Psychiatry In Kerala

'THE PROTECTION OF CHILDREN FROM SEXUAL OFFENCES ACT (POCSO), 2012' IN CLINICAL SETTINGS – PROMISES AND CHALLENGES.

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ABSTRACT

Many of us feel overwhelmed while handling a child abuse case in a busy outpatient unit. Though 'The Protection of children from sexual offences act, 2012' is strictly in action now, it possesses a lot of imperfections which challenges its effective implementation. This article highlights the strengths of the act and at the same time reflects the ethical and legal dilemmas we usually encounter in our day to day practice.

Keywords- child sexual abuse, POCSO, challenges

INTRODUCTION

The boundaries of child sexual abuse extend far beyond the numerous definitions proposed by various international agencies. While the magnitude of victimization is rising alarmingly, also the circumference of its impact is immeasurably wide. As healthcare providers, we are bound to dispense holistic care: A complete biomedical, psychosocial & medico-legal care. As psychiatrists, we have a significant role to play, since we are very likely to come across the victims as well as possible perpetrators of child sexual abuse.

By ratifying United Nations Convention on the Rights of the Child (UNCRC, 1989)[1] and SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia, 2002,[2] our nation is obliged to protect her children from the violation of their rights including violence towards them. The existing constitutional framework[3] (Article 14, 15, 21, 39) also emphasizes the same. As per the study on child

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abuse by the Ministry of Women and Child Development, in the year 2007[4] 150 million girls and 73 million boys under the age of 18 were reported to be abused in India. In 2013, 'Asian Centre for Human Rights' published 'India's Hell Holes' – A report revealing child sexual abuse in Juvenile Justice Homes in India.[5]

Earlier, child sexual abuse was dealt under IPC Sections 354, 375, 377 and 509.[6] All these legal provisions were designed to protect female victims. They often failed to serve child victims especially when such victim was a male. Also, old legislations do not specifically apply to non-contact abuses like using children for pornographic purposes, kissing and fondling. These shortcomings and the magnitude of abuse revealed by national surveys lead to the developments which took place in this area, in the last decade. The Prohibition of Child Marriage Act, 2006;[7] National Rehabilitation and Resettlement Policy, 2007;[8] Juvenile Justice Act, 2015;[9] and The National Plan of Action for Children, 2016[10] are some of those. The year 2012-2013 witnessed a lot more legal reformation, which includes POCSO (The Protection of Children from Sexual Offences Act), 2012;[11] National Policy for Children, 2013;[12] and the criminal law amendment act, 2013.[13] Finally, with the recent Criminal Law Amendment Act, 2018,[14] India hopes at bringing down the sexual crime rates by recommending stringent punishment up to death penalty for the perpetrators.

According to NCRB statistics, 2016,[15] the total number of cases reported under POCSO rose from 14,913 in the year 2015 to 36,022 in 2016. Though these statistical figures are terrifying at first glance, they need not implicate an increase in the actual incidence of these cases. There existed a remarkable gap between the actual incidence and the measured incidence of child abuse cases, formed by under-reporting as well as under-recording of these cases, which could have started shrinking because of the stringent nature of the new legislation. A considerable gap still remains behind-the-scenes, enveloped by silence.

HOPE FROM THE NEW LEGISLATION

In May 2012, the parliament of India passed 'The Protection of Children from Sexual Offences Bill', popularly known as POSCO 2012 into an act. The act has 9 chapters and 46 clauses. The act is the first-of-its-kind which deals exclusively with child sexual abuse. It is unique in the sense that it is gender-neutral, it covers both 'contact' and 'non-contact' offences and it also imparts stringent punishment up to life imprisonment to the perpetrators. POCSO defines 7 kinds of sexual offences including the 'abetment or attempts to commit an offence'. It specifically prefixes the term 'aggravated' to offences committed by those who are at a position to protect the child, such as police officials, hospital staff, public servants etc.

