEXUAL ABUSE - FORENSIC EVIDENCE COLLECTION

10

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Forensic evidence includes items that could link the assault to a person and that could link the assault to a location. The evidence collection should be performed if sexual contact occurred within 96 hours of the physical examination.

What is the need for a forensic examination?

- ✓ Whether a sexual act has been attempted or completed
- ✓ Sexual acts - slightest genital, anal or oral penetration by the penis, fingers or other objects, as well as any form of non-consensual sexual touching
- ✓ Whether such a sexual act is recent
- ✓ Whether any injury has been caused to the child's body. (Absence of injuries does not imply consent)
- ✓ The survivor's age, in the case of adolescent girls/boys.
- ✓ Whether alcohol or drugs have been administered to the child

Every hospital must have a Standard Operating Procedure (SOP)

- To provide comprehensive services.
- For the smooth handling of the cases and clarity of roles of each staff.
- To have uniform practice among all doctors in the hospital
- The SOP must be printed and available to all staff of the hospital

The Forensic protocol (SOP) includes

- Consent
- History taking
- Examination
- Evidence Collection
- Packing, sealing and handing over the collected evidence to police
- Documentation – Report writing

BE AWARE of

1. **Mandatory Reporting**
   - Even if a person does not want to complain but requires a medical examination and treatment, the Doctor is bound to inform the police as per law and provide all the needed medical care.
   - There is mandatory reporting in all POCSO cases.
   - Neither court nor the police can force the survivor to undergo a physical examination. It has to be with the informed consent of the survivor/ parent/ guardian (depending on the age).
2. **Informed Refusal**
   - If the survivor does not want to pursue a police case, MLC must be made, and the survivor must be informed that she has the right to refuse to file FIR.
   - An informed refusal must be documented in such cases, but that refusal will not be used to deny treatment to the survivor
3. **Rules of Examination**
   - Any registered medical practitioner can conduct the examination
   - It is not mandatory for a gynecologist to examine such a case.
   - In the case of a girl or woman, every possible effort should be made to find a female doctor
   - However, the absence of availability of a lady doctor should not deny or delay the treatment and examination.
   - If a female doctor is not available to examine a female survivor, a male doctor should examine in the presence of a female chaperone.
   - There must be no delay in conducting an examination and collecting evidence.
   - Police personnel must not be allowed in the examination room during the consultation
4. **Consent**
   - In life-threatening situations - initiate treatment without consent (section 92 of IPC)
   - If above 12 yrs. of age - The consent form must be signed by the person
   - If under 12 yrs. of age - Consent must be taken from the guardian/ parent

- In the case of persons with mental disabilities, special provisions are available
- The consent form must be signed by: the survivor, a witness – any 'disinterested' person (age above 18 yrs) and the examining doctor

HISTORY TAKING IN CHILD SEXUAL ABUSE

- History of the sexual act is what that will also guide the examination, treatment and evidence collection and; therefore, seeking a complete history is critical to the medical examination process, sample collection for clinical & forensic examination, treatment and police intimation
- Detailed entry has to be made to support the survivor's testimony
- Document/entry of history should contain

✓ Document who is narrating the incident- survivor or Informant - Name and relationship should be noted

✓ The date, time and location of the incident should be recorded.

✓ If more than one assailant - number along with names and relation if known

✓ If the assailant's identity is revealed, it is better to have a counter-signature of the Informant.

✓ Record the history of the incident in the survivor's own words - it has evidentiary value in a court of law.

- Information related to past abuse (physical/sexual/emotional) should be recorded
- In the case of children, illustrative books, body charts, or a doll can elicit the history of the assault. History of any Physical violence during the assault, i.e. Type of violence and its location on the body (e.g. Beating on the legs, biting cheeks, pulling hair, kicking the abdomen etc.
- Record the history of injury marks that the survivor may state to have left on the assailant's body - it can be matched eventually with the findings of the assailant's examination.
- If any weapon(s) were used: sticks, acid burns, gunshots, knife attacks etc.;
- Verbal threats should be recorded in the survivor's words, e.g. harming the child or its near and dear ones
- Record whether the survivor was menstruating at the time of assault/examination-

Some evidence is lost because of menstruation.

