Joint Submissions on the MoWCD National Child Protection Policy, 2019

Introduction

The Ministry of Women and Child Development has drafted the National Child Protection Policy and invited comments from stakeholders. The policy, while welcome, is inadequate in several aspects including, lack of definition of what is a child, homogenous consideration of all children without taking into account their evolving capacities, lack of clear objectives and a statement of policy, a provision for mandatory reporting which does not allow for any form of redress for those who do not wish to pursue the criminal justice procedures, lack of victim centric policies with regard to rehabilitation, and no mention of capacity development for service providers, research, monitoring and evaluation of existing services.

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1. The definition of child is unclear. Existing laws and policies pertaining to children in India have variations in the definition leading to ambiguity about those who are in age group of 15 to 17 years. The Protection of Children from sexual Offences Act, 2012 defines a child as any person who is below 18 years of age. The Child Labour (Prohibition and Regulation) Amendment Act, 2016 defines a child as any person below 14 years of age while those between 14 to 18 years of age have been considered as adolescents. Similarly in National youth Policy, the individuals in the age group of 15 to 17 are regarded as "Youth". The Prohibition of Child Marriage act defines a child as, if a male, who has not completed 18 years of age and a female, has not completed eighteen years of age. The Right of Children to Free and Compulsory Education Act, 2009 defines child between 6 to 14 years of age. On the other hand, the largest demographic survey which is Census of India defines child as a person below fourteen years of age.

The laws and the acts mentioned above have a direct bearing on the protection of children. The present draft mentions that "*The current policy draws upon the safeguards provided under the Constitutions of India,* ***various child-centric***

***legislations**, international treaties as well as other existing policies for the protection and wellbeing of children"*. In this scenario where definition of 'child' is not clear and uniform, it would be impossible for the existing child-centric legislations to promote the protection and wellbeing of children.

2. Children as a homogeneous population: The draft has considered children as a homogeneous group and has not paid any attention to the unique needs of children with disabilities, early childhood care (0 to 8 years) and those between 15 to 17 years of age.

The POCSO Act, 2012 doesn't recognize consensual sexual interaction among adolescents below 18 years of age. The act criminalizes any such consensual sexual act among adolescent of 15 to 17 years of age group and requires reporting to police. There is a dichotomy between the services provided under RKSK (*Rashtriya Kishor Swasthya Karyakaram*) programme and provisions of POCSO Act. The services acknowledge the sexual activity among adolescents and are aimed at improving the sexual and reproductive health of adolescents. On the other hand, POCSO makes it difficult for healthcare providers to provide the services to adolescents. The mandatory reporting by healthcare providers under POCSO jeopardizes the right to health of those adolescents who don't want to report to police. The policy on child protection needs to explicitly states that health rights of these adolescents are not jeopardized.

The draft has not addressed these complexities and the unique needs of children who are vulnerable and belong to different age groups.

3. Framework of the draft policy: The draft lacks a statement on the key principles and specific objectives. There is a lack of road map for government bodies on aspects they are expected to operationalise under the child protection policy. Child protection policies are expected to put down specific roles and responsibilities for institutions caring for children, these could be government institutions as well as private institutions. .The child policy does not explicitly provide definitions of abuse, neglect, exploitation. There is no mention of international obligations to protect and promote

rights of children such as United nations convention on rights of child and the like. So the policy does not allude to any international obligations.

4. Need to shift the focus from child welfare to child rights: There is evidence of violation of rights of children both in custody as well as those in need of of care protection. The language of the policy continues to use a "welfare" approach rather than use "rights based language" . This can result in undermining of the intentionally good welfare approaches based on the "best interest" of the children.

The draft mentions "*Professionals who provide services to children (teachers, counsellors, doctors/ other health workers and others) must follow child protection policy for reporting and taking action if they become concerned about a child's safety and welfare*".

It doesn't provide any safeguards for the survivors who do not want to report, thereby violating the rights of children.

5. Rehabilitation of children: The draft policy has nothing to offer on the plan of rehabilitation of the children who have faced abuse. It is needless to mention that the process of rehabilitation forms an important component of the child protection policy and is instrumental in safeguarding and promoting welfare of children.

