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Abstract

Until recently academic research in India had been primarily preoccupied with crimes against females in the reproductive age, such as rape or sex trafficking, downplaying the sexual abuse of boys and girls of pre-pubertal age or teenagers. However, of late Child Sexual Abuse is also being recognised and reported as a criminal justice issue and an increasing number of such incidents are being published in the country. Based on a systematic review of the existing literature, this article suggests a conceptual framework delineating the risk factors, outcomes, and protective factors of child sexual abuse in India. The paper concludes with implications for policy and research.

Key words: Child Sexual abuse, Disclosure, Perpetrator characteristics, Systematic review, India

Introduction

Child sexual abuse (CSA) is one of the most common yet underreported forms of violence against children prevalent across the globe (Pellai & Caranzano, 2015). In the year 2009, Pereda, Guilera, Forns & Gomez-Benito, conducted a worldwide study among the students and community to find the prevalence of child sexual abuse. The analysis of the available data from 22 countries revealed that CSA is a serious problem worldwide. The retrospective data suggested that almost 7.9 percent of men and 19.7 percent of women have suffered some form of sexual abuse before the age of eighteen. Widely underreported, the phenomenon of CSA has global prevalence irrespective of socioeconomic diversity amongst different nations. Millions of children are subject to varying forms of sexual abuse every year without coming into the preview of the criminal justice system. Until recently academic research had been preoccupied with crime against females in the reproductive age (mainly rape or prostitution), negating the sexual abuse of boys and girls of pre-pubertal age or teenager. However, of late, CSA is being recognised as a criminal justice issue and more incidents are being identified and
reported. In this backdrop, this systematic review attempts to delineate the risk factors of CSA in India and presents the conceptual framework highlighting the protective measures for CSA.

What is Sexual Abuse?

According to World Health Organization’s Violence and Health in the WHO African Region Report (2010), ‘sexual abuse is the involvement of a child in any kind of sexual liaison that he/she is unable to comprehend fully, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society’. Broadly, sexual abuse is classified into four categories: non-contact, non-penetrative contact, penetrative contact, and internet-based sexual abuse (Figure 1). Non-contact sexual abuse includes any verbal or non-verbal references to sexual matters such as implicit or explicit invitations for sexual liaisons, being exposed to genitals, sexual acts, or sexually explicit materials, or being asked to reveal own genitals to someone else. Non-penetrative contact abuse comprises of being kissed or fondled sexually, caressing others’ genitals or masturbating someone else or watching somebody masturbate, while attempting intercourse, oral intercourse, anal intercourse, and genital intercourse come under the preview of penetrative contact abuse (Elklit, 2015). The growth of the world wide web has exposed children to a new hazard of internet-based CSA comprising of creating, depicting or distributing sexual images of children online, stalking, grooming and engaging in sexually explicit behaviour with children through the internet (Pellai & Caranzano, 2015).

![Figure 1. Types of Sexual Abuse (Source: Elklit, 2015)](image-url)
Sexual abuse may be a single sporadic incident or multiple episodes occurring in succession (Behere, Rao, & Mulmule, 2013). Similarly, a child may be exposed to repeated abuses by different individuals during his/her childhood. Bhaskaran & Sheshadri (2016) rightly pointed out that CSA is an experience and not a disorder. Hence, it is challenging to detect CSA as some of the victims may manifest a wide variety of symptoms while the others may be asymptomatic (Bhaskaran & Sheshadri, 2016; Cromer & Goldsmith, 2010). Research suggests that sometimes initially asymptomatic sexually abused children may develop severe psychiatric disorders years after the trauma (Aydin, Akbas, Turla, Dundar, Yuce & Karabekiroglu, 2015). Any sudden change in the behavior of a healthy child may be suggestive of a probable abuse, and the parents must look out for following verbal, bodily, emotional, and sexual symptoms among the children (Jensen, 2005). The presence of any one or more traits may indicate a probable incident of sexual abuse. The self-disclosure of CSA is the best diagnostic tool to report a CSA. However, an explicit verbal disclosure of abuse is quite rare and may be quite indirect, which the caregivers may find difficult to decipher.

Further, sudden changes in child’s stimuli may also hint at the probable incidents of sexual abuse such as the presence of enuresis, encopresis, stomach aches, headaches, and so on. Sometime, sudden aversion towards certain food items such as yogurt or milk also may be suggestive of CSA (Jensen, 2005). Similarly, parents must watch out for any abrupt behavioural changes in their children, such as mood swings, frightening or anxiety reactions, bizarre behaviour, or refusal to meet or visit any specific individual as these may be indicative of probable CSA. Other subtle signs of a likely CSA are masturbation in children, sexualised play with dolls, sexual experimenting with other children, or drawing pictures or images of sexual acts.

