ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

(ASCCSA 2015)

22nd and 23rd September 2015

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ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

OUR THANKS TO

Bajaj Group

bajaj group

All speakers and panelists for sharing their expertise and time with us

All attendees for being there and making the seminar a success

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INTRODUCTION

Child Sexual Abuse is a malaise that continues to affect our society. According to the National Crime Records Bureau statistics for 2015, 36.6 % of the total crimes against children constituted sexual offences. Rape had the highest share of these at 31.5%. Sexual abuse of children is not just a malaise but a public health concern. With its associated short-term and long-term complications, including physical and mental consequences, preventing the sexual violation of children is a challenge that needs to be undertaken urgently.

India's ability to protect children from sexual abuse falls far short of meeting existing needs. In fact, there is a widespread lack of awareness among parents, teachers, children, criminal justice system and policymakers about the existence and complexities about the issue. While POCSO passed in 2012 has proved to be an empowering tool in our fight against child sexual abuse, implementation has not been satisfactory. Mechanisms and services are still inadequate to respond to the vast number of survivors and have to be updated and strengthened.

It has been 3 years since our initial dream of creating a common platform for convergence on the issue of child sexual abuse. A platform allowing stakeholders to share, debate, challenge, strategize and come up with best practices. A dream that was realized with the first ASCCSA in 2014.

A year later, as we set out to recreate the magic of the first seminar we found ourselves faltering. How could we better that? All the amazing feedback we received made it a challenge for us. Our only goal was to make it bigger and better. And that's what we did. ASCCSA 2015 saw us expand our wings. Not only did we make it bigger (literally, with 2 days of pre-conference workshops) but also roped in global perspectives. ASCCSA 2015 saw a fabulous participant turnout both within the country as well as internationally.

This report is a summary of the presentations at ASCCSA 2015. We hope that this report receives wide circulation and acts as resource material for all stakeholders. We dream of a world where no child has to go through sexual abuse and exploitation.

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Pre-seminar workshops

Topic	Facilitator	Workshop details
Using the Traumagenic Dynamic Framework to assess pre- and adolescent girls who have been sexually abused	Dr Lois Engelbrecht was born and brought up in India. After studying in the United States, she moved to Asia in 1985 and worked as a freelance social worker focusing on child sexual abuse and community organization.	Against the context of the ecological model, socio-cultural realities and from a mental health and therapeutic perspective, the workshop aims to give participants an overview of the concerns and variables involved, to address effects of sexual abuse on the well-being of a child who has been sexually abused and their family.
Stewards of Children Facilitator Training	Darkness to Light (D2L) is a nonprofit founded in 2000 with the mission to empower people to prevent child sexual abuse. They believe protecting children is an adult responsibility and that education is the first critical step, as well as the catalyst for larger cultural change.	Stewards of Children is an evidence-informed training program that teaches adults how to prevent, recognize, and react responsibly to child sexual abuse. The program is designed for parents, youth serving organizations, and other concerned individuals.
Let's#TalkSexuality: The Whys and Hows of an Affirmative Approach to Addressing Sexuality	TARSHI is a registered NGO based in New Delhi, India founded in 1996 that works to TARSHI support and enable people's control and agency over their sexual and reproductive health and well-being through information dissemination, knowledge and perspective building, within a human rights framework.	Sexuality is often a little-understood and highly controversial topic. TARSHI's workshop will address the following: 1. Expanding the understanding of sex and sexuality and gender 2. Exploring ways of equipping oneself to be able to give affirming messages and information around sexuality on children and young people, for their safety and well-being.

It starts with us – Evolving a Child Protection Policy	Tulir - Centre for the Prevention and Healing of Child Sexual Abuse is a non-profit, non-governmental organization committed to working against child sexual abuse in India, and is involved with both direct intervention and advocacy activities at various levels across the country and South Asia region.	A child protection policy (CPP) articulates an organization zero tolerance approach to child abuse. The goal of this workshop is to assist participants with an understanding of evolving a policy suited to their uniqueness but within a framework of non-negotiables, for reducing and managing risks of child abuse by persons engaged in delivering the organization program activities.
Web Rangers: Protecting your kids online	Google's innovative search technologies connect millions of people around the world with information every day. Founded in 1998 by Stanford PhD. students Larry Page and Sergey Brin, Google today is a top web property in all major global markets.	Google is always looking at ways and means of how awareness and technology can help empower people. As part of its Internet Safety Campaign, Google India has introduced Web Rangers, a program that empowers young people to promote the safe use of the Internet among their peers.
Working with Sexually Abusive Children and Community Systems	Ms. Zenaida Rosales is the Co-Founder and Executive Director of Center for the Prevention and Treatment of Child Sexual Abuse (CPTCSA). She is a social worker with years of experience of providing therapy to victims and young.	The aim of this workshop is to look at characteristics of the 40 young sexual offenders who have come to CPTCSA for treatment. With this information, we can design and implement effective services for prevention and treatment that focus on the individual, family, community and culture.

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Seminar Schedule

Day 1 – 22nd Sept 2015

Start time	End time	Program	Speaker
9:00	9:30	Tea & registration	
9:30	9:40	Inauguration and welcome	Rahul Bose
9:40	9:45	Introduction and logistical details	Suchismita Bose
9:45	10:30	Pursuing this thing called justice: Examining Majlis' research and intervention on sexual violence in Mumbai	Audrey D'Mello, Majlis
10:30	11:15	Implementing a comprehensive response to sexual violence: Learnings from the collaborative program between the MCGM hospitals and CEHAT	Sangeeta Rege, CEHAT
10 Minute break			
11:25	11:55	Prevention Police POCSO: Training cops for dealing with CSA cases	Kushi Kushalappa, Enfold
11:55	12:45	Media, Me, & the Mirror:	Moderator: Rahul Bose Panelists: Mr. YogeshSadhwani, Ms. Dhanya Rajendran, Ms. Svati Bhatkal, Ms. Anahita Mukherji
Lunch Break			
13:45	14:30	Bystanders Protecting Children from Boundary Violations and Sexual Abuse	Paula Sellars
14:30	14:45	Relevance of Discourse on Sex and Gender for Prevention of Abuse	Ishita Manek, Rubaroo
14:55	15:40	The German Dunkelfeld Project: Proactive Strategies to Prevent CSA and the Use of Child Abusive Images	Dr. Klaus Beier
15:40	16:40	Panel Discussion 2: Online interests, offline consequences	Moderator: Vidya Reddy Panelists: Mr. Nandkumar Saravade, Mr. Chetan Krishnaswamy
15:40	16:40	ChuppiTodo! Breaking the silence on Child Sexual Abuse: Report release	Satyamev Jayate Team
16:55 onwards		Tea	

