Child Abuse and Neglect India

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Abstract

India is home to the largest child population in the world, with almost 41 per cent of the total population under eighteen years of age. The health and security of the country's children is integral to any vision for its progress and development. Doctors and health care professionals are often the first point of contact for abused and neglected children. They play a key role in detecting child abuse and neglect, provide immediate and longer term care and support to children. Despite being important stakeholders, often physicians have a limited understanding on how to protect these vulnerable groups. There is an urgent need for systematic training for physicians to prevent, detect and respond to cases of child abuse and neglect in the clinical setting. The purpose of the present article is to provide an overview of child abuse and neglect from a medical assessment to a socio-legal perspective in India, in order to ensure a prompt and comprehensive multidisciplinary response to victims of child abuse and neglect. During their busy clinical practice, medical professionals can also use the telephone help line (CHILDLINE telephone 1098) to refer cases of child abuse, thus connecting them to socio-legal services. The physicians should be aware of the new legislation, Protection of Children from Sexual Offences (POCSO) Act, 2012, which requires mandatory reporting of cases of child sexual abuse, failing which they can be penalized. Moreover, doctors and allied medical professionals can help prevent child sexual abuse by delivering the message of personal space and privacy to their young patients and parents.

Key Words:
Child Abuse and Neglect, Girl Child, Child Labour, Child Sexual Abuse
Prevention, Protection of Children from Sexual Offences (POCSO) Act

Definition and Types of Child Abuse and Neglect

The World Health Organisation (WHO, 1999) has defined '*Child Abuse'* as a violation of the basic human rights of a child. It includes all forms of physical, emotional ill treatment, sexual harm, neglect or negligent treatment, commercial or other exploitation, resulting in actual harm or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. '*Child Neglect'* is defined as (a) inattention or omission by the caregiver to provide for the child: health, education, emotional development, nutrition, shelter and safe living conditions; (b) in the context of resources reasonably available to the family or caretakers; (c) and causes harm to the child's health or physical, mental, spiritual, moral or social development. '*Child Maltreatment*" sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. (1).

Within the above broad definition of Child Abuse and Neglect, five subtypes can be distinguished – physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation. (a) *Physical abuse* - of a child is that which results in actual or potential physical harm from an interaction, which is reasonably within the control of a parent or person in a position of responsibility, power, or trust. There may be single or repeated incidents. (b) *Child Sexual abuse* is the involvement of a child in sexual activity that he or she does not fully comprehend, unable to give informed consent to, or for which the child is not developmentally prepared, or that violates the laws of the society. Child sexual abuse is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power; the activity being intended to gratify or satisfy the needs of other person. This may include but is not limited to: the inducement or coercion of a child to engage in

any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and, the exploitative use of children in pornographic performances and materials. (c) *Emotional abuse*- the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development. (d) *Neglect* is the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes, or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible. (e) *Exploitation* refers to commercial or other exploitation of child in work (child labour), or other activities for the benefit of others, such as child trafficking (2).

Magnitude of the problem

Amongst all reported cases, the US National Child Abuse and Neglect system data (2009) revealed a prevalence of physical abuse 18%, sexual abuse 10%, emotional 8% and rest as cases of child neglect (3-4). A Government of India, Ministry of Women and Child Development (2007) survey revealed that the prevalence of all forms of child abuse is extremely high (physical abuse (66%), sexual abuse (50%) and emotional abuse (50%). (5). A more recent study by the National Commission for Protection of Child Rights (NCPCR), conducted amongst 6,632 children respondents, in 7 states; revealed 99% children face corporal punishment in schools (6).

In developing countries such as India, with adverse socio-economic situation and large population base, child neglect is a serious, widely prevalent public health problem. Poverty, illiteracy and poor access to health and family planning services, result in provision of very little care to the child during the early formative years. Even services that are freely available are poorly utilized. The urban underprivileged, migrating population (a very sizable number) and rural communities are particularly affected. In large cities, there are serious problems of street children (abandoned and often homeless) and child labourers, employed in menial work. Children in difficult circumstances such as children affected by disasters, those in conflict zones, refugees, HIV/AIDS, children with disabilities are a particular cause of concern (7). The

situation of the newborn and the periods of infancy and early childhood are particularly critical and the morbidity and mortality rates continue to remain very high. Maternal under-nutrition, unsafe deliveries, neglect of early development and education are major issues that need to be appropriately addressed. Child rearing practices reflect social norms and very often adverse traditions may be passed from one generation to the next, especially in illiterate and poorly informed communities. As guardians of health, the medical sector has to plan and manifest its efforts, to address child abuse and neglect in this scenario and tackle the many entrenched problems.