PHYSICAL AND BEHAVIOURAL INDICATORS OF CHILD SEXUAL ABUSE

PHYSICAL INDICATORS	BEHAVIOURAL INDICATORS
Unexplained genital injury	Regression in behaviour, school performance or attaining developmental milestones
Recurrent vulvovaginitis	Acute traumatic response such as clingy behaviour and irritability in young children
Vaginal or penile discharge	Sleep disturbances
Bedwetting and fecal soiling beyond the usual age	Eating disorders
Anal complaints (e.g. fissures, pain, bleeding)	Problems at school
Pain on urination	Social problems
Urinary tract infection	Depression
STI[a]	Poor self-esteem
Pregnancy[b]	Inappropriate sexualized behaviours[c]
Presence of sperm[b]	

[a] Considered diagnostic if perinatal and iatrogenic transmission can be ruled out.
[b] Diagnostic in a child below the age of consent.
[c] No one behaviour can be considered as evidence of sexual abuse; however, a pattern of behaviours is of concern. Children can display a broad range of sexual behaviours even in the absence of any reason to believe they have been sexually abused.

EXAMINATION IN CHILD SEXUAL ABUSE

- All the examination are to be done after consent and has to be documented
- Sexually transmitted infections (gonorrhea, HIV, HBV etc.) can be elicited by asking about discharge per-urethra/per-anus, warts, ulcers, burning micturition, lower abdominal pain etc. Based on this information, re-examination/ investigations - are done after the incubation period of that disease.
- Relevant surgical history concerning the treatment of fissures/injuries/scars of the anogenital area
- If the survivor is menstruating at the time of examination, then a second examination is required on a later date in order to record the injuries clearly and rule out pregnancy
- Orientation in space and time - can respond to questions asked
- Any signs of intoxication - ingestion or injection of drug/alcohol must be noted.
- Pulse. B.P., respiration, temperature and state of pupils is recorded.

- A note is made of the state of clothing if it is the same as that worn at the time of the assault. If it is freshly torn or has blood/ semen/ mud etc., the site, size, and colour of stains should be described.
- Injuries are only observed in one-third of cases of forced sexual intercourse.
- The absence of injuries does not mean the survivor has consented to sexual activity.
- As per law, if resistance was not offered, that does not mean the person has consented.

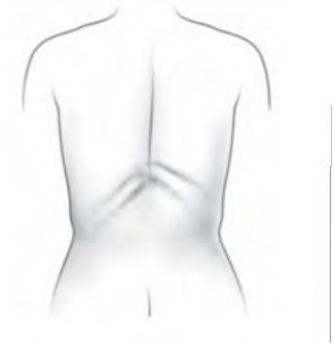
The entire body surface should be scrutinized for signs of bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fractures, tenderness, any other injury, boils, lesions, and discharge, especially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks

- Documentation of injuries
  - ✓ Describe all the injuries.
  - ✓ Describe the Type of injury (abrasion, laceration, incised, contusion etc.), site, size, shape, colour, swelling, signs of healing, simple/grievous, and dimensions.
  - ✓ Mention possible weapons of infliction such as hard, blunt, rough, sharp, etc.
  - ✓ Note the time of injury
  - ✓ Injuries are best represented when marked on body charts.
  - ✓ They must be numbered on the body charts, and each must be described in detail.
  - ✓ Describe any stains on the body - the Type of stain (blood, semen, lubricant, etc.), its actual site, size and colour. Mention the number of swabs collected and their sites

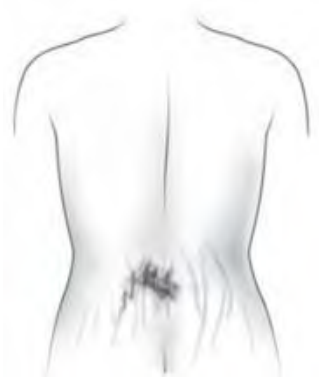
Top to Toe Examination – Corroborate with history – draw a conclusion