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9:00	9:30	Tea & registration	
9:30	9:40	Introduction and logistical details	Suchismita Bose
9:40	10:25	Making An Aarambh: Creating India's First Online Resource Portal against CSA	Uma Subramaniam and Siddharth Pillai, Aarambh
10:25	11:10	Child Protection in the UK: Learning objectives for India	Anjan Bhattacharya
10 Minute break			
11:20	12:05	Sexualized Behaviour in Elementary School Children	Dr. Lois Engelbrecht
11:55	12:45	'Masculinities and Child Sexual Abuse: How Society's Ideas About 'Being a Man' are Failing Male Survivors	Alankaar Sharma
Lunch Break			
13:50	14:35	Trauma and Talk Therapy: Brief Introduction to Trauma and the limitations of Traditional Talk Therapy	Dr. Rani Raote
10 Minute break			
15:30	15:45	Rescue and Remedy: A Journey of Psychotherapeutic work with Children in Institutions'	Dr. Manjeer Mukherjee, Arpan
10 Minute break			
15:55	16:55	Conceptualising responses to sexual abuse of children in institutional care: prevention, investigation and rehabilitation	Moderator: Mrs. Priti Patkar Panelists: Dr. Asha Bajpai, Ms. Manisha Tulpule, Ms. Enakshi Ganguly
16:55	17:05	Closing & Thanks	Rahul Bose
17:05 onwards		Tea	

**Any changes in the schedule are up to the discretion of the organizers*

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Individual Speaker Reports

Audrey D'Mello, Majlis, Mumbai

Topic: 'Pursuing this thing called Justice: Examining Majlis' research and intervention on sexual violence in Mumbai' by Audrey D'Mello

Audrey D'Mello joined Majlis in 2007 as its programme director. She has a degree in law from the Bombay University and a post graduate degree in management (specialisation in Governance and Accountability) from Narsee Monjee Institute of Management Studies (NMIMS). Apart from streamlining the existing programmes of Majlis around access to justice, her main contribution has been to evolve Majlis' collaborations with the Department of Women and Child Development, Government of Maharashtra in two important areas MOHIM a Cell for monitoring the implementation of the Protection of Women from Domestic Violence Act and RAHAT a pilot project in Mumbai for providing support to survivors of sexual violence and bringing in systems for state accountability towards victims.

Audrey D'Mello begins her presentation by introducing RAHAT, started in 2011, that coordinates with state agencies to ensure implementation of both the POCSO Act and the Criminal Law Amendment, with the modus operandi of providing victim support. It is through this that state accountability is ensured. Majlis' research looks at the social and legal profile as well as state responses in 644 cases of sexual violence handled by Majlis post 2008. Cases were studied through past judicial orders/ judgments of sessions court. Shocking research findings showed that state responses are based on various presumptions regarding the victim, accused, and place of offence.

In a bid to rectify this, RAHAT has taken the initiative to work with the system, resulting in collaboration with the Mumbai Police. The training conducted was Skill-Based Training; making them perform various tasks at the ground level, including writing victim statements and filing a charge sheet or interacting with the court. Discussing with them the various processes resulted in a better understanding of how an initial procedure may affect the course of development of the entire process. The arrangement made stipulates that Majlis will train the police officials in the field, but they will also monitor the behaviour of these police officials through victim support. Any complaints made by victims against specific police stations or officers will result in action being taken by the Joint Commissioner of Police. This has resulted in a significant change in the system for the better. Majlis has also put up posters of a pledge taken by the police for dignity and respect of women, displayed at the entrance of all police stations in Mumbai to establish a "pull-effect", in order to inform women of their rights and the demands they can make of the police.

Majlis also aimed at deriving holistic solutions to problems, by drafting several Government Resolutions in areas of concern, and following up by working with the police and public hospitals in order to resolve these problems. Next, Majlis worked with the Judiciary. Since rape-trials are conducted in-camera, there is a lack of information on how they are being conducted. Having entered this space

as support persons, they found glaring issues such as the victim and accused being made to face each other, and making the victim wait extensively and without proper arrangements. Following these observations, a report was presented to the Chief Justice, resulting, a year later, in the formulation of 'Guidelines to Judiciary on Functioning of Special Courts'.

One of RAHAT's crowning achievements has been Manodhairya, a scheme to provide rehabilitation and financial support to the marginalized, vulnerable victim. Now sexual violence victims can receive as much as 2-3 lakhs as compensation in Maharasthra, through the District Board.

Data from the study 'Pursuing this thing called Justice' that examined 644 cases, revealed a drastic increase in reported rape cases from 2012 to 2014, during which time the Nirbhaya case and the formulation of POCSO and mandatory reporting took place. It was discovered that 74% of rape victims were minors. Of these, 91% of the accused are known persons. This known person group includes family, close acquaintances, and males who have made the promise of marriage and subsequently deserted. It is also important to note that this group also comprises of complaints made by parents' against their daughters' lovers, since all sexual relations between minors have been criminalized. It is a revelation that threat by known acquaintances is as high as 91%. Yet, all government efforts are going into securing public spaces and preventing stranger rape.

Audrey further illustrates the connection between domestic and sexual Violence. Every 1 of 2 girls facing sexual violence have either been victims of/or witnesses to domestic violence. Fathers/step-fathers constitute 46% of family rapes and 7.2% of total rape cases, a very close figure to rapes by strangers (9%). She goes on to explain that 45% of abuse is long-term; most family rapes are long-term cases, which in a sense becomes a grooming of young victims through a large part of their lives. Furthermore, there is inaccurate documentation of time-lapse between the incident and FIR, which means there is a need for investment in high-tech forensic equipment in order to convict the rapist. Lastly, data shows that as the girl grows older, rape is "less believable", which especially holds true for girls between 16-18 years of age. This results in the victim being subjected to worse comments and attitude during the already tough process, culminating in an even more vulnerable victim.