Consequences of Child Abuse and Neglect

Child Abuse & Neglect (CAN) exerts a multitude of short and long term effects on children. Short-term effects of sexual abuse may include regressive behaviors (such as a return to thumb-sucking or bed-wetting), sleep disturbances, eating problems, performance problems at school, sexualized behavior, externalizing symptoms like aggression or bullying and internalizing like social withdrawal or complaints of recurrent generalized aches and pains (2). Physical health may also be affected with complaints of recurrent genital discharge, dysuria, abdominal pain and urinary tract infections. The short and long term consequence of children's exposure to child maltreatment includes elevated levels of post-traumatic stress disorder, aggression, emotional and mental health concerns, such as anxiety and depression. According to the Adverse Childhood Experiences (ACE) Study (8), a major American research project examining the effects of adverse childhood experiences on adult health and well-being, a powerful relationship has been established between emotional experiences during childhood and physical and mental health during adulthood.

UN Convention on the Rights of the Child (UN CRC) & Moral imperative

The UN Convention on the Rights of the Child (UN CRC) (1989) is the most widely endorsed child rights intrument worldwide, which was ratified by India (1992) and defines children as all persons up to the age of 18 years (9). Defining violence and children protection rights, the Article 19 of UNCRC declares, "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." (9,10).

Several developed countries of the world have well-developed child protection systems, primarily focused on mandatory reporting, identification and investigations of affected children, and often taking coercive action. The burden of high level of notifications and investigations is not only on the families, but also on the system, which has to increase it's resources(11). In these contexts, the problems of child abuse and neglect in India need serious and wider consideration, particularly among the underprivileged rural and urban communities, where child protection systems are not developed, or do not reach.

The term "protection" relates to protection from all forms of violence, abuse, and exploitation. Based on our understanding, the Indian Child Abuse, Neglect & Child Labour (ICANCL) group, Indian Academy of Pediatrics (IAP) has strongly propagated the view that in Indian perspective the term "child protection" must also include prevention from disease, poor nutrition and illiteracy in addition to action against abuse and exploitation (12). This underlines the importance of anticipating and averting what might happen to damage and demean a child -- not just response to hurt inflicted.

The 9th ISPCAN Asia Pacific Conference of Child Abuse & Neglect (APCCAN 2011) conference outcome document "Delhi Declaration" re-affirmed and pledged to stand against the neglect and abuse of children and to strive for achievement of child rights and the building of a caring community for every child, free of violence and discrimination. It urged and asserted the urgent need to integrate principles, standards and measures in national planning processes, to prevent and respond to violence against children. (12-13).

Cost Concerns

The financial costs for victims and society are substantial. A recent CDC study found the total lifetime estimated financial costs associated with just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse and neglect) is approximately $124 billion in the United States of America (14). In India, the central budget allocation for child

protection has never even reached 50 paisa (half a rupee) of every 100 rupees pledged for social development. This grave resource challenge calls for re-examination.

Clinical Manifestations of Child Abuse and Neglect

Injuries inflicted by a caregiver on a child can take many forms. Death in abused children is most often the consequence of a head injury or injury to the internal organs. Patterns of injury to the skin and skeletal manifestations of abuse may include multiple fractures at different stages of healing. There is evidence that about one-third of severely shaken infants die and that the majority of the survivors suffer long-term consequences such as mental retardation, cerebral palsy or blindness. Children who have been sexually abused exhibit symptoms of infection, genital injury, abdominal pain, constipation, chronic or recurrent urinary tract infections or behavioral problems. To be able to detect child sexual abuse requires a high index of suspicion and familiarity with the verbal, behavioural and physical indicators of abuse. Many children will disclose abuse to caregivers or others spontaneously, though there may also be indirect physical or behavioural signs. Emotional and psychological abuse has received less attention globally due to cultural variations in different countries. Moreover, corporal punishment of children i.e. in the form of slapping, punching, kicking or beating, is a significant phenomenon in schools and other institutions. Child neglect can manifest as failure to thrive, failure to seek basic health care, immunizations, deprivation of education and basic nutrition needs. A neglected child could be exposed to environmental hazards, substance abuse, inadequate supervision, poor hygiene and abandonment (15)