Fingertip bruising - Upper arm

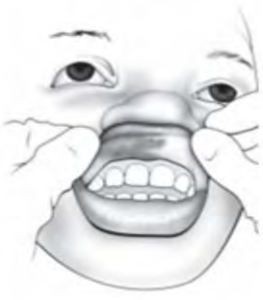
Abrasion / Laceration - Upper arm



Tram line bruise – Back



Abrasions – lower Back- assault on a rough road surface



bruising – inner lip

- **Physical genito-anal findings:**

Genital Normal/ non-specific

- ✓ hymenal bumps, ridges and tags;
- ✓ V-shaped notches located superior and lateral to the hymen, not extending to the base of the hymen;
- ✓ vulvovaginitis;
- ✓ labial

agglutination. Anal –

normal/non-specific

- ✓ erythema;
- ✓ fissures;
- ✓ midline skin tags or folds;
- ✓ venous congestion;
- ✓ minor anal dilatation;
- ✓ lichen sclerosis

- **Physical genito-anal findings –mimics for CSA**
  - ❖ lichen sclerosis;
  - ❖ vaginal and/or anal streptococcal infections;
  - ❖ failure of midline fusion;
  - ❖ non-specific vulva ulcerations;
  - ❖ urethral prolapse;
  - ❖ female genital mutilation
  - ❖ unintentional trauma (e.g. straddle injuries)
  - ❖ labial fusion (adhesions or agglutination)
- **Physical genito-anal findings suggestive of abuse include:**
  - ❖ acute abrasions, lacerations or bruising of the labia, perihymenal tissues, penis, scrotum or perineum;
  - ❖ Scarring or fresh laceration of the posterior fourchette not involving the hymen (but unintentional trauma must be ruled out):

- ❖ condyloma in children over the age of 2 years;
- ❖ significant anal dilatation or scarring.

- **Findings that are definitive evidence of abuse or sexual contact include:**

✓ sperm or seminal fluid in or on the child's body;

✓ a positive culture for N. gonorrhoeae or serologic confirmation of acquired

✓ syphilis (when perinatal and iatrogenic transmission can be ruled out);

EVIDENCE COLLECTION

General Principles for evidence collection

- Collect Specimen ASAP - evidentiary value decreases after 72 hours

✓ Evidence collection need not be limited to the areas in which the patient reports contact.

✓ Specimen collection - for foreign semen, blood, saliva, hair & DNA analysis,

✓ History of bathing - does not rule out obtaining skin or surface swabs - document

✓ Clothing – collect both underwear or diaper worn at the time of the incident and that worn to the examination - fold clothing in such a manner that the stained parts of the clothing are not in contact with unstained parts

✓ The use of a manufactured "Evidence Kit" is not mandatory

✓ Patient comfort should not be compromised for evidence collection

✓ Clothing worn at the time of the assault is to be collected

Details of clothing worn at the time of assault should be recorded.

✓ Once ready for collection, the provider sets the paper on the floor. Use Linens if a paper is not available.

✓ The patient then removes each item of clothing one at a time and places each item in a separate paper bag.

✓ The examiner should also fold the paper / Linen and include it in a separate paper bag.

✓ Following collection, every paper bag should have a label (refer below)

✓ Bags should be sealed and should never be left unattended

✓ Sealed Bags should be handed over to the police

✓ The label should avoid the Name, age and sex of the victim but mention all other

details like Packet number, Name of the hospital & place, Hospital number & date, Police station with MLC number, Sample collected, the examination required, Date & time signature of Doctor with seal

✓ **Post-assault activities are to be documented** as this would have a bearing on the trace evidence collected. Activities such as changed clothes, cleaned clothes, bathed, urinated/defecated/showered/washed genitalia(in all cases) and rinsing mouth, drinking and eating (in oral sexual violence)

Swabs

- It is helpful to affix labels to the drying rack to indicate the site of swabs
- Use cotton swabs only
- Use powder-free gloves, and frequently change during the exam to minimize cross-contamination
- Use the " wet-dry " technique for skin swabs, increasing the recovery of foreign DNA and other stains/evidence.
- Moisten one swab with one drop of water and lightly swab the skin area
- Repeat with a dry swab
- Water for moistening swabs may be supplied in a kit or from a sterile hospital supply