Ultimately, Audrey stresses on the importance of holistic support, ensuring rehabilitation step-by-step, with education followed by vocational work, in order to help the girl make the transition from a victim to a survivor. In a bid to achieve this, RAHAT focuses on catering to the needs of the individual, and outreach in their policies, to ensure that the victim has someone by her side through the entire process. In fact, intervention has resulted in higher number of convictions. Audrey concludes with the idea that 'Hard work comes after the gains'. She presents various amendments made between 1983 and 2012 which were simply repeated in 2013, and yet these have not been used by the very people demanding them in the first place. Hence, she ends, the larger question is not what new amendments need to be introduced, but how much of the old ones are being implemented.

Alankaar Sharma, Co-founder, Tulir

Topic: Masculinities and Child Sexual Abuse: How Society's Ideas About 'Being a Man' are failing Male Survivors of CSA

Alankaar Sharma is a social work trainer, educator and researcher, working in the fields of sexual and gender-based violence, child abuse and protection, and gender and sexuality. He holds a master's degree in social work from Tata Institute of Social Sciences, Mumbai, and is currently writing his PhD dissertation focusing on men who have experienced child sexual abuse. He has worked in India on issues such as CSA, children's rights, violence against women, prenatal sex-selection, and cofounded Tulir - Centre for the Prevention and Healing of Child Sexual Abuse, a Chennai-based NGO working on preventing and addressing child sexual abuse. He has worked in the USA as social work educator and researcher at two universities. He has published papers and articles in peer-reviewed journals, magazines, websites, and newspapers on child sexual abuse, men and masculinities, children's rights, race and racism, and sexuality rights, besides consulting with multiple civil society organizations on resource development, and professional and organizational capacity building.

Alankaar Sharma begins his presentation by introducing child sexual abuse as a gendered event, with patriarchy at the root of it. Often, he claims, in a bid to maintain gender neutrality in formulation of laws and policies, one forgets the patriarchal nature of society, and the fact that CSA is in fact a gendered experience. While 3-7% of overall victims of CSA in the world are male, data from the survey conducted by the Ministry of Women and Child Development (2007) shows that men constitute 53% of CSA victims in India. However, Sharma cautions that one must keep in mind the methodology used, quality of research and the manner in which abuse is operationalized, in such research.

Alankaar goes on to explain that the notions that lay the foundation of child sexual abuse are patriarchal. This is seen in various forms in our society: victim blaming and shaming, the notion of victims of CSA as damaged goods, the idea of women in a binary as either the Madonna or the Slut, the silence over sexuality, the control over women's reproduction and sexuality and the concept that women and girls are the repositories of family honour. However, patriarchy, privileging men and boys over females, works as a double-edged sword, as the "masculine notion" in patriarchy has a damaging effect on male CSA survivors.

He further unpacks "masculinity". Currently, masculinity is understood as one simple concept; a monolith, and needs, instead, to be understood more complexly. It is the group of men that subscribe to the dominant archetype and the idealized tenets of masculinity that hold power over other subordinate groups of men. Hence, patriarchy not only creates inequity between men and women and other genders, but also establishes unequal relationships between men. This is also influenced by other social factors that determine power, like caste, religion, ethnicity, sexual orientation and gender identity.

Alankaar then goes on to draw on the analogy of a box, with a sticker claiming 'fragile' on it, representative of masculinity. This box includes the dominant cultural archetype and provides the idealized measure for men and boys to determine the size of their manliness. Fitting in this box makes them "manlier". He explores what this box includes, who it excludes, and how it oppresses men and boys that are victims of CSA. It includes qualities such as compulsory heterosexuality, compulsory sexual prowess and virility, contempt towards feminity, contempt towards homosexuality, physical strength, and emotionlessness. This heteronormative structure excludes from it gays and transgenders, stay-at-home fathers, unemployed men, men with effeminate qualities, men with disabilities, and men marginalized through casteism and racism. It also promotes and idealizes measures of misogyny, compulsory heterosexuality, homophobia, invulnerability and emotional stoicism.

Alankaar draws on relatable examples to illustrate the concept of misogyny. It is the idea that boys should not do any "sissy stuff". In elementary schools, being called a 'girl' is considered an insult by boys, and any feminine-identified behaviour is treated with disgust, hatred and contempt. From a very young age, birthday parties for boys and girls differ from each other significantly. This holds true even in their manner of dressing and the gifts boys receive. When such behaviour is deviated from or when something is done that is gender non-conforming, remedial measures are employed.

The speaker then explores the idea of compulsory heterosexuality. Heterosexuality is considered "normal" according to patriarchy. It recommends what men's sexual behaviour should be: seeking out sex, having frequent sex, and having multiple sexual partners. These qualities are very prescriptive. Moreover, a teenager having sex with an older woman is often considered a "rite of passage" or "coming of age".

Leading from this is the idea of homophobia. Not really a 'phobia' in the clinical sense of the word, it is instead a social construct that is defined by contempt, not fear, of the LGBT community. Society equates being penetrated with the idea of abdicating power, be it in a heterosexual or homosexual relationship. However, in a homosexual relationship, it is the very structure of patriarchy that is abdicating power because it is established on a system of heteronormativity. Similarly, Alankaar explores the idea of gay bodies as being seen as "problematic". It is the thought of a male body receiving pleasure through penetration that is seen as a troublesome and revolutionary that thus needs to be controlled.

Next, the ideas of invincibility and invulnerability are considered cultural ideals for men and boys, and subsequently, shame and retribution for expressions of vulnerability or dependence are employed. Hence, independence and self-reliance are privileged qualities. Similarly, emotional stoicism is promoted amongst boys and men, in order to project independence, rationality and self-reliance, and an ability to make decisions. However, aggression is an emotion that is considered acceptable for men to project, as it is equated with being a go-getter, protector and a breadwinner.

Coming to the big question: how does the idea of masculinity oppress male survivors of child sexual abuse, Alankaar presents numerous aspects to answer it. First is silencing, either self-imposed, or a result of the abuser claiming that people will not believe the victim. There is a lot of shame and guilt associated with thinking that they won't be believed, or denial on part of the victim that what took place wasn't in fact, abuse. Second, being a victim of abuse is seen as a sign of vulnerability and weakness, a concept that is not complementary with the idea of masculinity. This acts as a barrier in the life of the victim from disclosing to seeking help. Third, disclosing their experience of abuse or seeking help requires emoting, once again seen as unfavourable quality. Moreover, boys receive no preparation through life in how to emote when one needs to seeks help. Next, families, communities and professionals may disbelieve or minimize, or subscribe to myths regarding sexual abuse of the child. Lastly, the male child is often made to feel responsible for participating in or contributing to their own abuse. This guilt would be further intensified if the survivors experience ejaculation, orgasm, erection or any form of pleasure during the abusive act, making them feel that they should not complain.

