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Incidence And Patterns of Sexual Offenses Among Minors: An Analysis Under The POCSO Act 2012 At A Tertiary Centre

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ABSTRACT

Sexual offenses against minors are a significant public health issue and the Protection of Children from Sexual Offenses (POCSO) Act, 2012 aims to combat these crimes. The study describes the demographic and clinical profiles of the minor victims of sexual offenses, thus illuminating patterns and contributing factors to abuse. This prospective observational study consisted of 176 minors less than 18 years of age, followed up over a period of two years from a tertiary care center in Mumbai. It showed that 84.1% were female victims and 57.4% fell within the 12-18-year age bracket. Most attacks took place in the daytime. In most cases, more than 24 hours passed before reporting the attacks. Victims often knew their assailants, and the non-consensual acts took place in 68.8% of cases. Genital injuries occurred in 20.5%, and penetration took place in 70.5%. The patterns of abuse differed according to gender and age, thus pointing out the importance of targeted intervention. Early intervention, legal aid, and counseling are essential factors for effective management.

Keywords: *Sexual offenses, minors, POCSO Act 2012, abuse patterns, genital injuries, penetration.*

1. INTRODUCTION

Sexual crimes, especially those committed against children, are serious problems society faces and have direct and indirect effects on personal and social life (Rawat & Masthanaiah, 2015). Children are highly vulnerable to sexual abuse across cultures, economies, and geography (Choudhry, Dayal, Pillai, Kalokhe, Beier, & Patel, 2018). The problem in India has, in the last decade, gained increasing visibility. Cases of child sexual abuse appear regularly in the media. These incidents emphasize the need to deal with this crisis through all-inclusive legal, medical, and social interventions (Rawat, Guin, & Dadich, 2018). The POCSO Act, 2012, was a landmark legislation in India aimed at dealing with the menace of child sexual abuse and ensuring justice and protection for victims (Anchan, Janardhana, & Kommu, 2021).

The POCSO Act has provided a robust legal framework to safeguard children from offenses of sexual assault, sexual harassment, and pornography (Anchan, Janardhana, & Kommu, 2021; Kumar-Pal, Sharma, Kumar Sehgal, & Singh-Rana, 2015). It defines a "child" as any person below the age of 18 years and explicitly recognizes various forms of abuse, including penetrative and non-penetrative assault (Moirangthem, Kumar, & Math, 2015; Panda, Mullick, Adhikari, Basu, & Kumari, 2020; Arpana, Vineeta, & Kavita, 2015). The Act mandates stringent punishments for offenders and

underscores the importance of child-friendly procedures for reporting, recording, and trial of such offenses (Panda, Mullick, Adhikari, Basu, & Kumari, 2020; Arpana, Vineeta, & Kavita, 2015). Despite these legal provisions, the incidence of sexual offenses against minors remains alarmingly high. According to the National Crime Records Bureau, cases registered under the POCSO Act have been increasing steadily over the years, which reflects the prevalence and persistence of this heinous crime. (Yadukul, Vidya, & Kavyashree, 2017).

Sexual offenses against minors often occur in environments where children should feel safest, such as their homes, schools, and neighborhoods (Pullman, Sawatsky, Babchishin, McPhail, & Seto, 2017). Perpetrators are frequently individuals known to the victims, including family members, neighbors, and acquaintances, making it difficult for children to report abuse (Stephens, McPhail, Heasman, & Moss, 2021). The psychological impact of such crimes on minors is profound, often leading to long-term trauma, mental health disorders, and developmental challenges. These crimes require early detection and intervention to reduce the damage inflicted, and require a multidisciplinary approach with legal, medical, and psychosocial support systems (Letourneau, Schaeffer, Bradshaw, & Feder, 2017; Silovsky, Hunter, & Taylor, 2019).

Healthcare professionals play a crucial role in cases of child sexual abuse. The medical examination of survivors is not only a critical component of the legal process but also an important step for their physical and psychological recovery. However, the examination and care of minor survivors are challenging and require sensitivity, expertise, and child-friendly protocols (Mokros & Banse, 2019). Documentation of injuries, collection of forensic evidence, and assessment of the survivor's psychological state are integral to building a strong legal case against perpetrators (Cortoni, Babchishin, & Rat, 2017; Silovsky, Hunter & Taylor, 2019; Wild, Müller, Fromberger, Jordan, Klein & Müller, 2020). Medical records are crucial evidence in courts of law, and any lapse in their preparation can compromise the pursuit of justice.