Disclosure of CSA

Research suggests most people who experience sexual abuse in childhood do not disclose this abuse until adulthood and delays in the disclosure are also not uncommon (McElvaney, 2015). The disclosure is delayed when the perpetrator is a family member or a close relative. Age is a significant predictor of the disclosure. For example, older children are more likely to divulge and report CSA compared to younger children. Besides, children who are abused by a family member are less likely to come forward to reveal the abuse, or there would be some delay compared to those abused by strangers or someone outside the family.
Gender has also been found to influence the phenomenon of the disclosure. Usually, boys are more reluctant to disclose CSA incidents as compared to girls. The boys perceive disclosure of abuse as a threat to their manly stature or stigmatisation of being weak and docile. Parental bonding is also a significant predictor of revelation for both boys as well as girls. Children from the protective families may find it easier to report experiences of abuse to their parents or caregivers.

Despite being one of the most common forms of violence against children worldwide, available statistics or data have underestimated CSA. Research revealed that 1 out of 4 girls and 1 out of 6 boys face some form of CSA before the age of 18 (GHPSPHS, 2009). In their study of child abuse victims and their parents in India, Bala, Maji, Satapathy & Routray (2015) found that CSA is quite rampant in India. The low reportage could be on account of the stigma associated with the disclosure of CSA. The fear of social stigma may force them to stay numb to avoid social ridicule even if they are aware of any CSA incident. The stigma surrounding sexual violence in India fosters a pervasive culture of silence around CSA in the country (Bala et al., 2015). Further, children also frequently hide their experiences of abuse from their caregivers or parents due to fear of retribution (Carson, Foster, & Chowdhary, 2014). Often children are unable to comprehend incidents of abuse and are perplexed about what to report and whom to report. Victims do not disclose the experiences of CSA fearing rejection or disbelief, especially when the perpetrator is from the family or an ally. They often choose to stay silent burrowing the episodes of abuse within them (Virani, 2000).

On the other hand, the closed relationships can also act as a deterrent to disclosure in several cases. Sometimes victims are reluctant to share their ordeal due to concerns of upsetting their parents while others may choose to deliberately remain silent evaluating the repercussions and the consequences for others of their disclosure (McElvaney, 2015). Furthermore, the severity of abuse (e.g., penetrative abuse) is also a significant predictor of disclosure as in the case of an explicit physical injury the victim is unable to hide the abuse from parents or caregivers.

The phenomenon of ‘recantation’ related to disclosure is also not uncommon among the victims of CSA (McElvaney, 2015). The recantation is the denial of previously held opinion or retraction from one’s statement. Many children are found to deny incidents of CSA due to vested interests. Sometimes, children may
disclose initially, but later may have mixed feelings about their abuser and fearing the implications of disclosure upon their abuser may then revoke their complaints. Many times, the abusers are found to take an oath of secrecy about their activities from the child, and this dilemma of breaking the promises may coerce the victims to withdraw from their charges.

Further, many times children are so bewildered by CSA that they may not be able to face to it, and this mystification may lead them into a state of uncertainty where they display inconsistent behaviour. They might say something at one moment and deny it later. Sometimes families may also force children to recant to avoid confrontation with the abuser. Recantation is common in cases where the abuser is a familiar person or is related to the family. Further, a delay in the prosecution of the perpetrator may also lead a child to recant to avoid further distressing involvement in the legal process. A minuscule percentage of children retract later as they may have made a false accusation due to vested interests (GHPSPHS, 2009). The negative responses to a disclosure from the parents or the caregivers are quite hazardous and intimidating for the child and restrict them from disclosing any such events soon also. The impact of negative responses to disclosure is cyclical and continues to deter other children from disclosure (Wallace-Henry, 2015).