Specific sub-groups at risk of child abuse and neglect

(a)The girl child

The Indian census data has revealed some shocking statistics: a high prevalence of **female feticide** (an act of aborting a fetus because it is female). The sex ratio of boys to girls in the 0-6 age group in India has risen from the normal 102.4 males per 100 females in 1961, to 104.1 in 1981, to 107.8 in 2001, to 108.8 in 2011. (16-17). Moreover, the child sex ratio is significantly higher in northwestern states such as Punjab (118) and Haryana (120). In these regions, female feticide can be seen through a cultural background, where male babies are preferred because they provide socio-economic advantages and success in the family lineage (18)

The rise in female feticide has been linked to the arrival of affordable ultrasound sex detection technologies, initially introduced in India's urban regions in 1980s, and later widely adopted in rural village areas by 2000s (19-20). This has lead to a thriving business of "travelling ultrasonologists" in the villages of northern India. A study estimated that 100,000 abortions are performed every year in India solely because the fetus is female (21). The Government of India has launched multi-pronged strategies to curb female feticide, which include legislative measures such as Pre-Conception and Pre-natal Diagnostic Techniques (PCPNDT) Act in 2004, advocacy, awareness generation and programmes for socio-economic empowerment of women.

There is evidence that 'Girl child' is systemically neglected from before birth and right through their life cycle (22). A study demonstrated significant differences in gender violence and access to food, healthcare, immunizations between male and female children. This leads to high infant and childhood mortality among girls, which causes changes in sex ratio (21). Girls may lack formal recognition (e.g. birth registration), legal protection, and social networks; married early (child marriage), they are disproportionately burdened both at home with household chores and at outside home doing domestic labor, and are less likely to be in secondary education or in the formal paid workforce (23).

(Insert Box 1: Case example of an abused girl child)

(b)Disabled children

Several international studies have established that children with disabilities are at greater risk of child maltreatment (24-27). Children with disabilities may comprise about up to 10% of school going children and as such their needs are even more likely to be ignored in developing countries. Inadequacies in the school system fail to meet children's special educational needs; leads to neglect, beyond parental control.

(c) "Child labour" is a serious violation of fundamental rights of children. It deprives children of their childhood potential and their dignity, and that is harmful to their physical and mental development. It is essentially a socio-economic problem, inextricably linked to poverty and illiteracy. There is a consensus emerging that when a child is not in school, the child would perforce be part of the labour pool. In linking child labour to education, the tasks of eliminating child labour and of universalizing education have become synonymous. There is an essential need in developing countries to develop a comprehensive plan to withdraw children from work

and mainstream them into schools, in order to provide them basic right to education (28-30). The Government should see this is as a working challenge in trying to access children in need -- in institutions, in street groups, in work-places, on the move, or even in prisons. Linkage with NGOs connected to such kinds of settings may be considered as an outreach option.

(Insert Box 2: Case Example of a Street Child labourer)

Approach to Protection of Children from Abuse and Neglect

Background Measurers & National Legislations

The Government of India has assigned focal responsibility for child rights and protection to the Ministry of Women and Child Development (MWCD) (31). The National Commission for Protection of Child Rights, set up in 2007, enquires, investigates, and recommends action again against perpetrators of child abuse and neglect. Government launched an Integrated Child Protection Scheme (ICPS) (2009), which is expected to significantly contribute to the creating of a system that will efficiently and effectively protect children. *The guiding principles recognize that child protection is a primary responsibility of the family, supported by community, government and civil society* (32). A new 'National Policy for Children (2013)' has just replaced the 1974 policy (33). It establishes 18 years as the ceiling age of childhood, and adds an affirmation of India's acceptance of the UN CRC. The legislative framework for children's rights is being strengthened with the formulations of new laws and amendments to existing laws (28).