Collection of swabs

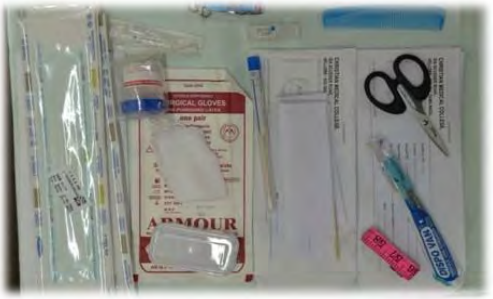
- Moistened swabs are used to collect smears from the oral cavity, bloodstains on the body, foreign material on the body surfaces, semen stains on the skin surfaces, and other stains.
- Always ensure that samples are air-dried in the shade before storing them in their respective containers
- The genital and anal area is examined last. Separate swabs must be taken from the vagina, vulva and anal opening
- Smear the swab on a glass slide for examination of sperm

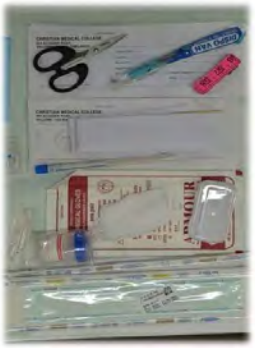
Collection of Hair & Nail

- The head hair of the survivor is then combed for any loose hairs or debris, and 5-10 scalp hairs are cut and preserved in an envelope.
- Material under the child's nails is collected using a moistened swab. Nail clipping is then collected and placed in a separate envelope.
- All collection and handling procedures must be carefully documented.

- Always ensure that envelopes containing samples are labeled and sealed before being handed over to the police.

SAFE KIT





Safe kit contains

- Forms for documentation
- Large sheet of paper to undress over
- Paper bags for clothing collection
- Catchment Paper
- Comb
- Nail Cutter
- Wooden pick for finger-nail scrapings
- Small scissors
- Urine sample container
- Tubes/ vials/ vacutainers for blood samples [(EDTA), Plain, Sodium fluoride]
- Syringes and needle for drawing blood
- Distilled water
- Disposable gloves
- Sterile cotton swabs and swab guards for biological evidence collection
- Glass slides – vulvar/vaginal/anal/oral smears
- Envelopes or boxes for individual evidence samples
- Labels
- Lac(sealing wax) for sealing
- Clean clothing and shower/hygiene items for survivors' use after the examination

HANDING OVER THE EVIDENCE TO POLICE

- Following collection, every paper bag should have a label

- Bags should be sealed and should never be left unattended
- Law enforcement will then need to collect the evidence with the signature on the receipt.

PROVISIONAL CLINICAL OPINION

- Drafting is done immediately after examination based on the history of sexual violence, clinical examination of the survivor, and samples sent for analysis to FSL.
- An inference must be drawn in the opinion, correlating the history and clinical findings.
- Normal examination findings - neither refute nor confirm the forceful sexual intercourse
- The absence of injuries or negative laboratory results may be due to the following:
- The inability of the survivor to offer resistance because of intoxication or threats
- Delay in reporting for examination
- Activities such as urinating, washing, bathing, changing clothes or douching
- Use of condom/vasectomy or diseases of the vas
- The reasoning must be mentioned while formulating the opinion.

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MEDICAL MANAGEMENT OF CHILD SEXUAL ABUSE

11

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Medical Management of Child sexual abuse is a multidisciplinary approach. It includes the following:

1. Emergency/ Primary care
2. Treatment of Infection
3. Pregnancy Prophylaxis [Emergency contraception]
4. Psychological care
5. Specialized/ Specific care
6. Follow up care

1. **Emergency/ Primary care:**
    a. Assurance
    b. Counseling with parents and Child
    c. Stabilization of a Child
    d. Primary Basic Care
    i. Wound care – Cleaning and dressing of the wound
    ii. Tetanus Toxoid vaccine and Immuno-globin as per the immunization status of the child.

2. **Treatment of Infection:**

A. ***Sexually transmitted Diseases:***

It can be given two forms for specific infection or Prophylaxis. If clinical signs of sexually transmitted disease are present, treatment should start along with post-exposure prophylaxis for HIV. If there are no clinical signs, treatment can be on hold till the investigation reports are available

Investigation for the Sexually transmitted disease include:

- Gram stain of vaginal or anal discharge
- Genital, anal, and pharyngeal culture for Gonorrhea
- Genital and anal culture for Chlamydia.
- Serology for syphilis – VDRL
- Wet preparation of vaginal discharge for Trichomonas vaginalis

- Culture of lesions for herpes virus

Prophylaxis can be started as Azithromycin 1gm [10mg/kg/dose] stat OR Doxycycline 100mg [5-10 mg/kg/day]bd for seven days along with Metronidazole 400 mg [20 mg/kg/day] for 7 days. Antacid/ PPI can be given on a need basis. Metronidazole should NOT be given in the first trimester of pregnancy.