Alankaar then arrives at the idea of anxieties vis-à-vis masculinity. Male victims of child sexual abuse may feel that their masculinity has eroded away, or that they are left with a damaged and weakened masculinity. Others may feel that they have been "made gay", or begin to question their sexual orientation and wonder if it is because that they are gay that the abuser chose to abuse them. Alankaar concludes with briefly describing most therapeutic models as trying to 'bandage the idea of broken masculinity'. They aim at convincing the victim that the latter can still fit themselves into this box, but what Alankaar believes is that change needs to take place by challenging this very box, and the idea of "masculinity" itself.

Dr. Lois Engelbretch,Centre for the Prevention and Treatment of Child Sexual Abuse,Manila

Topic:Sexualised Behaviour in Elementary School Children

Dr Lois Engelbrecht was born and brought up in India. After studying in the United States, she moved to Asia in 1985 and worked as a freelance social worker focusing on child sexual abuse and community organization. She founded the Centre for the Prevention and Treatment of Child Sexual Abuse in Manila in 1995 and still sits on its Board of Trustees. She now lives in Ghana, but continues to develop training programs and materials. Several Asian and Middle Eastern cities have invited her to help replicate the CPTCSA.

At ASCCSA 2015, Dr. Lois Engelbrecht introduces her topic of working with children for two reasons. To explain the first of these, she draws on the analogy of going upstream, the idea that you have to go to the base of a problem to cure it. Thus, it is to work with young children to prevent sexual misbehaviour as adults, and also to catch a child being exposed to sexual misbehaviour or abuse, or learning inappropriate sexuality. The second reason is to build a puzzle surrounding CSA, and understand this tiny but important piece of it, since CSA is a complex phenomenon, and especially so in India.

Lois then explores what can be considered "problematic sexual behaviour" in little children. One expression of it could be via a single incident, where the child has knowledge on the subject that they should not have. This need not necessarily be a result of abuse. In such cases, it is essential to understand the source of this information. Second could be a pattern of sexual behaviour. This could be normal sexual behaviour for their age, but if one does not respond to correction by adults, and continues to participate in peeping, peeking under dresses or such behaviours incessantly, this becomes problematic. Third, it could be an expression of sexual behaviour that is atypical for the child's developmental level, or it could be a preoccupation with sex. Lastly, it could be any kind of sexual behaviour that seriously disturbs or bothers other children, such as public masturbation, overly touching or hugging behaviours.

Discussing various socio-cultural norms that shape abuse in India, the first of these is the understanding that abuse is about 'power'. However, Lois argues, it is just as much about sex, which is a complex notion in India. Referring to SudhirKakkad and his psycho-social stages of development in the Indian context, Lois talks about how sexuality is an integral part of relationships, and even at a young age, talking about sex is unavoidable. Moreover, for teachers to teach personal safety, there needs to a level of comfort with one's own sexuality, to disband the mystic aura surrounding "sexual" words. She stresses on the importance of, and comfort with the simple vocabulary of sex. She goes on to explore how we as a society respond to sexual behaviour in an inappropriate manner. Living in a homophobic country, often children are rewarded for sexual misbehaviours to disguise the relief

that they are not gay. This behaviour is then excused with 'boys will be boys', while girls are told to keep their distance from boys. These excuses further result in helping boys become offenders. More commonly, however, is certain behaviours being inappropriately punished. Acts of masturbation, peeking and touching someone's private parts are harshly punished, making these behaviours even more traumatic for children. Similarly, the use of "sexual language" is surrounded by a lot of stigma, which eventually results in a lack of trust on part of the children to discuss their experiences of abuse.

Next, Dr. Engelbrecht talks about how adult response to the behaviour is just as important as the behaviour of the child. Discussing the sexual development of children, Lois talks of how children are born sexual; at a young age, boys get erections and girls have lubrication. At a very young age, the context is within the family: there is a lot of mimicking and disinhibition as children run around naked. Even when they are a little older, the context is within the family while their behaviour is limited to self-exploration, fun and curiosity. As they grow older, they begin to have relationships with other children, but they are still mimicking and disinhibited, till a later stage when there develops a repulsion and attraction towards children of the other sex. Here, they are starting to learn about their own bodies. As in the case of kids bathing with their mothers, children have to be taught things they have to learn.

Coming to what constitutes healthy and natural sexual behaviour, is behaviour that is light-hearted and spontaneous, simply as a means of exploration, curiosity and done on an impulse, often accompanied by a sense of embarrassment when caught. When does this spontaneous behaviour become problematic? Child sexual behaviour expert, Toni Cavanagh Johnson classifies these into 4 categories: the first of these is inappropriate sexual behaviour that is just an expression of curiosity and exploration. While this may be relatively normal, it does require a response. The second type is sexually reactive behaviour. In this case, something has happened, and the child is responding sexually to it. This need not be a result of abuse, but certainly needs to be responded to. The third category is that of extensive mutual sexual behaviour. Here, Lois draws references to Hansel & Gretel and Arundhati Roy's 'The God of Small Things' (1997). While this is by definition implies mutuality between two participants, it is inappropriate behaviour and needs to be responded to. Lastly, at the extreme, are sexually abusive children, who aim to hurt other children.

Lois further discusses how adults generally tend to deal with children displaying behaviour from all four of these categories. She stresses on the fact that most children that have had sex with adults need not be scarred for life. Children behaving in a sexually reactive manner may be responding sexually to something that need not be abuse, but may be traumatic in nature. They respond spontaneously when in a situation that triggers the previous memory. As this is impulsive and performed without planning, this could lead to confusion on part of the child. In the case of extensive mutual sexual behaviour, it tends to be children that are very sad and deprived of attention from adults, and hence get this from each other. While this behaviour needs to be stopped, the cause behind

it needs to be understood first. With sexually abusive children, the behaviours are frequent, mimicking exactly what adults do, and are very planned, coercive and manipulative in nature. Hence, looking at sexual misbehaviour, it could just be children confused and unaware of the implications of their behaviour, or it could be a result of something that has happened, and thus requiring help to deal with it.