All through the process of reporting, recording, investigating and testifying, POCSO emphasizes a child-friendly environment. The child need not report to any officials regarding the abuse. Any person including the parent, teacher or doctor, who notices the occurrence, or the likely occurrence of sexual abuse is required to report it to the police. Failure to report or record a case is punishable under this act. Once it is reported the child's identity is kept confidential. Disclosing the identity of the child victim by media is also a punishable offence. During the investigation proceedings, the police officer recording the statement of the

child will not be in uniform. They will first see whether the child's situation is secure or not and if not he/she will be shifted to the care of the government. Meanwhile, he or she will be taken for a medical examination. Then the child goes through judicial proceedings. Special provisions added in this area include assignment of special courts, the appointment of a special public prosecutor, trial in the presence of parents and video recording of the trial. The burden of proof is also shifted on to the accused. POCSO also ensures trial completion, within a period of one year.

As per the act, the duty of a doctor begins right from reporting a case, as soon as the occurrence or possible occurrence of sexual abuse is suspected. The act mandates CrPC section 164A[16] to be followed during the medical examination of the victim. It is mandatory that a girl child should be examined by a female doctor and any victim should be examined in the presence of their parents or significant others. In addition to this, the law integrates the services of special juvenile police unit (SJPU) and child welfare committee (CWC) established under the Juvenile Justice Act, for the relief and rehabilitation of the victim.

CHALLENGES IN IMPLEMENTATION

Though this act has various positive aspects it poses a huge challenge to its stakeholders, especially medical professionals for its proper implementation. The act has several ethical, legal and administrative drawbacks. In-depth thinking is in fact required on whether or not these provisions would meet the real need of the vulnerable population.

A mandatory disclosure from the health professional might deter people from accessing health care. The dreaded outcome would be an increase in suicides, septic abortions, infanticides, and sexually transmitted diseases. There are many factors which are possibly feeding the under-reporting. In its November 2017 report, "Everyone Blames Me", [17] The Human Rights Watch reviews the barriers faced by sexual offence victims in India. The poor Police response, failure to provide access to adequate health services, lack of access to effective legal assistance and the lack of coordinated support services are highlighted issues. Other factors include social stigma, fear of retaliated reaction from the perpetrators and lack of faith in the state machinery. To improve on this, tougher missions are to be formulated and large-scale efforts are required.

Though the whole process is termed 'child-friendly', the child is apparently revictimized in each and every stage of the procedure. From the child's perspective, the revictimization begins at the very act of disclosing it to his/her parents. Later it continues to happen in the hands of family, healthcare professionals, Police, Child welfare committee, Judges, media and society as well. This law has hoped that by putting a time frame the time taken from reporting to conviction will be brought to acceptable levels. Though the law instructs speedy justice, it is not in practice yet. Speedier justice is an unmet need in India and mandating a one-year time limit for conclusion of the trial is a step in the right direction, but clearly there is some distance to go.

According to the law, the revelation of the child's identity by media is strictly prohibited. The national commission for protection of child rights has put forward clear guidelines[18] for

media to be followed while covering child sexual abuse. However, this may not be sufficient. Often demographic data relating to the crime could lead to the identification of the victim with reasonable certainty.

At the administrative level, another drawback is being focussed on is the lack of awareness among the public and stakeholders. The National and State commission for the protection of rights of the child is entrusted to generate awareness campaigns and all the stakeholders including the Police, doctors, parents, and teachers are to be trained on various provisions of the act which are still on paper only. On the other hand, there are chances of children getting so sensitized that mere pampering and kissing without sexual intent could be erroneously reported as abuse.

In addition to this, there are some difficulties which we, as healthcare professionals encounter in our day to day clinical practices. Many a time we get caught between patient's autonomy and the consequences of not reporting. Also, the direct involvement of the Police in situations where things are unclear may lead to patients and families disengaging with mental health facilities. In many countries there are intermediary agencies comprising of trained professionals in mental healthcare who would decide whether such cases should be escalated to the Police or not. Very often the unavailability of a female registered medical practitioner to examine the girl victim, as the law mandates, would result in a referral and unnecessary delay in medical examination. Many of the general medical practitioners, psychiatrists and various other specialists do not have expertise in detailed gynaecological examination, sample collection and emergency management. We need more clarity on these issues and the concerns need to be translated into reformations in the legislative framework.