B. ***Hepatitis B infection***

All the victims must be evaluated for HBsAg at the time of the first evaluation. They should be provided with 0.06ml/kg HB Immune globulin immediately. It can be given anytime up to 72 hours after the sexual act. Active immunization with Hepatitis B vaccination should be given per the Immunization status and AntiHBs titre.

On follow-up, repeat HBsAg/ Anti Hbs should be done after six months to confirm the Hepatitis B status of the child.

C. ***HIV treatment and Prophylaxis***

HIV- ELISA test should be done for all the victims. Post Exposure prophylaxis should be given if a survivor reports within 72 hours of the assault.HIV risk should be assessed before prescribing.

Repeat HIV testing on follow-up should be done after six months.

D. ***Wound Infection***

Wounds can be bruises, abrasions, or Lacerated wounds. Wound/ Injuries are Genital injuries and other body areas. Genital injury may have perineal tear sometimes, which may require Pediatric Surgery intervention. Injury locations following sexual assault are usually present in the Posterior fourchette (70% of those with genital injury), Labia minora (53% of those with genital injury), Hymen (29% of those with genital injury), Fossa navicularis (25% of those with genital injury) Slaughter et al. (1997).

If the survivor is already immunized with Tetanus Toxoid or has no injuries, TT is not required. If there are injuries and the survivor is not immunized in 5 years, administer ½ cc TT IM. Tetanus immunoglobulin should be given as a passive immunization in an unimmunised child.

Other injuries, such as bruises, abrasions, and lacerations, must be treated as per routine surgical protocol. Surgical reference can be taken if lacerations require repair and suturing, which is often the case in minor girls.

E. ***Urinary tract Infection*** is treated with Oral antibiotics such as Cefixime [15 mg/kg/day].

3. **Pregnancy Prophylaxis [Emergency contraception]:**

A urine Pregnancy test is done in all pre and adolescent girls who are at high-risk.

For Prophylaxis for pregnancy, two tablets of Levonorgestrel 750 mcg. Repeat dose if vomiting occurs within 3 hours OR 2 tablets COCs Mala D - 2 tablets stat repeated 12 hours within 72 hours. Most efficacious if given within the first 72 hours, it can be given for up to 5 days after the assault.

Reassessment must be done on follow-up or if she misses her next period. If the Test is positive for Pregnancy test MTP [Medical termination of Pregnancy] is planned as per the MTP Act.

4. **Psychological care**: Psychosocial care for all survivors should be provided as the first line of support. It is a vital part of management. It includes Primary care for Acute Stress Reaction and subsequently for Secondary [Long term care] for Post Traumatic Stress Disorder.

Psychiatric treatment may need to be continued along with Psychological counseling for months after the assault in rehabilitation. The common mental health issues seen are both Immediate and long-term. Immediate mental effects include fear, Anxiety, Aggressive/ delinquent behavior, substance abuse/ dependency, Impaired social functioning, Distorted cognitive function, Impaired affective processing, Low self-esteem, depression, Anger and hostility, and Sexual behavioral problems. Long-term Mental health effects are Sexual disorder, Depression, Anxiety Disorder, Substance abuse/ dependency, personality disorder, Dissociative disorder, Somatic complaints, Low self-esteem, and Increased vulnerability to other victimization and traumatic experiences.

5. Specialized/ Specific care

It includes referrals as per the case-based need, such as Pediatric Surgery, Orthopedics, Gynecologist, and plastic surgeon.

6. Follow-up care

It is ideal to call the survivor for re-examination two days after the assault to note the development of bruises and other injuries; after that, at 3 and 6 weeks. All follow-ups should be documented. Repeat the test for gonorrhea if possible. Repeat after six weeks for VDRL. A pregnancy test is indicated in pre-pubertal girls if she misses their period. HIV- ELISA test is repeated after six months.

Assess for psychological sequelae and reiterate the need for psychological support.