Methodology

For the current study, the Google Scholar, Medline, PubMed, EMBASE, Web of Science, and PsycINFO were used to extract articles from January 1, 2000, to August 31, 2018 using a keyword search strategy. The search input yielded around 450 literatures; however, studies reporting only on child sexual abuse were included for the final review (10). These electronic searches were supplemented by screening the reference lists of included papers, citation tracking, and expert recommendations. The following inclusion criteria were adopted: (1) The study location was restricted only to India. (2) The literature published only in the English language was included in this review. (3) The studies were eligible for inclusion if they: (a) included participants (males or females, adults, or children) who self-identified, or were defined by researchers, as having been sexually abused; (b) only the peer-reviewed research based on either a cross-sectional survey; a case-control study; cohort study; case series analysis; or experimental investigation. Data was extracted from published articles only which were peer-reviewed papers reporting on the prevalence, risk factors and outcomes of child
sexual abuse, including physical, mental, or sexual issues among the victims of child sexual abuse. This systematic review suggests a high prevalence of child sexual abuse in the country and adverse outcomes of sexual abuse on the health and well-being of the victims.

**Child Sexual Abuse in India**

India has the world’s most significant number of CSA cases every year. One out of every ten children is a victim of CSA in India at any given point of time (Virani, 2000). Behere et al. (2013) found that every second child is prone to one or the other forms of sexual abuse such as eve-teasing, molestation, sexual violence, etc. and every fifth child faces critical forms of CSA in the country. According to the Childline India (2014), every 155th minute a child less than 16 years of age is raped, for every 13th hour child below 10, and one in every ten children is a victim of CSA.

Tata Institute of Social Sciences undertook the first ever study on child sexual abuse in Mumbai in 1985 among the adults aged twenty and twenty-four (Virani, 2000). The results of the survey revealed that one out of three girls and one out of every ten boys had been victims of CSA and half of these abuses happened at home. Later in the year 1996, a group of medical practitioners carried out a research study to find the prevalence of CSA among 348 girl students from eleven schools and colleges in Bangalore. The results revealed that 15 percent of the sample was sexually abused as children inclusive of being subjected to rape, forced into oral sex or penetrated with foreign objects, and so on. The family members or relatives inside the households were the most common perpetrators.

In the year 1998, Recovery and Healing from Incest (RAHI) conducted a nationwide survey among 600 English speaking middle and upper-class women to find the prevalence of CSA. Around 76 percent of these women revealed being sexually abused in their childhood. In more than fifty percent of the cases, the perpetrator was a familiar person including family members or relatives. The Tulir-Centre for Prevention and Healing of Child Sexual Abuse (CPHCSA) also carried out a large-scale survey to find the prevalence of CSA among 2211 school going children in Chennai in the year 2006. The study revealed that, irrespective of their socioeconomic backgrounds, around 42 percent of the children had been sexually abused.
The first ever government sponsored research assessing the extent and gravity of child sexual abuse in the country was carried out in the year 2007 by the Ministry of Women and Child Development, Government of India. The sample consisted of a total of 12447 children, 2324 young adults, and 2449 stakeholders across 13 states of the country. This study covered multiple dimensions of abuse like physical abuse, sexual abuse and emotional abuse. The study also included child neglect in 5 evidence groups, namely children in a family environment, children in schools, children at work location, street children, and children in institutions. The study reported a widespread prevalence of emotional, physical and sexual abuse prevalent in all the states surveyed. While every second child reported emotional abuse, 69 percent (n = 12,447) of the children said being subjected to physical abuse, while 53 percent (n = 12,447) of the children reported incidents of some forms of sexual abuse. Sadly, half of the sexual violations were committed by the persons known to the child or caregivers responsible for their growth and well-being (Kacker, Baradan, & Kumar, 2007). The results of the study further highlighted the absence of child-specific legislations to check child abuse in the country impinging on the need for specific legislation to deal with CSA in the country.

**Risk Factors to Child Sexual Abuse**

Although India has the highest prevalence of CSA (Singh, Parsekar, & Nair, 2014), yet there is a lack of research on CSA in the Indian context. The limited research evidence suggests that it is quite difficult to predict the risk factors to abuse as there is a wide discrepancy in the profile of the CSA victims. It is found that the children from all backgrounds affluent as well as poor are prone to CSA. Similarly, it is quite difficult to earmark the age of the victims as media reports suggest that babies as young as 2-3 months are also being sexually abused.

**Geography, Race and Ethnicity**

It is commonly believed that the prevalence of CSA is higher in the urban areas; however, Matiyani (2011) and Patel & Andrew (2001) suggest that the prevalence of CSA is similar in rural and urban settings but the reporting of CSA is higher in urban areas. Similarly, in other contexts ethnicity is also found to be associated with the prevalence of child sexual abuse (Meinck, Cluver, Boyes, & Mhlongo, 2015), however, in the Indian context sporadic studies assert that race and ethnicity do not seem to be risk factors for CSA and children from all
socioeconomic groups are equally vulnerable (Matiyani, 2011; Pal, Rana, Sharma, & Sehgal, 2018; Virani, 2000).