6. Coordination with stakeholders: India lacks a child protection mechanism. The policy does not address this critical issue. Establishing a strong child protection system clearly requires engagement and coordination with different stakeholders who are concerned with the protection of children. Some of these stakeholders include social welfare officers, police, judiciary, health professionals etc. The draft has not acknowledged the role of the different stakeholders in influencing the implementation of child protection policy, and the platforms that can be used in building a holistic and coordinated response.

7. Capacity building: The policy has missed addressing the initiatives for capacity building of service providers –healthcare providers, teachers, child welfare committee members, police, social workers and NGOs to fulfill their roles and responsibilities of

child protection. There is no mention of Standard Operating Procedures for reporting and referral mechanisms between stakeholders.

8. Role of research in policy and practice: The policy has not acknowledged the role of collecting, analysing and using service data in continuous development and implementation of child protection policy. It is important that the establishments of preventive and responsive measures are informed and build on the evidence emerging from the implementation of the services related to children like healthcare services, education etc.

9. Mandatory Reporting: The direction of "mandatory reporting" under POCSCO 2012 has been detrimental to those in the age of 16 to 18 years. Those in this age group may be engaged in consensual sexual activity; however, when they report to health institutions with a health concern such as "unwanted pregnancies", sexually transmitted infections or the need for contraceptives; they invariably get reported to the police. This is owing to the homogenous treatment of all persons under 18 years of age as children. Further the health institution is mandated to report such children. Mandatory reporting is pushing adolescents away from accessing health care even at the cost of ill health . This will lead to them seeking abortions underground and will end up encouraging unsafe abortions.

Below are the legal provisions dealing with mandatory reporting in current legal scenario.

a. Section 357C Code of Criminal Procedure, 1973 (CrPC) under Criminal Law (Amendment) Act 2013, (2013) directs all hospitals, private or public, run by central or state government to report the incident after provision of first aid or medical treatment.
b. Section 166B Indian Penal Code (IPC) further states that whoever, being in charge of a hospital, public or private, whether run by the Central Government, the State Government, local bodies or any other person, contravenes the provisions of section 357C of the Code of Criminal Procedure, 1973, shall be punished with imprisonment for a term which may extend to one year or with fine or with both."

c. Section 19 of Protection Of Children From Sexual Offences Act, 2012 (POCSO) states that any person (including the child), who has apprehension that an offence under this Act is likely to be committed or has knowledge that such an offence has been committed, shall provide such information to, - the special juvenile police unit; or the local police. Section 21 of POCSO states that any person who fails to report the commission of an offence under

subsection (1) of section 19 shall be punished with imprisonment of either description which may extend to six months or with fine or with both.

I. Concerns in the Indian context:

A. The current Ministry of health and family welfare (MOHFW) guidelines recognize the challenge for health professionals in the context of mandatory reporting and thus include a direction termed “informed refusal “in instances where survivors do not wish to record a police complaint immediately but can avail of health care services. The MOHFW medico-legal guidelines for responding to sexual violence survivors has set up a mechanism called “informed refusal”. When the doctor informs the survivor about disclosing the incident to the police for recording an FIR, and if the survivor refuses a police complaint, then an “informed refusal is documented at the level of the hospital. A medico legal report is prepared at the hospital, which states that she wants to avail of therapeutic care and does not wish to make a complaint. The police are informed that the survivor does not wish to take the complaint ahead. Such documentation is stored at the level of the hospital itself as a component of medico legal records. There is a need to recognise medico legal documentation at the level of the hospital as compliance by the health system and doctors. If survivors are forced to record FIRs against their will, it will sabotage their access to health services.

However such a direction needs to be brought in to the legal framework too.

Besides, Mandatory reporting contradicts existing legal provisions in India. These have been listed below.

B. Medical termination of pregnancy (MTP): Mandatory reporting by doctors to the police contradicts with the Medical Termination of Pregnancy Act. MTP law mandates that doctors should keep all

information confidential about the person seeking MTP. But POCSO makes it mandatory to report all sexual activity less than 18 years (whether consensual or not) to the police. When a survivor wants to undergo MTP because the pregnancy is an outcome of rape and does not want to file a police complaint, the doctor has no choice but to inform her about the mandatory reporting law. This can have implications on the survivor's health, as she may decide to seek MTP from any other unauthorized place for the sake of anonymity, which may in turn jeopardize her health. This also leads to abortions going underground and reducing access to safe abortion services.