Some factors that can impact children's sexual behaviour could be age, what's happening in one's family, violence, access to pornography in the family, community or on the television, the level of stress in the family, and importantly, the prevalent socio-cultural norms. Hence, confusion may arise in the child's mind based on what they see on television but don't get directly from their parents. Another cause can be a lack of parental supervision; children feel like they can get away with certain activities if no one is watching. Next, living in a neighbourhood where sex is a major influence, or a home with a sexualised environment, where parents fight often regarding sex or pornography. Conversely, homes that have little or no physical, sexual and emotional privacy, where parents feel the need to tell their children how to behave and even feel at all times. Also, parents that are sexualised after drinking, or witnessing sex being routinely paired with aggression, can contribute to sexual misbehaviour in children.

Children may express sexual misbehaviour in various different ways. One such expression could be showing fear on sexual topics; while alternatively, another could be asking endless questions about sex. Asking questions about sex and being satisfied with the answers constitutes normal behaviour, but if the questions are incessant and the child remains dissatisfied with the answers, it is problematic. Lastly, children peeking continuously even after being reprimanded or refusing to let people be alone in bathrooms are signs of sexual misbehaviour.

Dr. Engelbrecht concludes her presentation with what can be done to remedy this situation. First and foremost, she stresses on encouraging communication between children and adults. Secondly, one should take advantage of teachable moments when kids sexually misbehave, taking the opportunity to explain why it is inappropriate, and then subsequently move on. This ensures that the child develops empathy, which plays an essential role later in their future, as sexual offenders lack empathy towards children. Lastly, it is necessary to promote accountability in the child, documenting the abuse to look for patterns if repeated, and warning the child of consequences if repeated in the future. Finally, Lois stresses on talking to and informing parents of their child's sexual misbehaviour, so they know if patterns emerge in the behaviour. Lastly, following up and monitoring a child's behaviour is essential for effective prevention.

Dr. Rani Raote, Psychotherapist, Mumbai

Topic:'Trauma and Talk therapy: Brief introduction to trauma and the limitations of traditional talk therapy'

Dr. Rani Raote has been working as a psychotherapist in Mumbai, India, since 1992. She has had regular columns in the Times of India publications for 10 years and a radio programme Heart-to- Heart. She conducts workshops and group sessions for professionals and also for laypeople. In 1999 she developed, supervised and conducted a year-long internship programme for counsellors in training along the guidelines of American Psychological Association. Dr. Raote has worked with several NGOs like Dignity Foundation, Forum Against Child Sexual Abuse (FACSE) and now Arpan.

Dr. Rani Raote commences her presentation by introducing the concept of Trauma. The DSM-IV definition of trauma is 'events outside the range of normal human experience that evokes horror or terror and from which there is no escape'. The DSM-V definition of trauma is 'exposure to actual or threatened death, serious injury or sexual violence via direct experience, witnessing it happening to family members/friends, or repeated exposure'. Trauma can be categorized into either events outside control of human functioning such as earthquakes, floods, forest fires and avalanches, or man-made accidents such as physical and sexual violence, stalking, kidnapping and acid attacks. EMDR further divides trauma into Big-T Trauma which is more obvious trauma, such as natural disasters, car accidents or rape, and Small-T trauma, which is the stuff of everyday life that mostly goes unnoticed, such as verbal aggression and discrimination and negative comparisons. It is the Small-T trauma that is seen to inflict much more damage to the human psyche.

Another way of looking at trauma is simple trauma, which is exposure to one major trauma while other areas of life remain more or less intact; such has having a strong support system, intellectual success and financial and emotional stability. These surrounding factors can help in aiding a faster recovery. Complex trauma, on the other hand, is repeated exposure to traumatic events of varying intensity occurring throughout life, often starting at an early age at the hands of a close family member or caregiver. This type of trauma is more difficult and takes longer to treat.

Dr. Raote stresses on the fact that trauma is not the event per se, but the way in which it is stored in our body and the way it changes us after the event. Regardless of when the traumatic experience took place, it remains encoded in our brain, our body and our relationships. Research shows that trauma literally changes one's brain structures. It is carried in our body through sensations and urges. Trauma changes one cognitively; it alters memory. While some may remember traumatic experiences vividly, others may not remember them at all. It affects us in the numerous distorted beliefs we have of ourselves. It affects one in terms of one's relationships, mostly with oneself. There is a lot of self-loathing, hatred and disgust. It alters one's relationships with the world, leading to mistrust,

suspiciousness and a disconnect felt with oneself. Conversely, it could also lead to indiscriminate trust and naivety while facing the world. It can also alter one's worldview, making one feel vulnerable victimized and not in control of one's own life, as well as approaching the world with a sense of doom and gloom. If left untreated, this could carry on from generation to generation.

Dr. Raote goes on to explain two concepts of great importance to therapists. The first of these is the Triune Brain by Paul MacLeane. This literally translates to "three brains in one". This, she explains, is a more simplistic understanding of a much more complex phenomenon. The first of the three parts is the Brain Stem or the Reptilian Brain, which is located deep down at the back of the head, right above the spinal cord. This controls the automatic functioning of the body that is essential to one's survival, and that one is unaware of. This includes processes such as regulation of oxygen levels, heart beating, and digestion. The language of this part of the brain is body sensations and impulses. The second part of the brain is the Limbic System or the Mammalian Brain. This part deals with emotions and relationships. It contains an essential organ called the Amygdala, most of which is devoted to sensing and picking up danger. The job of the Limbic System is to pick up danger and start to alert us, along with feeling emotions of fear, anxiety, anger and so on. The language of this part of the brain is emotions and feelings. The last part is what the conventional understanding of the 'brain' is. This is the Frontal or the Homo-Sapiens Brain, also known as the Neo-Cortex. It is involved in cognitive processes such as thinking, planning, recalling, decision-making, listening and writing. It is involved with intellectual functioning, executive functioning, verbal language, conscious thought and self-awareness.

All three parts of the brain are needed to work together. However, they behave differently under threat. This threat may be environmental, such as a loud noise outside the room, or interpersonal, such as rejection, criticism, abandonment, sarcasm or disapproval. In such cases, the Amygdala picks up threat from the thalamus, and transfers it to the hypothalamus. Now, the reptilian brain gets into the genetically programmed ways of dealing with threat: fight, flight, freeze, submit and collapse, or cry for help. During this time, the Neo-Cortex goes offline. This is because, under threat, time is crucial, and it gets wasted in communication with the Frontal Brain.