Despite the elaborate provisions of the POCSO Act, several impediments exist which impede the proper implementation. These include social stigma, poor awareness among the children and their families, deficient training of the health care givers, and tardiness in judicial proceedings (Assini-Meytin, Fix, & Letourneau, 2020; Beier, Grundmann, Kuhle, Scherner, Konrad & Amelung, 2015). Neglect, discrimination, and victim-blaming attitude against sexual offense survivors increases the trauma factor (Assini-Meytin, Fix, & Letourneau, 2020; Cortoni, Babchishin & Rat, 2017). An overarching goal of this challenge is ensuring safe reporting channels, community programs that raise public awareness, and building the skills of professionals managing these cases.

Demographic and clinical profiles for sexual offense survivors give insight into who the victims of sexual offenses are and what can put them or other people in their position at risk (Coker, Bush, Cook-Craig, DeGue, Clear, Brancato, Fisher, & Recktenwald, 2017; Stephens, McPhail, Heasman, & Moss, 2021). Study of these can be used for targeted prevention policies based on known trends, identification of population vulnerability, understanding offender modus operandi, among other things (Lätth, Landgren, McMahan, Sparre, Eriksson, Malki, Söderquist, Öberg, Rozental, Andersson, Kaldo, Långström & Rahm, 2022). Tertiary care centers, as referral centers for medico-legal cases, form an integral part of this initiative. It is a conduit that bridges survivors to the judicial system, providing medical, forensic, and psychosocial care (Engel, Körner, Schuhmann, Krüger & Hartmann, 2018).

The following study was undertaken to assess the incidence and pattern of sexual offenses against minors under the POCSO Act in a tertiary care center. The study aims to analyze the incidence and patterns of sexual offenses among minors reported under the POCSO Act, 2012, at a tertiary care center, with special emphasis on the demographic and clinical profiles of survivors and the medico-legal challenges involved in their care.

2. MATERIALS AND METHODOLOGY

A prospective, observational study from a tertiary care center's department of forensic medicine and toxicology, in this case, is located in a single center: Mumbai. The study was conducted for two years from November 1, 2018, to October 31, 2020. The aim of the study was to assess the demographic and clinical profiles of minors who alleged sexual offenses under the Protection of Children from Sexual Offenses (POCSO) Act, 2012. A total of 176 cases of victims below 18 years of age, both male and female, were studied based on their willingness to give positive consent for the study.

Inclusion and Exclusion Criteria

The study involved all minors under the age of 18 who experienced a history of sexual assault, natural or unnatural, and gave consent. In cases of victims under 12 years, consent was sought from their parents or guardians. The cases were excluded if the victim or a guardian refused to give consent or if the victim had mental illness, was not of sound mind, or was unconscious at the time of examination.

Ethical Considerations

The study was conducted in compliance with ethical standards and after obtaining clearance from the Institutional Ethics Committee. Informed consent was obtained in the victim’s native language, and interpreters were used if required. Confidentiality of the victims’ identities was strictly maintained, with only anonymized data used for analysis and publication.

Study Process and Procedures

a. Investigation and Consent Procedure

Victims were investigated after receiving a call from the Department of Gynecology. Both departments conducted joint examinations to ensure full investigation and recording. The process was initiated by seeking informed consent from the victim and, for children below 12 years of age, their parents or guardians. This is done in a victim's own language to ensure one understands the procedures. For the victim who cannot read or understand a specific language, the use of a translator is called for. Conducting medical exams only after obtaining consent from them.

b. Data Collection and History-Taking

A detailed and comprehensive history of the alleged assault was obtained, avoiding interpretation or leading questions to ensure accuracy and neutrality. This included the nature of the assault, details of the perpetrator(s), and any contextual information. General medical history was also recorded to identify pre-existing conditions that might influence clinical findings.

c. Clinical Examination and Evidence Collection

The clinical examination of the victims involved a general medical examination and a meticulous genital examination. Injuries were documented in detail, including their site, size, color, number, and location. Evidence collection followed standard forensic protocols, ensuring chain of custody requirements. Collected specimens were sealed, labeled, and handed over to the on-duty police constable, with receipts obtained to document the transfer. When the age of the victim was unknown, radiological, dental, and physical evaluations were done with a view of preparing an age certificate. Such findings were merged into the final medico-legal report.

d. Refer and Counseling

After clinical assessment, the case was referred to social workers and psychiatrists for counseling. Such a move had the view of addressing psychological distress that had befell the victims and aiding the recovery process for them.