Economic Factors

Some data indicate higher rates of CSA reports in areas with high levels of poverty (Matiyani, 2011; Priyanka, 2015), whereas other studies demonstrate no associations between CSA and economic status (Carson et al., 2014; Cromer & Goldsmith, 2010). Poverty may not directly stimulate abuse. However, overcrowding may facilitate sexual abuse due to the necessity of co-sleeping and lack of privacy.

Familial Factors

The size and the structure of the family are essential indicators of sexual abuse victimisation. Children from larger families or living in extended households are quite vulnerable as parents may be unable to spare more time for each child (Matiyani, 2011). Similarly, children from single parent or divorced partners are particularly susceptible (ibid). Further, children from dysfunctional families or poor parent-child relationship are quite vulnerable to sexual abuse victimisation. Educational status of the mother is also found to influence the prevalence of CSA. The mental health of the parents is further found to be a risk factor to CSA. Besides, parental substance abuse or alcohol addiction is also associated with sexual abuse victimisation (Matiyani, 2011; Whitehead & Roffee, 2016). Orphanhood is another predictor for sexual abuse victimisation (Kamuwanga & Ngoma, 2015). Research suggests that street children are particularly vulnerable (Malhotra, 2010; Matiyani, 2011; Seth, 2015).

Gender

Research suggests females are exposed to sexual abuse more often than males (Pal et al., 2018; Singh, 2009). However, others argue that sexual abuse of male victims is under-reported (Carson et al., 2014; Kacker et al., 2007; Patel & Andrew, 2001). Social stigma, including the fear of being labeled as gay, as well as issues related to victimisation and masculinity, may make it difficult for boys to seek help (GHPSPHS, 2012). Garnefski & Diekstra (1997) suggest that gender appears to influence symptom expression, with boys having worse outcomes than girls (Tyler, 2002).
Individual Factors

Certain categories of children are found to be susceptible to CSA such as emotionally insecure children, children lacking strong support from the parents and caregivers, and so on (Saul & Audage, 2007). Sexual victimisation is also associated with child hyperactivity, child disability, and wasting (Seth, 2015; Virani, 2001). CSA is quite common among mentally challenged or deaf and dumb children as they are unable to vocalise their dissent, or, disclosure to others is less likely.

Social Factors

Research suggests that a particular social structure facilitates abuse implicitly. At the societal level, low recognition of the child’s rights, patriarchy, and prevalence of violence, discrimination and weak social norms also perpetuate child sexual abuse (Minto, Hornsey, Gillespie, Healy, & Jetten, 2016). For example, in South Africa and Namibia, Jewkes et al. (2005) noted that child rape might be used as punishment or a method of communicating power and control (cited in Cromer & Goldsmith, 2010). Further, lax laws and legislation, and low prosecution also enable a culture of abuse and victimisation (Meinck et al., 2015).

Outcomes of Child Sexual Abuse

CSA is one of the most heinous forms of crime against children prevalent worldwide. CSA has been found to be detrimental for the affected children and leads to severe dysfunction among the victims. Although it is quite difficult to estimate the damages cost to the children, the socioeconomic prices are profound. Some of the common physical outcomes of CSA include, but are not limited to, pain, discoloration, sores, cuts, bleeding or discharges in the genitals, anus or mouth, persistent or recurring pain during urination and bowel movements, gynecologic conditions, gastrointestinal problems, and so on. For many children wetting and soiling accidents are the allusive outcome of CSA (GHPPHS, 2012; Seth, 2015). CSA is also associated with subsequent sexual victimisation, unwanted pregnancy and HIV transmission (Meinck et al., 2015). Further, CSA also results in a range of long-term adverse sexual outcomes for the victims such as sexual inhibition, sexual avoidance or aversion, and vaginal or pelvic pain to sexual dis-inhibition, compulsive or impulsive sex, risk-taking sexual behaviours, and numerous sequential or simultaneous sexual partners.
The experiences of CSA lead to multiple adverse outcomes for children, paralysing the victims’ minds more than their bodies (Berkowitz, 1998; Cromer & Goldsmith, 2010; Elklit, 2015; Johnson, 2004; Matiyani, 2011; Meinck et al., 2015). Post-traumatic stress disorder, delinquency, academic difficulties, low self-esteem, withdrawal, conduct disorders, substance abuse, depression, anxiety, suicidal ideation and personality disorders are not uncommon among the victims. Victims of CSA may experience avoidance, dissociation or denial which could have initially developed as adaptations to the abuse. The severity of the mental health outcome is dependent upon the age of the onset, the duration of the abuse, relationship with the perpetrator, as well as the kind of abuse – penetrative or non-penetrative (National Child Traumatic Stress Network Child Sexual Abuse Committee, 2009; Ventus, Antfolk, & Salo, 2017).