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ONE STOP CENTRE (OSC)

12

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Gender-Based Violence (GBV) is a global health, human rights and development issue that transcends geography, class, culture, age, race and religion to affect every community and country in every corner of the world. Article 1 of the UN Declaration on the Elimination of Violence 1993 defines gender-based abuse, calling it "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

In India, gender-based violence has many manifestations, from the more universally prevalent forms of domestic and sexual violence, including rape, to harmful practices such as dowry, honour killings, acid attacks, witch-hunting, sexual harassment, child sexual abuse, trafficking for commercial sexual exploitation, child marriage, sex-selective abortion, Sati, etc.

One Stop Centres (OSCs) are intended to support women and children affected by violence, in private and public spaces, within the family, community and workplace. Women and children facing physical, sexual, emotional, psychological and economic abuse, irrespective of age, class, caste, education status, marital status, race and culture, will be facilitated with support and redressal. Aggrieved persons (women & children) facing any violence due to attempted sexual harassment, sexual assault, domestic violence, trafficking, honour-related crimes, acid attacks or witch-hunting who have reached out or been referred to the OSC will be provided with specialized services.

Under this Scheme, in the first phase, one OSC is envisaged to be established in each State/UT to facilitate access to an integrated range of services, including medical, legal, and psychological support. **At the Government level, it will include key stakeholders** from Ministry of Women and Child Development, Ministry of Health & Family Welfare, Ministry of Law & Justice and Ministry of Home Affairs

CRITERIA FOR ALLOCATION and LOCATION OF OSC

The weightage of 40% was assigned to crime registered, 30% to the female population as per census and 30 % to Child Sex Ratio in the State.

- First preference: within a hospital / medical facility.
- Second preference: Within an existing Government/Semi-Government institutions/Women Institutions, including Mahila Shakti Kendras/ Swadhar Grehs/ Working Women Hostels located within a 2 km radius of the hospital/medical facility
- Third preference: The OSC may be constructed on adequate land within a hospital/medical facility or within a 2 km radius of the hospital/medical facility.

TARGET GROUP

Women, including girls below 18 years of age are affected by violence, irrespective of caste, class, religion, region, sexual orientation or marital status. For girls below 18 years of age, institutions and authorities established under the Juvenile Justice (Care and Protection of Children) Act, 2015 and the Protection of Children from Sexual Offences Act, 2012, will be linked with the OSC.

MODEL OF ACCESS to OSC

A woman affected by violence can access OSC in the following manner:

- By herself; or
- Through any person, including any public-spirited citizen, public servant, relative, friend, NGO, volunteer (Fig 1)

Figure:1

Table 1 TYPE OF SERVICE

SR. NO	TYPE OF SERVICE	DESCRIPTION
1	Emergency response & rescue services	Rescue and referral services to the women affected by violence. Linkage- NHM, 108 services, Police
2	Medical assistance	Medical aid/examination which would be undertaken as per the guidelines and protocols developed by the MoHFW
3	Assistant to woman in lodging FIR/NCR/DIR	Facilitate the lodging of FIR/NCR/DIR.
4	Psychosocial support/ Counselling	Give aggrieved women & child confidence and support to address violence or to seek justice for the violence perpetuated.
5	Legal aid & Counselling	Provided through empanelled Lawyers or National/State/District Legal Service Authority.
6	Shelter	Temporary / Long term
7	Video conferencing	Speedy and hassle free police and court proceedings

MULTIDISCIPLINARY TEAM AT ONE-STOP CENTRE

1. Caseworker
2. Police facilitation officer
3. Para legal personnel/ lawyer
4. Para medical personnel
5. Counselor
6. IT staff
7. Multipurpose worker
8. Security