Data Collection Tool

A specially designed pro forma, developed for the study, was used for recording data. Key areas that the pro forma covered included:

a) General information and consent details.

b) Detailed history of the alleged sexual offense.

c) General medical history and physical examination findings.

d) Detailed findings of genital examination.

e) Documentation of injuries, specimens collected, and forensic observations.

Throughout the research, patient records' confidentiality was preserved. Access to patient files and case sheets was limited to authorized persons such as members of the Institutional Ethics Committee and researchers.

Statistical Analysis

Data gathered in the study were put into Microsoft Office for organizing and analyzing. All the variables were calculated for frequency distribution to check the completeness of data. Descriptive statistics, such as percentages, were used in summarizing the demographic and clinical findings. Chi-square tests were used to determine the association between dependent and independent variables, and a p-value of less than 0.05 was considered statistically significant. This analytical approach helped identify patterns and correlations within the dataset, contributing to a comprehensive understanding of the incidence and characteristics of sexual offenses among minors at the tertiary care center.

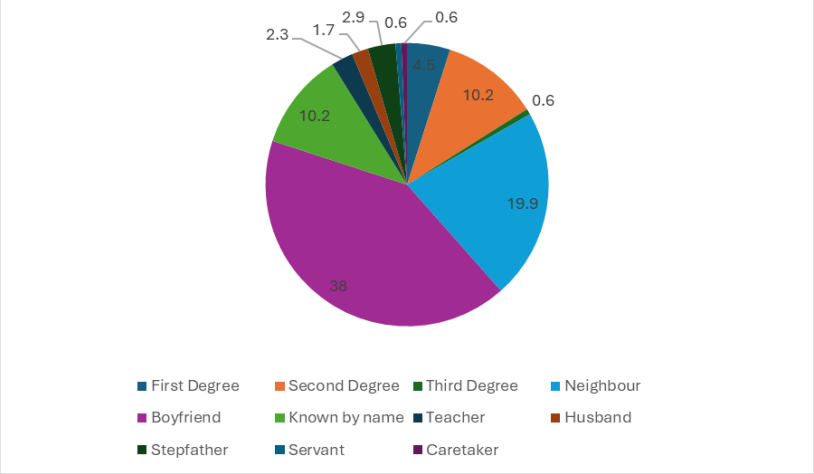
3. RESULTS

This study analyzed 176 cases of sexual offenses against minors under the POCSO Act, 2012, at a tertiary care center in Mumbai between November 2018 and October 2020. Most victims (57.4%) were adolescents aged 12–18 years, followed by children aged 6–12 years (32.4%) and 0–5 years (6.8%). Females accounted for 84.1% of victims, and males 15.9%. Socioeconomic stratification was a feature, for 81.3% hailed from low socioeconomic backgrounds, 15.9% from middle, and 2.8% high. Religious affinities came in the way of 54% Hindus, 40.3% Muslims, 3.4% Buddhists, and 2.3% Christians. Victims stayed in chawls (43.2%), slums (38.1%), and in buildings (18.2%). Educationally 32.4% were into grades 8–10 while 50.6% claimed to have formally received sex education.

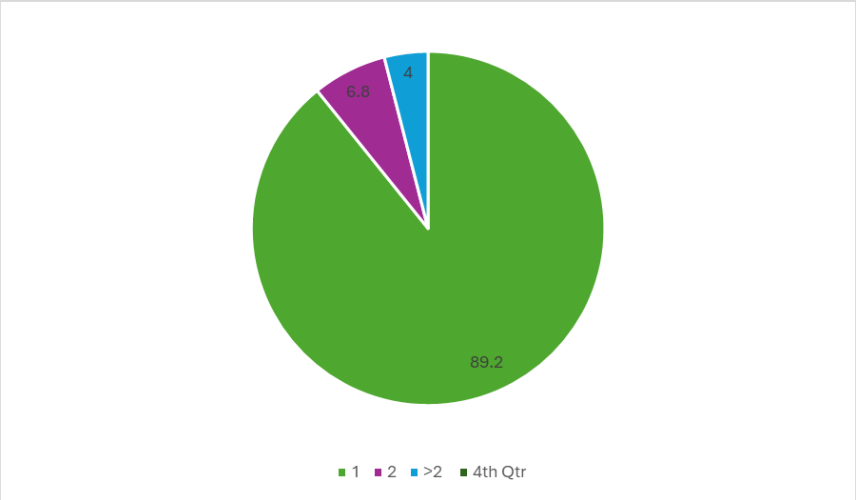
Most attacks occurred during the day (59.1%), and 83.5% of the victims reported to the examination room more than 24 hours after the incident. Attacks occurred most frequently at the assailant's home (58%), followed by isolated places (23.3%), the victim's home (11.9%), and hotels (5.1%). In 68.8% of cases, consent was absent. Assailants were known to

the victims in 90.3% of cases, including boyfriends (38%), neighbors (19.9%), and relatives (4.5%). Multiple perpetrators were involved in 10.8% of cases, and contraception was used in 10.2% of cases.