C. Informed consent: Section 164A CrPC amended in 2005 makes it binding for medical professionals to carry out the medico-legal examination only after seeking informed consent. As a component of the "consent seeking process", doctors are expected to inform the survivor that they have a legal obligation to inform the police about the episode of sexual violence. A challenge encountered by the doctor is when a survivor wants to seek only treatment and does not want to file a police complaint. For doctors, not informing the police attracts punishment where as informing the police against the consent of the survivor would also be a violation of "informed consent". This may result in denying access to health care services and also lead to several health complaints going untreated. One of the ways of resolving the conflict is to treat the medico legal complaint documented at the hospital by a doctor as compliance to mandatory reporting.

D. "Voluntary reporting" came after a long period of struggle. A landmark Supreme Court judgment in the case of *State of Karnataka v. Manjanna (2000) 6 SCC 188* reconized "rape" as a medico legal emergency and made it obligatory for the health facilities to provide survivors with immediate health care. The judgment highlighted pathways by which survivors could reach a health facility, either voluntarily, or by police requisition or through a court directive. It recognised that survivors may reach a health facility to receive treatment for their health and therefore immediate services ought to be provided without any police requisition. But with the mandatory reporting laws related to sexual violence, it will deter survivors from accessing health care and accessing hospitals voluntarily.

E. POCSCO and Mandatory Reporting:

The mandatory reporting to police in case of Child Sexual Abuse is problematic and based on our experience we feel the reporting should be to an agency/system that focuses on welfare and rehab of children such as Victim Protection Services seen in the US and other countries. Such a service provides a full range of assistance in such matters, such as physical safety, psycho social services to the assaulted persons and witnesses, as well as provision of in court psychological assistance. Victim Assistance Programs are based on an understanding that survivors of sexual violence /gender based violence, trafficking for sexual exploitation may feel particularly vulnerable and reluctant to access the criminal justice system if specific protection mechanisms are absent. In the United States of America, Canada, United Kingdom and Bangladesh the witness/victim protection/assistance programs operate under the Department of Law and Justice.

II. Concerns Related to Mandatory Reporting under POCSO

In case where a child is abused by a close relative, the close family members (generally the parents) tend to deny such abuse and make up stories in front of the police due to the fear of social stigma which can be attached if such news is made public and that leads to police not filing any FIR. On attaining majority if the child later decides to come out with such news or even wants to file an FIR, the burden to proving becomes more difficult than it already is.

III. Suggestions:

There are situations in which the family does not wish to pursue a criminal case and refuse to record an FIR, it is important to create a separate mechanism for reporting. Such a reporting could then be made to organisations providing psycho social services, one stop centres set up by the MWCD, and child welfare committees. A record can be kept of the abuser through voluntary self reporting and the abuser should agree to be on a mandatory counselling service for a few years with periodic monitoring

It is critical to develop a victim[1]/witness protection scheme in India. Such a program/scheme assists survivors who have decided to take recourse to legal justice. The role of such a program to enable protection of survivors and other witnesses from the time of the police complaint till the final court outcome. The program requires components such as on going psycho social care at the level of the courts, access to shelter services, anonymity and protection from

[1] Victim/ witness protection schemes are established in United states of America , United kingdom, Australia and Bangladesh amongst others . These schemes work towards encouraging and enabling victims of crimes to participate in the criminal justice system to the extent that they wish to. In order for their participation a host of services are created such as accompanying them to the court , preparation for court trials , psychological support inside the court , and other social welfare services such as alternate accommodation / shelter , education , health care and the like

the perpetrators/ accused throughout the criminal justice process. These components can enable survivors and their families to not drop out of the system as they are hand held, protected and consulted throughout the process.

When hospitals receive survivors who wish to avail of treatment only and do not wish to access the criminal justice system, the referral can be made to such

a victim/witness protection program so that the obligation of reporting is fulfilled and at the same time the program can enable survivors to access services not related to the criminal justice system. These could be services such as alternate accommodation to ensure safety of the survivor, support for

relocation and psychosocial support. The program can also work in coordination with the existing one stop centre scheme of the MWCD.

In appropriate cases, after an FIR is filed, the offender may be mandated to attend counseling regularly, failing which the FIR may be prosecuted. This would address some of the concerns with mandatory reporting.