Figure 2. RESPONSE MANAGEMENT

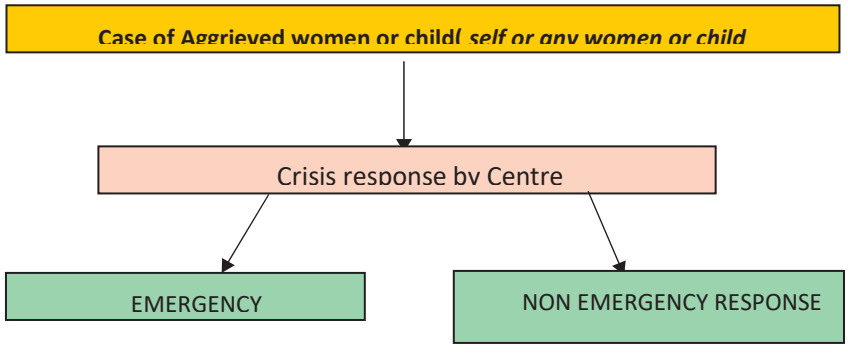


Figure 3. EMERGENCY RESPONSE

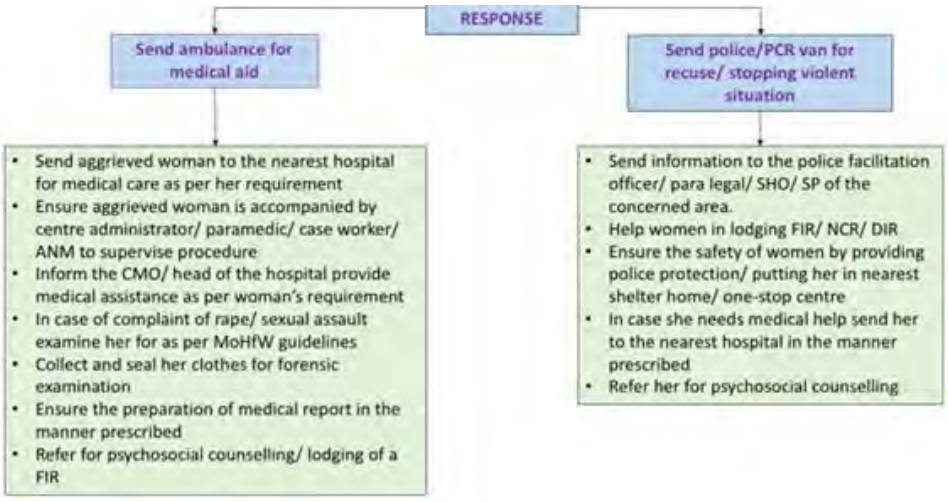
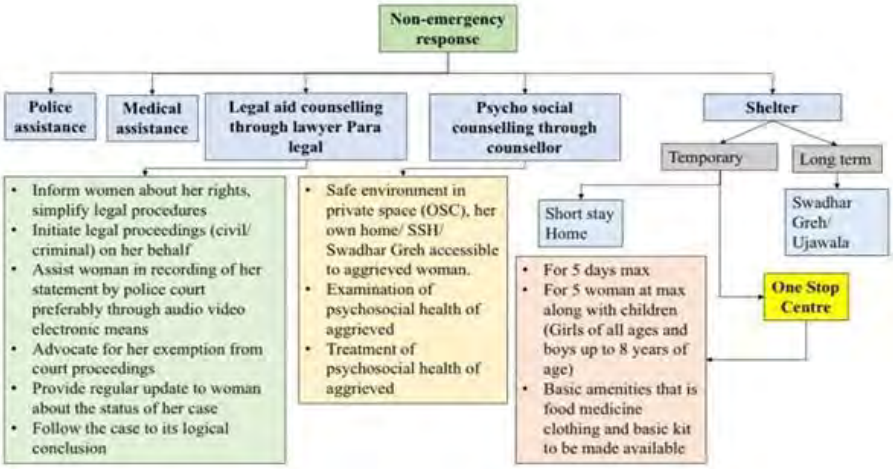


Figure 4. NON-EMERGENCY RESPONSE



STANDARD OPERATING PROCEDURE (SOP) FOR DAY-TO-DAY ADMINISTRATION AND OPERATION OF THE ONE STOP CENTER

Steps for Initial Handholding of women coming to One Stop Centre:

a. Greet the survivor by name; use her preferred name

b. Make her your central focus. c.

c. Introduce yourself to the survivor and tell her your role, e.g. Centre Administrator,

Para-medic

d. Offer her water, and put her at ease.

e. Ensure privacy for history taking, examination and counseling.

f. Aim for respect and professionalism within the boundaries of your survivor's culture.

g. Have a calm demeanor. A frightened survivor will want to be in the company of people who are not frightened.

h. Be unhurried; give time.

i. Maintain eye contact. Be empathetic and non-judgmental as your survivor recounts her experiences.

j. Aim to limit the number of caregivers attending to the survivor: 'one-on-one' care works best in sexual assault cases.

k. Ask the survivor if she wants to have a specific person present for support.

l. Ask the survivor if she has any questions.