While under threat, the Amygdala works efficiently, but even when the threat has passed, the Amygdala works to remember and keep a close record of the threat that has been experienced, so that in the future, if it senses anything even remotely similar or even the vaguest signal to a previously threatening experience, it starts signaling to the brain stem that the body is under threat. This takes place whether not one is actually under threat, and for this reason it is seen that trauma alters the brain. Due to any trigger, real or imagined, the body responds in the same ways to cope. For example, if one coped with trauma in childhood by watching television, he returns to watching TV when something is triggered in adulthood. Dr. Raote then goes on to illustrate the previously explained concept using Daniel Siegel's 'Brain and Hand model'.

The second concept Dr. Raote illustrates is 'The Window of Tolerance' (Siegel, 1999). This is useful in moment to moment decision-making. It concerns the Autonomic Nervous System (ANS), which is constantly monitoring arousal. It is responsible for high and low arousal. When in a safe environment, level of arousal keeps fluctuating, and one can even moderate one's own arousal. However, when the ANS senses threat, it takes the arousal system out of the window of tolerance and into the hyper-arousal zone, which is necessary to either perform actions of fight, flight or freeze. If the hyper-arousal state doesn't work, one can get angry, anxious, and wanting to fight, but there is no way to do that, so the autonomic nervous system moves one down to the hypo-arousal state, where one dips down and submits, in order to conserve energy.

During trauma, our nervous system gets recalibrated in a way that keeps us in the chronic hyper-arousal state any time there is a reminder of trauma, making one emotionally overwhelmed, panicked, impulsive, defensive, or, alternatively, gets down in the hypo-arousal state where one is numb, dead, passive and giving in. For any learning to take place, one needs to be in the optimum zone, where feeling and thinking can occur simultaneously.

Coming to traditional therapy practices, Dr. Raote discusses why they may not necessarily be effective. The first is Emotional Catharsis, where the patient is encouraged to get everything troubling out of their system. However, only the limbic/emotional area is being employed here, and hence no learning will take place. The second is the Intellectual Approach, where the therapist uses rationalizing; appealing to the patient's thinking brain. But the Amygdala will disconnect when one perceives threat, rendering the rationalization useless when needed most. Third are Distraction Strategies that encourage the patient to get a new life, a new job in a new city, telling them to forget about the incident, and to not talk about it; that time will heal everything, though it does not. The problem with this technique is that one does not allow the trauma stored in the lower brain to be resolved. Lastly, therapists often engage in punishment and scolding, or coaxing, bribing and blackmail. But one will not remember these in the face of threat, therefore rendering this technique ineffective.

Dr. Raote concludes with good trauma practices. She first stresses on the fact that the way the trauma is stored in the body is essential, and one needs to keep the patient in the optimum arousal state, so that the one can repair and not just recall the damage inflicted by the trauma. Second, the therapist must educate the patient on what is happening in the brain and what constitutes the window of optimum arousal. This way, she says, the patient can monitor their level of arousal through the week. Lastly, trauma treatment needs to take place in phases. First, one needs to stabilize and educate the patient; processing the trauma memories comes later, and lastly, slowly integrate the person back into their lives.

Kushi Kushalappa, Enfold, Bangalore

Topic :'Prevention Police POCSO: Training cops for dealing with CSA cases' by Kushi Kushalappa

Kushi Kushalappa is the Coordinator for the Collaborative Child Response Unit (CCRU) project, Enfold Trust in Bangalore for the past 5 years. She works as a support person designated through CWC for children and families as they negotiate the perilous maze of police, doctors, courts and society. She also trains police, doctors, and social workers on the processes in sexual assault cases.

Kushi Kushalappa, Enfold's Chief Trainer for Government Stakeholders, begins her presentation by introducing Enfold and its work based in Karnataka. Currently, the sanctioned police force in Karnatakaconsists of 77,000 members, while the actual police force comprises 57,000 members, resulting in a short fall of 25%. However, of these, a mere 20% are available for the investigation of crimes with the remaining involved in bandobast, escort duty, court duty, or as drivers. Moreover, the prominent police priority seems to be that of bandobast (arrangement or organization). Kushi also presents the shocking revelation that the police are the least paid amongst all government functionaries, including teachers, women and child development department, first division clerks and postal services.

The challenges encountered by Enfold in their support work for CSA cases are include a lack of sensitivity, extremely long drawn-out investigations and trials, along with limited or no information on case status for the child and their family, low conviction rates and a lack of clarity on government services and schemes on part of the police. This results in extremely low confidence in society to report a crime of this nature, due to the insensitive and undignified approach of the police. This consequently results in a lack of faith in the criminal justice system, and hence, a low percentage of reporting.

Breaking down these challenges to understand the reasons behind them, Kushi lists out the probable causes for them. The first of these is the lack of awareness of incidents of CSA, particularly inter-familial abuse prevalent in society. Kushi stresses on the fact that the cops too, belong to the same society that finds it hard to believe that incestuous abuse even occurs. Hence, the police officers and judges should be educated on the statistics regarding inter-familial abuse. Second, there is insufficient training of stakeholders, medical persons, social workers, prosecutors and the judiciary. Third, there are no specialized teams or units managing these cases. However, now, under a DWCD and UNICEF initiative, a Collaborative Child Response Unit has been made successful. Fourthly and most importantly, there is a lack of convergence between stakeholders, and without coming together, cases cannot reach convictions.

In a bid to rectify this, training and sensitization of the police force was planned. With 57,000 police

personnel involved, this is no easy feat. This process was, however, made easier due to Karnataka's police force undergoing the Gender Sensitization Police Program for the past 8-10 years, driven by the UNICEF. This comes under the Training Division of the Police Department. They trained the special juvenile police units and child welfare officers. They also conduct regular monthly review meetings, discussing cases to do with child safety, and specific challenging cases. Lately, a three-day specialized training program for child welfare officers is being conducted, where 7 officers each are nominated from all 7 zones of the Bangalore Urban District to attend, and these officers then become the designated child welfare officers.