Graph 1: Distribution of Relation with Assailant



Graph 2: Distribution of Number of Assailants



Among the victims, 94.3% (166 cases) reported no history of intoxication prior to the assault, while 5.7% (10 cases) admitted to intoxication. Of those intoxicated, 70% (7 cases) involved mixed intoxication with food or drinks, and 30% (3 cases) involved alcohol. Clothing changes after the assault were reported by 88.1% (155 cases), while 11.9% (21 cases) did not. Regarding pubertal status, 59.65% (105 cases) had attained menarche, 24.43% (43 cases) had not, and 15.9% (28 cases) were male, making this parameter inapplicable for them. A urine pregnancy test was conducted in 41.4% (73 cases) of female victims, with a 20.5% (36 cases) positivity rate. Of the positive cases, 8% (14 cases) were within 12 weeks, 8% (14 cases) between 13–26 weeks, and 4.5% (8 cases) between 27–40 weeks.

Injuries were absent in 90.3% (159 cases). Among the injured, abrasions (6.9%, 12 cases) were the most common, followed by contusions (3.4%, 6 cases) and lacerations (1.2%, 2 cases). The injuries primarily involved the upper limbs (7.4%, 13 cases). Genital injuries were noted in 20.5% (35 cases) of which edema and redness were the common findings. Hymenal tears were found in 79.8% (118 cases) of which 84.74% (100 cases) were old tears mostly circumferential, 61.86%, (73 cases). Perineal injuries were rarely reported (98.9%, 174 cases) while urethral injuries were reported in 0.6% (1 case). No anal injuries were found in 96% (169 cases), with tenderness and abrasions recorded in some of the cases. Oral injuries were noted in 0.6% (1 case), with no major oral injuries found. Body stains were found in 1.7% (3 cases),

which include seminal stains found in 1.1% (2 cases) and blood stains found in 0.6% (1 case). 39.8% of 70 cases provided forensic evidence with 4.5% showing the presence of spermatozoa.

Of the offenders, 99.5% (175 cases) were male while female was 1.1% in 2 cases. In all, penetration occurred in 70.5% (124 cases) while attempts at penetration took place in 17% of the cases or 30. In fingering, the frequency was 42% in 74 cases. Genital manipulation occurred in 45.4% or 80 cases. Kissing that involved face happened in 30.1% or 53 cases. 41% (72 cases) reported cases of physical aggression, and 55.1% (97 cases) indicated that the perpetrator threatened them. Furthermore, 3.4% (6 cases) involved blackmailed individuals being forced to video record their sexual acts. Age was found to be very strongly associated with threatening behavior, $p < 0.001$, and with exposure to pornography, $p < 0.001$. Hymenal condition, $p < 0.001$, and fingering, $p = 0.017$, were significantly related to age if penetration had been involved. Higher frequencies of rubbing, kissing, and forceful oral sex occurred in older minors, $p < 0.001$. Anal injuries occurred more frequently among older minors, $p = 0.030$.

Sociocultural forces may account for the higher levels of some such behaviors among the older minors. Gender-specific breakdown revealed that among the victims' female victims were relatively more exposed to pornography, whereas their male counterparts showed more genital manipulation. Other modes of abuse that included physical attack and blackmail are not significantly differing by gender because $p > 0.05$. Abuse trends differ by both gender and age, thus making a case for gender- and age-specific interventions.