The medical professionals must have basic understanding of the following two legislations meant to protect children: (a) **the Juvenile Justice (Care and Protection) Act 2000** (amended in 2006) is the primary legal framework for juvenile justice in India (34). It establishes a framework for both children in need of care and protection (CNCP) and children in conflict of law (CCL). Child in need of care and protection(CNCP) and reports of child abuse are heard by Child Welfare Committee (CWC), which has a chairperson and four other members of whom at least one is a woman and at least one expert in children's issues. CCL are handled by Juvenile Justice Boards (JJBs), which have a Metropolitan or Judicial magistrate and two social workers, where one of the workers must be a woman. (b) **the Protection of Children from Sexual Offences (POCSO) Act, 2012,** specifically address the issue of sexual offences committed against children, which until now had been tried under laws that did not differentiate between adult and child victims.

The POCSO Act requires mandatory reporting of cases of child sexual abuse by doctors and multidisciplinary professionals. As soon as a complaint is made to the Special Juvenile Police Unit (SJPU) or to the local police, the law provides for relief and rehabilitation of the child. (35). Moreover, the recent Criminal Law Amendment Act (CLA) 2013 has expanded the definition of rape to include all forms of sexual violence. CLA, 2013 and POCSCO Act, 2012 both recognize that any registered medical practitioner can carry out a medico legal examination and provide treatment and records of that health provider will stand in the court of law(164A CRPC)(36).

CHILDLINE 1098: This is an emergency telephonic help line, which helps link children in situations of abuse/neglect with rehabilitation services. CHILDLINE 1098 has become an exceptional model of public private partnership, operational in more than 200 cities/districts across the country (37). *During their busy clinical practice, medical professionals should use this telephone help line to refer cases of child abuse to CHILDLINE, thus connecting them to socio-legal services.*

Medical Assessment & Response

Physicians are often the first point of contact of a child, whenever abuse is suspected; the concerned doctor must try to gather a detailed medical history from the child, if possible, and the caretakers. Most cases of child abuse are committed by people known to the child, in secrecy and in homes. Therefore, the physicians must be sensitive to the child's possible apprehensions and home situations. The history taking should be appropriate to the child's developmental level and avoid any further trauma. The interviewer should maintain a professional, non judgmental approach and adhere to the best interest of the child, in accordance with the law of the land. Assessment is a continuing process. Interventions and services should be provided alongside the assessment. The health assessments should be comprehensive, multi-disciplinary, respond to developmental and psychosocial concerns. The IAP Child Rights and Protection program recommends appropriate and timely referrals, as illustrated in the flow chart (fig1) (38).

Medical guidelines for victims of sexual offence

The Ministry of Health and Family welfare, Government of India (39) has recently framed guidelines for doctors who might one day be called upon to handle female victims of sexual

abuse, assault / rape in the course of their duty whether in a government hospital or even a private one. Sexual assault victims cannot be denied treatment in either of these hospitals, when they approach them, as denial has lately been made a cognizable criminal offence punishable with appropriate jail terms or fines or both. All medico-legal examinations and procedures must respect the privacy and informed consent has to be taken. Every hospital must have a Standard Operating Procedure (SOP) for management of cases of sexual violence. The examination room should have adequate space, an examination table and equipment required for a thorough examination, and the sexual assault forensic evidence (SAFE) kit containing for collecting and preserving physical evidence following a sexual violence. Figure 2 provides an approach to respond to victims of sexual abuse/assault.

Prevention

Given the large child population, particularly among the underprivileged rural and urban communities in India, socioeconomic constraints and lack of well developed child protection systems, it is of utmost importance to take all possible measures towards primary prevention of child abuse. The practice of pediatrics has to shift from a primary focus on the delivery of acute care to one which focuses increasingly on the provision of anticipatory guidance and preventive care to assure optimal growth and development. While we cannot “immunize” every child against possible child abuse, we can help prevent children from abuse. Pediatricians can prevent child sexual abuse by delivering messages on personal space/body safety at every annual health maintenance assessment, in a developmentally appropriate manner, from as early as 3 years onwards. There is not a parent who would not want to protect their child against a sexually abusive experience. Parents should explain (to children) that if anyone ever touches them in a way that is uncomfortable, or makes them touch someone else's private parts, they need to tell two adults right away. It is a shared responsibility to protect all children. Children armed with information about personal safety are 6-7 times more likely to develop protective behaviors, enhance potential for disclosure and experience less self blame (40, 41).

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