The topics of training included: understanding sexual violence, dynamics and effects-particularly of incestuous abuse, forensics interview methodology, medical examination, crime scene management, POCSO procedure offences rules, and the importance of convergence. With regard to the last topic, Kushi stresses on the importance of the police knowing what kind of medical exam should be conducted, based on when the abuse has taken place with reference to when it is reported. People from a variety of occupations led the training, such as staff of the Forensics Science Laboratory, doctors, police officers, and forensic and legal experts. The methodology used was case analysis and discussion, interactive sessions, role play, and convergent sessions with stakeholders. While the police displayed an eagerness and enthusiasm to learn and to be trained, the effects on the ground are yet to be observed.

Following the 3-day program in March, a study was conducted in May, on a population of Bangalore's general police staff, to measure awareness of the POCSO Act in police stations. In the 55 police stations, the study included 145 police officers, of ranks ranging from constables to inspectors. Some questions asked included:

1. How did you hear of the POCSO Act?
2. How many POCSO cases have been reported to the station?
3. Have you ever handled a case under POCSO?
4. Have you ever attended POCSO training?
5. Do you need more information about the POCSO Act?

Moreover, in a bid to further study their attitudes and beliefs, questions asked included:

1. Do you think everybody needs to be trained about the Act?
2. Does CSA happen more to girls than boys?
3. Is CSA more prevalent in poor families than rich families?
4. Can a woman sexually abuse a child?

The results of the study revealed that:

› All officers requested additional training on POCSO
› 70% hadn't attended any training on POCSO, especially senior officers. It is these officers that are mostly the investigating officers in cases involving heinous crimes. With a lack of training on POC SO, they tend to depend on sub-inspectors and assistant sub-inspectors for information, which is very often biased and prejudiced
› 67% of the police personnel hadn't handled a single POCSO case
› 100% of the officers and 90% constables had heard of the Act
› 90% personnel believed that girls are sexually abused more than boys. This is the most common impression held by the general public and people across most occupations
› 56% believed that CSA is more prevalent in poor rather than rich families

The first training was followed by the study. Post this study, as it was seen that senior officers require more training, Enfold approached the Commissionerate, and were met with cooperation and enthusiasm. It has been decided that training of inspectors and ACPs will take place zone-wise in the city to begin with, and then go down to the districts. As of now, an initial round of training for ACPs in the Bangalore Urban Area is being conducted. Moreover, training and sensitization is needed on an on-going basis, as police personnel are constantly being transferred.

Therefore, Kushi concludes, there is an urgent need for systematic training on the dynamics of abuse, especially incestual abuse. Forensic interviewing, coupled with specialized investigation of crimes of sexual violence, not just the POCSO Act and procedures, is essential. Lastly, convergent training, to interact with doctors, social workers, NGOs and the judiciary is crucial. Kushi ends with an example of a case involving incestuous abuse, which revealed the importance of a dialogue between various stakeholders, and therefore reflected the critical role convergence plays in effective handling of CSA cases.

Anuja Gupta, RAHI, Delhi

Topic: 'Healing through Social Action: The RAHI Model' by ANUJA GUPTA

RAHI Foundation, Delhi is a centre for women survivors of incest and child sexual abuse (CSA) started in 1996. It is India's first incest/CSA response organisation and the only one focusing exclusively on adult women survivors and their unique recovery needs. RAHI's pioneering work includes support and recovery through the distinctive RAHI Model of Healing, education, awareness raising, advocacy, capacity building, research and communication. Professionally informed and with deep experience, RAHI's work has developed a powerful voice that strives to mainstream the discussion about incest/ CSA in India and include it in social dialogue. It not only forms the backbone of work on this issue in India but has also paved the way for incest/CSA to become a 'field' in the country and inspired other organisations that have come up in this area. RAHI works with survivors and their families, school children, college students, social workers, mental health professionals, parents, teachers and other communities in Delhi and Kolkata as well as other parts of India.

Anuja Gupta, RAHI's Founder and Executive Director, begins her presentation by introducing RAHI as an activist feminist organisation that was born out of the Feminist Movement in India. RAHI's work is located in the framework of mental health and trauma and social change. While their core is recovery and healing, they also advocate for change, and social action plays an integral role is this process. Hence, their work is both preventive and restorative. The capacity in which RAHI deals with survivors is as direct clients, volunteers, interns and peer educators, and even journalists and media persons, who, in the process of filming or taking interviews, make links to their own abuse and thus return seeking help. The RAHI model of healing comprises a combination of individual counseling, group work, and social action.

Coming to the Social Action aspect, Anuja discusses why it is important, how it has evolved in RAHI over the years, the understanding, learning and struggles experienced, and finally, survivor voices on their experiences with this organisation. Anuja discusses how RAHI itself is an expression of social action as it was born out of individual experiences and journeys of healing. In order to get women to come and seek help with the foundation, it was first necessary to create the right conditions: breaking the silence on CSA and incest, approaching school and colleges but most importantly, giving out information on what child sexual abuse is, which would help people make links to their own abuse or current symptoms, and encourage them to seek help. RAHI noticed that as more and more people got into recovery, they got involved in working with the organization as well. Hence it was seen as a cyclical process: survivors coming into recovery led to social change, which further led to survivors seeking help.

Discussing how RAHI has evolved over the years, Anuja stresses on the fact that their understand-

ing of social action is based on individual experiences, survivor feedback, discussions with colleagues and further readings on the topic. The survivor stories have also lent themselves to plays and books such as 'The House I Grew Up In' (1999) and Mahesh Dattani's famous play '30 Days in September' (2011), as survivors feel it is necessary for their own stories to be heard in order to help others. Over the years, RAHI has learned that if used properly, social action can be an important part of healing. However, it must first be based on clinical evidence that it will enhance the patient's healing. Second, the decision has to be taken in conjunction with the client, and third, the timing of it is essential, since action can be taken too early and backfire because it cannot be sustained. Keeping this in mind, social action encourages clients to take risks in a safe environment and learn from their mistakes, resulting in the work itself becoming therapeutic. Social action can also not be random; it needs to be planned. Moreover, it is good to have a planned duration of it with a definitive beginning and end, as it then allows the survivor to move on. Lastly, simply being a survivor in recovery does not enable them to take social action without training. The survivor needs to be trained and prepared for it accordingly.

Social action can take many forms. It could be coming into office and working on office and filing and admin work, or taking phone calls. This is when survivors come in specifically to be a part of this work as a part of their healing. On the other hand, it could also be campaigning, media advocacy, sharing personal testimonials as part of their training teams, or sharing their experiences with fellow survivors (survivor-survivor work) and fundraising. And since social action can use a variety of skills, everybody has a chance to contribute. While social action can be an excellent intervention, it can also be counterproductive and backfire at times.