Table 1: Age-wise Distribution of Manipulations and Kissing (N=176)

	Age (Years)				**P Value**
	1-5	**6-12**	**13-18**	**>18**	
Manipulations					
Rubbing over genitals	1 (8.3)	2 (3.5)	1 (1.0)		0.204
Touching genitals	4 (33.3)	13 (22.8)	11 (11.0)		
Both	7 (58.3)	42 (73.7)	87 (87.0)	6 (100.0)	
No history			1 (1.0)		
Kissing					
Face	3 (23.1)	22 (33.3)	69 (54.3)	4 (57.1)	<0.001*
Chest	1 (7.7)	11 (16.7)	32 (25.2)	1 (14.3)	
Whole body		1 (1.5)	15 (11.8)	1 (14.3)	
Genitals		1 (1.5)	1 (0.8)		
No history	9 (69.2)	31 (47.0)	10 (7.9)	1 (14.3)	
Force for oral sex					
Yes	3 (25.0)	32 (56.1)	20 (20.2)		<0.001*
No	9 (75.0)	25 (43.9)	78 (78.8)	6 (100.0)	
No History			1 (1.0)		

Table 70: Age wise Distribution of Anal Injuries, Eloping Mutually and Consensual Intercourse (N=176)

	Age (Years)				**P Value**
	1-5	**6-12**	**13-18**	**>18**	
Anal Injuries					

Abrasion		1 (1.8)			0.030*
No Injuries	11 (91.7)	53 (93.0)	99 (99.0)	6 (100.0)	
Edema & Redness			1 (1.0)		
Lax anal tone		3 (5.3)			
Consensual Intercourse on pretext of marriage					
Yes		1 (1.8)	47 (47.0)	5 (83.3)	<0.001*
No		5 (8.8)	28 (28.0)		
NA	12 (100.0)	51 (89.5)	25 (25.0)	1 (16.7)	
History of eloping mutually					
Yes			34 (34.0)	1 (16.7)	<0.001*
NA	12 (100.0)	57 (100.0)	59 (59.0)	5 (83.3)	
No			7 (7.0)		

4. DISCUSSION

Most victims in this study were from the 13-18 years age group (57.4%), followed by the 6-12 years group (32.4%), with a smaller proportion from the 1-5 years group (6.8%). These findings are in line with previous studies, including Ingemann-Hansen O et al. and Walby S et al., which also reported a higher prevalence of victims in the 11-20 years age range. Shyamal Sarkar et al. found 68.88% of victims in the 11-20 years age group, and Kumar SP et al. and Hakan Kar et al. similarly observed that most victims were in this age range. Other studies found 77.2% of victims in the 10-19 years range, while Jorge Costa Santos et al. reported 61% of victims were between 0-19 years. Gender differences were notable, with females accounting for 84.1% of the victims, mirroring the findings of M. Maqsood et al. (81.4%) and Soumyajyoti Bandyopadhay et al. (96.2%). Other studies, such as those by Tamuli RP et al. (98%) and Jorge Costa Santos et al. (92%), also showed a predominant number of female victims. Religion distribution showed that the largest group of victims were Hindus (54%), followed by Muslims (40.3%), and a small portion were Christians (4%) and Buddhists (6%). Shyamal Sarkar et al. reported 75.5% Hindu victims, while B. Roy Choudhary et al. noted 57% Hindus. In contrast, Al-Azad MAS et al. observed 76.08% Muslim victims, suggesting regional variations in religious backgrounds.

Most victims were educated up to school level, consistent with Sujatha PL et al.'s findings, where 74.2% of victims had similar education levels. Jorge Costa Santos et al. found 36% of victims were students, and M. MAQSOOD et al. noted 55.55% were students, indicating that the school-going age group is particularly vulnerable. Socio-economic status played a significant role, with 81.3% of victims coming from low-income families. This is comparable to the findings of Shyamal Sarkar et al. (92.22% from low-income backgrounds) and Al-Azad MAS et al. (77.89% from low-income backgrounds), underscoring the connection between victimization and socio-economic status.

Most victims (83.5%) were examined more than 24 hours after the incident, contrasting with studies like Rahul Jain et al., who found 59.25% examined within 12-24 hours. In this study, only 6.8% were examined within 12 hours. Delayed examinations align with findings from Aparna S et al. (3.9% examined within 24 hours) and Samuel Ononge et al. (27.6% within 24 hours), highlighting the need for improved timeliness in medical examination following such events, as stipulated by NCPCR35 guidelines. Most incidents occurred at the assailant's house (58%), followed by isolated places (23.3%) and the victim's house (11.9%), consistent with studies like M. MAQSOOD et al. (55.5% at the assailant's house). Al-Azad MAS et al. found the victim’s house as the most common location (31.3%).