The outcomes of incest or abuse perpetrated by close kin are more devastating as victims may find it difficult to trust others in their social network forever which in turn jeopardizes their recovery post abuse. Research suggests in cases of violence by the known person, the dilemma to report or not to communicate further aggravates the trauma (Durham, 2003). The experience of CSA is often emotionally paralysing for the victims and many victims fail to recover throughout their life. Unfortunately, CSA has a cyclical effect, and CSA victimisation does appear to be a risk factor for future perpetration (Becker & Murphy, 1988; Bhaskaran & Sheshadri, 2016). In their study of 224 male victims of CSA, Salter et al. (2003) found that around 12 percent had official records of perpetrating a sexual offense against children (cited in Cromer & Goldsmith, 2010). However, the model of a victim-perpetrator cycle has been found to be relevant for the males, but not for the females (Glasser, Kolvin, Campbell, Glasser, Leitch, & Farrelly, 2001; Virani, 2001).

**Perpetrator Characteristics**

Popular literature indicates that sexual abuse is more prevalent than was once believed and that the perpetrators are usually unknown to the victims (Segal 1992; Virani 2001). Underreporting of incest or molestation by parents/relatives is quite common. The spate of media reports on sexual abuse by strangers does not always imply that abuse is any less by persons familiar to the child. On the contrary, it highlights that abuse by strangers is treated seriously and reported to the law enforcement agencies. Parents are often found to suppress incidents of sexual violence by familial persons to avoid strain in relations (Carson et al., 2014;
Jensen, 2005). Research further suggests that, contrary to popular belief, the perpetrator could be a female as well as male (Behere et al., 2013; Matiyani, 2011).

The perpetrator and the victim may be of the same sex or opposite sex (Behere et al., 2013). Further, perpetrators may be single individuals or may act in compliance with other individuals, familial or non-familial. Regarding age span, it is difficult to detach the specific age group for CSA perpetrators, as the perpetrators have been found to belong to pre-teens up to elderly individuals. Many CSA cases involve teenagers as perpetrators. There is no conclusive evidence regarding the marital status of the perpetrators in the literature. Both married as well as single individuals have been found to be complicit in CSA. Besides, the perpetrators could be reputed or trusted caretakers, such as parents, priests, aid workers, hospital workers, and educators (Matiyani, 2011). Matiyani (2011) further suggests that alcoholism is often associated with sexual abuse offenses. Alcohol results in a state of inebriation and emotional excitement in an individual that they lose their normal restraints over their sexual desire causing them to satiate themselves through any individual including children. Most common tactics employed by perpetrators include befriending children, seducing, or luring with gifts. Many times, they also resort to threats or use of violence to gain subservience from the child. Contradicting the popular norm that home is the safest haven for children, most popular den for CSA perpetrator includes homes of the children.

**Laws and Legislation concerning Children in India**

Before 1986, each state in India had its enactment of juvenile justice with children being treated differently by the respective state legal systems. The Juvenile Justice (JJ) Act of 1986 was the first central legislation concerning juveniles passed by the Union Parliament of India in the year 1986. With the inception of the JJ Act in the year 1986, India became the first country in the world to have introduced a universal juvenile justice, the law that covered both children in need of care and protection, and children who come in conflict with the law under its preview. The JJ Act ensured protection for children in difficult circumstances. In the history of legal jurisprudence in the country, protection of children came to be viewed as an integral part of social justice as well as the justice delivery system. The JJ Act 1986 however, was discriminating in nature. It was applicable for girls till they
attained majority, i.e., up to eighteen years of age, while for boys the age limit was only sixteen years.