GAPS TO BE BRIDGED

The act has many legal lacunae which need to be refilled. The National Commission for Protection of Child Rights, in its recently released handbook on POCSO[18] recognizes the fact that any person including a child can be prosecuted as a sexual offender. At the same time, it also realizes that developmentally appropriate consensual sexual activity among children need not be labelled as a sexual offence. The act bears a certain degree of inconclusiveness in this area. What would be the law's take on adolescents exploring their romantic attachments through touching and kissing? Would it be considered as a crime or a children's play? Who decides the legal boundaries of 'developmentally appropriate sexual activity'? Remember that the law's definition of sexual harassment even includes the act of uttering words to a child with sexual intent.

As psychiatrists we may come across furthermore complicated situations. What should we do if an adolescent boy reveals his own sexually inappropriate behaviour towards another child, while he was in a diseased state? Clinically we do encounter children especially with conduct disorder abusing adults. In such cases with whom does the burden of proof lie? What if an adult reveals being abused as a child? The law needs to be redefined for all these situations.

CONFLICTS WITH OTHER LAWS

Article 3 of UNCRC emphasizes that the 'best interest' of the Child should be of primary

concern. The 'best interest of the child' is defined in the Juvenile Justice Act, 2015 as 'the basis for any decision taken regarding the child, to ensure fulfilment of his basic rights and needs, identity, social well-being and physical, emotional and intellectual development. But whether our existing facilities would assure these standards is still a question and mandatory reporting often fails to promise this.

On a par with the right to privacy, an intrinsic part of article 21[3] of our constitution, The MTP Act, 1971[19] has made it mandatory for all doctors to keep all information on all those seeking abortion confidential. Mandatory reporting under POCSO is again conflictual in such situations.

Age continues to be an area of conflict between different legislations in India. POCSO defines Child as a person below the age of 18 years, which is in union with the Juvenile Justice Act, The Prohibition of child marriage act[7] and The Indian Majority Act.[20] Though the Prohibition of child marriage act, 2006[7] prohibits marriage of a girl child below 18 years and makes it voidable, the Criminal law amendment act, 2013[13] specifically excludes the sexual intercourse by a man with his own wife, above the age of 15 years, from the definition of rape. The dissonance is explicit, and the question is what would be POCSO's stand in such cases.

DILEMMAS IN CLINICAL PRACTICE

According to Section 357c of CrPC,[13] all hospitals, public or private are bound to provide free medical treatment to sexual assault victims (irrespective of their age) and such incidents must be mandatorily reported to the Police. Section 202 IPC[6] describes the punishment for failure to report such cases to the Police. This is further reinforced by POCSO. Under POCSO, medical examination and emergency medical care of the child victim should be done by any registered medical practitioner (public or private) to whomsoever the child is brought, and it should be availed free of cost. Under 'mandatory reporting', a doctor, even if the alleged victim is not his patient, has the legal responsibility to report the occurrence or the likely occurrence of any kind of child sexual abuse he/she comes across.

But confusion still remains in the area of medical examination. As mentioned earlier POCSO doesn't give clear answers to the following questions. Is it necessary to do a medical examination in all cases including an assault occurred months or years back? Unless brought by Police for medical examination, are we bound to do the physical examination and evidence collection with our inexperienced hands, or can we refer the child to a specialist? Can a referral potentially delay the evidence collection and further care is given to the patient? An ethically sound answer would be if immediately accessible speciality care facilities are available, the child may be referred to them

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CONCLUSION

Though this act is widely in force now, it is still incomplete in its administrative level. Workshops equipped with practical recommendations to overcome its ethical, legal and clinical dilemmas need to be conducted by the professional bodies. Emphasis should be given to education on child' rights and protection, and awareness should be created

among professionals, teachers, parents, children and the public.

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