In terms of the number of assailants, a majority of cases (95.8%) involved a single assailant, with studies by Malene Hilden et al. and M. MAQSOOD et al. also showing similar trends. However, some studies, such as Rahul Jain et al. and Riggs et al., pointed out that multiple assailants were involved in a significant number of cases. The study revealed that 90.3% of victims knew their assailant, aligning with the National Crime Records Bureau's data, which reports that over 90% of such cases involve known perpetrators. Kumar SP et al. and Cecile Grossin et al. also found that most victims were familiar with their assailants. The relationship between the victim and the assailant showed that boyfriends were the primary perpetrators (38%), followed by neighbors (19.9%) and second-degree relatives (10.2%). This pattern was mirrored in studies like Ado D. Geidam et al. (33.2% boyfriends) and Bhowmik K et al. (55.4% boyfriends). Rahul Jain et al. also noted a high percentage of neighbor involvement (46.75%). Only 5.7% of victims in this study reported intoxication prior to the assault, a lower figure compared to Soumyajyoti Bandyopadhay et al. (6%) but more in line with Cecile Grossin et al. (47.8%).

Regarding consent, 68.8% of victims did not consent to the act, while 31.3% reported consensual intercourse. These results align with Soumyajyoti Bandyopadhay et al. (53% non-consensual, 47% consensual) and Sujatha PL et al., who also found that most rape cases were non-consensual. Most victims (89.8%) did not use contraception, with 9.1% using barrier contraceptives, 1.1% using emergency contraceptives, and 0.6% using withdrawal. Cecile Grossin et al. reported 6.2% of victims using barrier contraceptives. Pregnancy was confirmed in 20.5% of victims, with 36 cases. The second trimester was the most common (14 cases), followed by the first (13 cases) and third (8 cases) trimesters. Rahul Jain et al. reported 12.5% pregnancies, while Biswajit Sukul et al. reported 16.9%, and Tamuli RP et al. noted a lower rate of 5%. Z Lackew et al. observed 6.5% pregnant victims. The study also documented other-than-genital injuries, but further research on these injuries could provide additional insights into victims' health and recovery.

5. LIMITATIONS OF THE STUDY

The sample is confined to certain regions, and therefore there may be sampling bias and limited generalizability of findings. The use of retrospective data is at risk of recall bias since victims or their families may provide inaccurate or incomplete accounts, especially concerning the incident or attacker's identity. This means that underreporting, spurred by fear and stigma and often by a lack of awareness, further obscures the true scale of the issue, particularly amongst young victims. Failure to investigate psychosocial consequences negates important understandings of victims' long-term mental health, social relationships, and well-being. The cross-sectional design only allows for associative, not causative, inferences, whereas differences in reporting practices between jurisdictions can affect consistency in data collected.

6. CONCLUSION

This study showcases the alarming presence and different nature of sexual abuses committed against the minors in the city of Mumbai, as interpreted using the POCSO Act 2012. The findings illustrate that the majority victims are female minor, and have portrayed an unfortunate trend where, more often than not, they have been abused within familiar areas, with people known to the victim. Socioeconomic deprivation and absence of sexual education may be a risk-enabling factor for the victims. Important correlations to emerge from the study include between age, type of assault, and patterns of victimization. This again underscores the significance of targeted prevention and intervention strategies. Legal as well as psychological services to the victims at appropriate time, along with increasing awareness and education, are important to deal and minimize such offenses.

7. RECOMENDATIONS

Child sexual assault is an abhorrent crime affecting both boys and girls equally and, therefore, requires preventive measures at all societal levels. It is at the parental level that moral values are instilled, and children should be educated regarding personal boundaries and what constitutes "good touch" and "bad touch" right from childhood. Effective communication between parents and children ensures that victims feel safe sharing their experiences without fear or guilt. Schools should integrate sex education into their curricula and train educators to identify signs of abuse, while promoting awareness of the legal aspects of sexual assault. Schools should also enhance safety by installing surveillance systems and ensuring female staff presence on buses. Medical colleges need to focus on the care of sexual assault victims, so proper and meticulous examinations should be carried out and record maintained. A "One Stop Help Centre" should be opened, where access to medical care, legal counsel, and psychosocial support can be provided. Ngos and social workers need to be collaborated in counseling the victim to uncover hitherto unreported cases. Judge level: judicial vigilance and public awareness should be ensured by conducting regular training of police personnel and surveillance in high-risk areas. This will ensure a swift and effective crime prevention process. The media, with its vast reach, must also raise public awareness regarding the importance of preventing child sexual assault through simple, accessible messages. These strategies, which are holistic, can reduce child sexual assault as a whole, and therefore decrease its destructive impacts on victims.

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