In the year 2000, the JJ Act (1986) was repealed and the Juvenile Justice (Care and Protection of Children) Act, 2000 came into being. It was later amended in 2006 to build on minimum standards of care and protection as part of justice delivery and to strengthen the existing child protection mechanisms. The Act underwent further amendment in 2010 to end the segregation of disease-hit children from other occupants within child care institutions. This JJ Act of 2000, with modifications made in 2006 and 2010 is followed till date. The JJ (C & CP) Act 2000, amended in 2006 and 2010, internalises the Constitution of India (as prescribed in Article 15 (3), Article 39 (e) and (f), Articles 45 and 47); the United 18 Nations Convention on the Rights of the Child, 1989; the UN Standard Minimum Rules for the Administration of Juvenile Justice, 1985 (‘the Beijing Rules’); the UN Rules for the Protection of Juveniles Deprived of their Liberty, 1990; the UN Guidelines for the Prevention of Juvenile Delinquency, 1990 (‘The Riyadh Guidelines’); the UN Standard Minimum Rules for Non-custodial Measures, 1990 (‘The Tokyo Rules’); and many other international conventions/treaties and instruments.

The current JJ Act is highly progressive legislation that has as its primary focus the protection of the best interests of the child. This law covers all children less than eighteen years of age. It provides for appropriate care and protection of the children by catering to the child’s needs and rights by adopting a child-friendly approach in the adjudication and disposition of the cases relevant to the children. The focus of the Juvenile Justice Law in India, as it currently stands, centres on the protection of the dignity of the child and ensuring their access to their rights, security, and rehabilitation through State responsibility and action.

**Protection of Children from Sexual Offenses (POCSO) Act, 2012**

Until 2012, the only sexual offenses against children recognised by the law were covered by three sections of the Indian Penal Code (IPC) not specific to children. Only three kinds of crimes viz., rape (sexual intercourse without consent – section 376), outraging modesty of a woman (unspecified acts – section 354) and unnatural acts defined as ‘carnal intercourse against the order of nature with any man, woman or animal’ (anal sex, homosexuality or bestiality – section 377) were treated as severe and registered and reported in the annals of the law enforcement.
Other forms of non-penetrative sexual assaults, harassment and exploitation were not explicitly recognised as crimes and therefore not recorded (assuming if they were reported). The 2007 National Study on Child Sexual Abuse highlighted the wide prevalence of child sexual abuse in the country and the dire need of specific legislation to deal with these abuses. After years of deliberation, the Government of India passed the first ever specialised legislation on the ‘Protection of Children against Sexual Offenses (POCSO) Act’ in the year 2012. The POCSO Act criminalises all sexual offenses against a child (under 18 years of age) namely penetrative, non-penetrative, genital, non-genital, touch and non-touch based including internet-based abuses and is gender neutral (The POCSO Act, 2012). The Act requires mandatory reporting of child sexual abuse by doctors and other professionals. The POCSO Act emphasises incorporating child-friendly mechanisms for reporting and recording of evidence. It also attempts to safeguard the interests of the child at every stage of the judicial process of investigation such as the speedy disposal of trials through the designated Special Courts. The law is very stringent and comprehensive as even the intent to abetment is punishable under the POCSO Act and the onus of the acquittal rests with the accused and not on the victim.

Child Welfare Committees (CWC)

The Juvenile Justice Act follows a two-pronged approach, the Juvenile Justice Boards (JJBs) being the competent authority for the Children in Conflict with Law (CICL), while for the Children in Need of Care and Protection (CNCP) the Child Welfare Committees (CWCs) exercise the highest administrative prerogative. In usual practice, all juveniles or adolescents engaged in deviant or criminal behaviour are known as the CICL. On the other hand, CNCP includes vulnerable children such as orphans or abandoned children, street children, homeless children or children living on the streets. Moreover, child brides, or child victims of physical/sexual abuse, trafficked children, mentally/physically challenged children, children affected by HIV/AIDS, missing or runaway children, children harmed by natural disasters or human-made disasters like armed conflicts, earthquakes, floods, etc. are also treated as CNCP. The CWCs are final authority regarding disposal of cases for the care, protection, treatment, development and rehabilitation of the children as well as to provide for their basic needs and safeguard their human rights (Child Welfare Committees in India: A comprehensive analysis aimed at strengthening the Juvenile Justice System for children in need of care and protection, 2013). According to Section 29 (5) of the
JJ Act, the CWCs are to function as a Bench of Magistrates. The power of the CWCs are equivalent to the powers held by a Metropolitan Magistrate or a Judicial Magistrate of the first class as conferred by the Code of Criminal Procedure (CrPC) 1973 (2 of 1974). The CWC comprises of a chairperson and four members. The chairperson should be a person well versed in child welfare issues, and at least one member of the CWC should be a woman. The CWCs are responsible for tracking the progress reports during inquiry meanwhile delivering the best care to the child. The CWCs have the authority to remove the child from his/her home and place him/her in short-term care or long-term care if the need arises. The CWCs are also responsible for monitoring of the child care institutions and other child-related agencies. Besides, the CWCs are also authorised to review and report about the quality of the child care institutions within their jurisdictions to the Department of Women and Child Development (DWCD).