Figure 5. Overview of services provided by OSC

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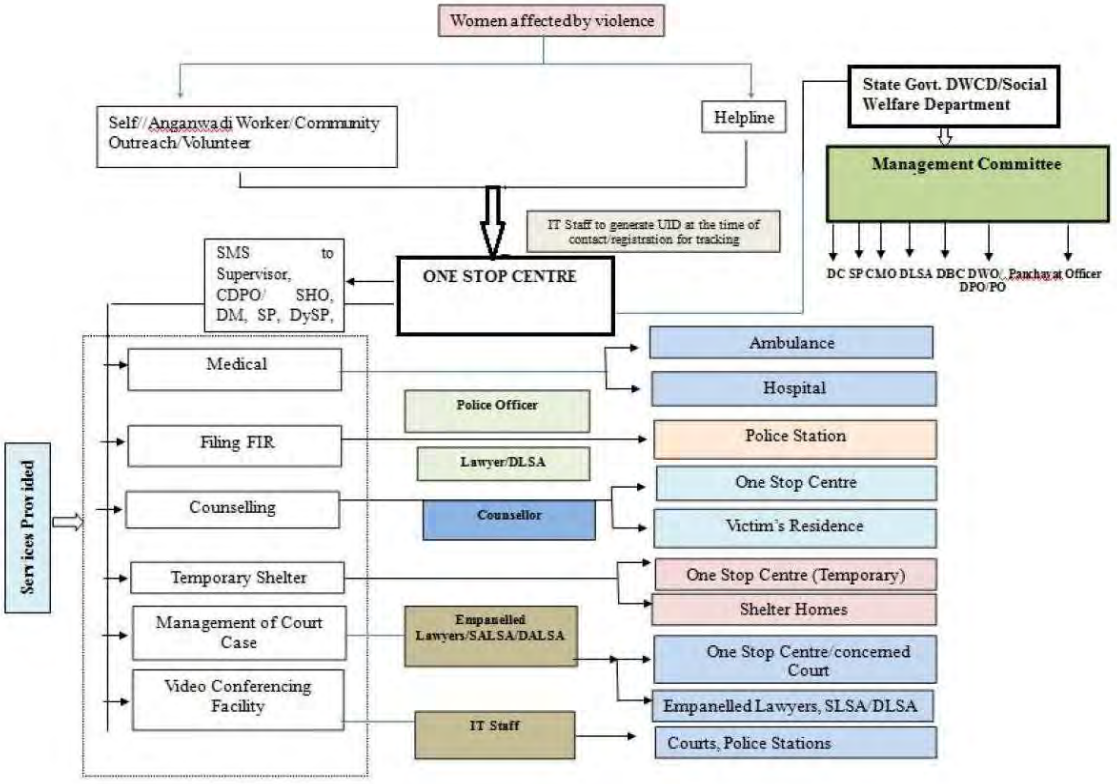

Case-Specific Steps:

The first point of contact for women approaching One Stop Centre would be the Centre Administrator or Case Worker (authorized by her on this behalf), who will take the following steps:

a) She would listen to her grievance, document the case history and ask the IT person to register the case in the online/web-based case management to generate a UID. She would be responsible for the overall supervision of each case.

b) As soon as the complaint is registered, a text message (SMS/Internet) will be sent to the PO/DPO/CDPO/ SHO/ DM/ SP/ DYSP/CMO of the district/area as required.

c) Based on an assessment of the needs of the women affected by violence as expressed by her, the Centre Administrator will refer her to the Counsellor or the Paralegal worker, to the hospital, or to the Police Facilitation Person where she is desirous of registering an FIR.

d) If the woman were provided temporary shelter at the Centre, she would be provided with a Basic Kit with soap, comb, shampoo, hair oil, sanitary pad, toothbrush, toothpaste, and diapers (in case of infants).

e) The next functional interaction with the woman will document the additional information received, the remedy/support sought by the woman, and the action taken in the online case management system. This would be done through password-protected access and adding to the UID-generated case documentation made by the IT person. For instance, if the aggrieved woman is referred to the Police Facilitation Officer for registration of FIR, she will do the needful and document the progress and any additional details in the case management system. This will ensure that the aggrieved does not have to repeat/narrate her story/incident each time she interacts with a new functionary.

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