The Proposed Conceptual Framework

Child sexual abuse is one of the universal forms of violence against children prevalent across all socioeconomic groups in India, however, research on the etiology of CSA is still in its nascent stage in the country. Hence, it becomes imperative to invoke theories on incest and mating to unveil the etiology of CSA. Universally mating and intimacy between biological kin is forbidden due to specific natural and cultural reasons and is popularly known by the term incest. Incest includes any physical relationship between blood relations example between father and daughter, or mother and son, or brother and sister, and so on. Any sexual advances made by father or mother and brother to an under eighteen offspring or sibling respectively qualifies as sexual abuse. The incest CSA and the non-incest CSA are two broad categories under consideration in the present study. The incest CSA includes sexual abuse by blood relatives from within the family ties while non-incest CSA encompasses all other sexual abuse categories outside the preview of incest such as the sexual abuse by relatives, acquaintance or strangers. Although incest CSA and non-incest CSA are entirely different, yet both bear certain commonalities regarding elements of vulnerability, perpetrator characteristics, outcomes, and so on.

All incidents of CSA involve the presence of two individuals: at-risk child susceptible to abuse and another individual preying upon the vulnerability of the child. Now, this vulnerability may stem from the economic condition of the child and his family. For example, overcrowding and lack of privacy in a household
may dispose child to the risk of abuse. Further, the structure and configuration of family also make children susceptible to abuse. Children from single parents, dysfunctional families, substance abusing parents or uneducated parents are quite vulnerable to CSA. Individual factors contributing to vulnerability include, but are not limited to gender, disability, hyperactivity, and so on. Besides this, the socio-cultural configuration of society also facilitates CSA such as gender inequality, social tolerance of violence, inadequate legislation, and so on. For example, in several African countries, child rape is used as punishment or a method of communicating power and control over the child (Cromer & Goldsmith, 2010). For the current study, vulnerability is of four types: economic, familial, individual and social vulnerability.

The perpetrators of CSA are a heterogeneous population with varying age, sex, sexual orientation, marital status, and socio-cultural background. Perpetrators could be males as well as females and may target victims from the same or opposite sexes. Further, they may be elderly or adults as well as children less than eighteen years of age. Marital status has no significant relationship with the perpetrator history. It is generally believed that individuals without sexual partners would potentially sexually abuse the children; however, it is found that married individuals having sexual partners also indulge in sexual abuse of children. The perpetrators may target known children as well as unknown children (Santhosh, 2016). According to Wiehe (2003), perpetrators are self-centered, narcissistic individuals who lack self-confidence, impulse control and usually will be deficient in empathy (cited in Santhosh, 2016). Contrary to popular belief, perpetrators are often reputed and well-known individuals of the society. CSA perpetrators are of two types: paedophile and non-paedophile. The former belongs to a specific group who preferentially abuse children for sexual gratification. The non-paedophile is an opportunistic predator targeting the vulnerable children to satisfy their sexual urges.

The asymptomatic nature of CSA often makes it quite difficult to detect the abuse. Nevertheless, sometimes it may include the use of violence resulting into visible bodily symptoms such as cuts or abrasions in the body, pain in private body parts, or soreness in the genitals, and so on. Though the physical health outcomes of CSA are quite severe and gradually heal with time, however, the mental health outcomes are quite complex and irrevocable leaving lasting trauma in the minds of the victims. The victims of CSA are found to suffer from the Post-traumatic
Stress Disorder (PTSD), depression, anxiety, academic difficulties, conduct disorders, substance abuse, personality disorders, suicidal ideation, and so on.

The prevention of CSA is multipronged and requires cumulative efforts of diverse stakeholders such as parents, caregivers, community, government, etc. Since the damages caused by CSA, trafficking, or similar abuses are irreparable hence the best possible measure should be to prevent the occurrence of these events in the first instance. Therefore, the best intervention would be to avoid CSA through education and awareness. Education and awareness of CSA is the single potent measure to prevent CSA. Aware and informed children will be able to defend themselves and confront their abusers. Similarly, educated parents will be able to protect their children from potential perpetrators in their family or vicinity.

The reporting and prosecution of offenders is also vital to prevent and control CSA. The trial not only helps in the conviction of the offenders but also deters future perpetrators from committing CSA. The biggest challenge against law enforcement is the low disclosure rate of CSA. Very few parents are interested in reporting the crimes of CSA, and in fact, many parents coerce their children to remain silent about the abuse. The low disclosure rates also inhibits authorities acting in legal and child custody cases and constitutes an obstacle in establishing public awareness for CSA. Hence, parents must encourage their children to report incidents of CSA and get the offenders convicted. Further, the role of legislation and judiciary in controlling CSA cannot be undermined. CSA laws must be strengthened worldwide to protect vulnerable children. CSA cases must be expedited in the court of rules to minimise the distress and inconvenience caused to the children during the court proceedings.

The following model (Figure 2) presents the framework for the risk factors, outcomes, and protective factors of child sexual abuse in the country:
Figure 2. The conceptual framework representing risk factors, outcomes, and protective factors of child sexual abuse.
Limitations of the Study

Although the current study presents an exhaustive overview of child sexual abuse in the country, yet the generalisation of the review is limited in the following contexts. Sexual abuse does not occur in isolation, and the other forms of violence and maltreatment are found to be complicit. However, the current review explicitly focuses on child sexual abuse. Secondly, the present study does not highlight the social construct of certain types of child sexual abuse such as incest. Several anthropological pieces of literature suggest that in certain communities incest is socially acceptable up to certain degrees and is not viewed as a form of sexual abuse; hence a separate review may elaborate upon this fact.

Scope of the Study

Child sexual abuse is a serious form of violence against children which has several detrimental outcomes on the growth and development of the child victims. Besides the physical violation of the genitals, the victims of CSA are found to suffer from severe emotional and psychological outcomes. The victims of CSA need rigorous medical and psychological assistance for recovery and reconstruction. Sometimes, the trauma of CSA may last forever. However, CSA is not taken as a serious health hazard violating the rights of the children. The exposure to CSA strongly interferes with the growth and well-being of children, hence, this review strongly advocates in favor of strict intervention measures for the prevention of CSA.

The results of the review reveal that research in the Indian context on CSA are in nascent stage; hence, the review recommends undertaking research on different aspects of CSA such as victim or perpetrator characteristics, disclosure of CSA, effective prevention and intervention measures for CSA, and so on. The review further suggests that children from dysfunctional or broken families are quite susceptible to CSA; hence, the sensitisation material on CSA must include the probable role of dysfunctional or broken families in aggravating vulnerability to CSA. It is found that the current research is basically victim-centric, i.e., the popular subjects of research are characteristics of the victims of CSA, outcomes of CSA, disclosure pattern of CSA and so on. The perpetrator-centric studies are virtually absent; hence, the review advocates for more research centering around perpetrators in order to design suitable intervention and sensitisation material for CSA prevention. Further, the perpetrators are often related to the victims and incidents take place in and around the homes of the victims; hence, sensitisation
programmes for the public regarding this may come in handy in preventing a potential episode of CSA. Little sensibility and insight can help an individual detect a prospective victim and save many lives from the scourge of CSA. Further, the government must promote research prima facie on crime sites, context, space/location, information on the background of the victims and the perpetrators to generate more data which will aid in policy formation and development.

Keeping in mind the prevalence of CSA in the Indian context, there is a dire need to establish suitable intervention programs for the prevention of CSA for an at-risk cohort. Parents are the primary caregivers hence education campaigns on CSA for parents would be quite fruitful in informing parents about the potential abuser and risks factors for CSA. Prevention programs should emphasise to parents that the risks of sexual abuse to children are more likely to come from family members, friends and acquaintances. The sensitisation training must include the risk factors for CSA, essential traits of the abuser as well as what to do if parents believe their child is at risk or has been sexually abused. Age-appropriate Information and Communication Material (IEC) on CSA must be included in the school curriculum to educate children about CSA. The informed children will be able to defend themselves better from a probable CSA. In his paper *Moving Upstream: The Merits of Public Health Law Approach to Trafficking*, Todres (2011) advocates in favor of public health law approach to prevention of trafficking. Similarly, doctors and paramedical professionals are in the best position to detect a likely case of rape and violence as they are often the first to come into contact with the victims. But due to lack of training and sensitisation, they fail to distinguish between a causal wound and a violent wound. Training of professionals, paraprofessionals and lay people to identify children at risk and situations of child abuse as well as providing trauma-informed care to parents and children is vital in preventing and treating child sexual abuse, and could be quite fruitful and pragmatic in the long run.
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