Social action has been seen to help clients in a variety of ways. First, it helps transform their trauma experience into something meaningful. Second, it helps them find their own voice and gives them a source of power. Further, it assists them in drawing on their own initiative, energy and resourcefulness and gives them a chance to give back and become a contributor, guiding them on their journey from a victim » survivor » thriver » contributor. It also helps clients feel connected; to themselves, and to an external world, an important step in recovery. It helps in speaking the unspeakable, and allows victims to show gratitude and give back, to others in the hope that they do not share a similar experience, and to RAHI itself.

However, this journey is riddled with its own challenges and obstacles for RAHI. Organizationally, they have no role models for a centre like theirs, and therefore need to draw from various streams, such as Therapeutic Communities, to understand how to set up something like that at RAHI, Mental Health Centers, and Feminist Movements. There are also numerous issues faced in working with staff or team members that are survivors as they are also dealing with their trauma at the same time. One such problem is that during work and training on the topic, people can get triggered as they

find links to their own abuse, and get dissociated or go underground for some days. Another problem is that of over-identification. When a person has unresolved issues, they can over-identify with survivors, wanting to mollycoddle them and take care of their needs to a great extent in order to vicariously satisfy their own unmet needs; it is important for survivors not to be treated like they are very special or fragile, as that results in isolating them further. In this way, over-identification becomes problematic. Further, people can reject survivors. If someone hasn't dealt with their own issues, they don't want to talk to other survivors either. Another challenge faced is when survivors are suspicious of help from others, when they haven't dealt with their own trauma or are in denial of it. Problems of projection and transference also come in to play; as a lot of survivors have issues with power and authority, these may be transferred to the leaders of the organisation. Moreover, volunteers that are survivors often approach RAHI with a sense of entitlement and with the expectation of their needs being met in a particular way. In this way, they may take the organization for granted as boundaries get blurred in the process.

Another commonly faced challenge occurs when people who first come in as clients are making the transition to taking social action. At such a time, the therapy space now becomes the work space, and it becomes necessary to negotiate their relationship with the therapist. It also becomes difficult for the therapist who is being viewed by the client in a different light- in an authority position or as a boss. It therefore becomes a vulnerable situation for the therapist, as it leaves them open to be seen in a different way, and boundaries and roles need to redefined. Moreover, they are expected to be a constant role-model to other survivors and are hence constantly under scrutiny.

Anuja Gupta goes on to play a tape of five volunteers and interns that share their experiences as survivors in RAHI. While some felt empowered and liberated as a result, being able to make links to their own abuse, for others, the experience only fuelled their trauma instead of providing relief. Anuja then concludes with some things coming up at RAHI, the first of which is building a support centre. While RAHI was originally conceived as a support centre for adult women survivors, over the past 20 years, with more and more women coming in, developments are being made to the structure of the organisation to further build it as an effective support centre. Next is the Firebird Project, which is born out of social action, as RAHI is thinking of creating an entire training program of social action by survivors, supported alongside with healing. Another idea is that of having a national conference with, for, and led by survivors. Lastly, RAHI aims to support start-up ventures on the topic to take the movement forward, as it fulfills their dream of building an entire movement of survivors on Child Sexual Abuse.

Dr. Manjeer Mukherjee, Arpan, Mumbai

Topic: Rescue and Remedy: A Journey of Psychotherapeutic work with Children in Institutions'

Dr. Manjeer Mukherjee is a sociologist working in the area of gender, sexuality, medicine, technology and abuse. She completed her doctorate from Jawaharlal Nehru University, Delhi on the implications of Assisted Reproductive technologies on kinship relations. Dr. Manjeer has been extensively working with the developmental sector for the last 10 years and also presented papers in various national and international forums and networks including World Social Forum, International Women's Health Meet, National Bioethics Conference and Annual Meet of Health Action International Asia Pacific. She is associated with Arpan for the last 5 years. Currently as the Director Services, she leads Prevention, Healing, and R&D team and is committed to achieve the goal of holistic response to child sexual abuse.

Manjeer Mukherjee begins her brief presentation at ASCCSA 2015 by providing a glimpse of the journey ARPAN undertook to evolve the book: 'Rescue and Remedy.The book deals with psychotherapeutic work done with children in institutions based on Arpan's work with Advaitfoundation, based in Vasai, which houses rescued minors.

Starting in 2008, Arpan has spent the last 6 years working with the institute. When they started on with Advait, the institute was in its 5th year of existence. While it was well-run administratively, and dealt well with settling issues, issues around children's outburst, attachment cries, interpersonal relationships, and suicidal ideations were not being dealt with. Arpan stepped in at this juncture, and evolved a model for psycho-therapeutic programme. There was no blueprint for how to go about this, and it was therefore a very organic process. Today, Arpan has been counselling 65 adolescent girls in last 6 years. When these children first came, all symptoms of trauma were visible. The children looked disciplined, but they had on a mask. It was in this situation that the therapy process began. It started with group sessions, and evolved to individual therapy alongside working with caretakers, and evolving organisational policies conducive to trauma work.

The group sessions were focused on 3 critical areas: Psycho-education, Skill Development, and Need-Based Intervention. In the initial years, the group session focused on day to day challenges of settling down in an environment very different from where the children had come from. They had to adjust to a set time schedule, limited resources, so many children in one home, and the relationship with adult caretakers. Over the years, however, the group sessions became a platform to discuss more critical issues of gender, sexuality, power and relationships. Indvidual therapy started with a need to work with children; their behaviours, feelings, and thoughts through challenging and influential memories which had to be handled in a caring environment. Attachment theory and EMDR were used greatly during individual therapy.

During the documentation of the process, what stayed with Arpan was the journeys' the children made- an articulation of dreams and aspirations. Therapy went beyond a reduction of symptoms, and the changes seen were unthinkable. While some children pursued higher education, others settled down; some told their parents they wanted to stay in the institution, not their unsafe homes. Others told their boyfriends they didn't want to marry just because they're 18.

There were others who felt it was their responsibility as children to take care of their parents, and felt guilt for not providing economic support to their families. They were falling prey to over-responsibility, a key symptom of trauma. These very children eventually became advocates of organizational policies for keeping children safe. However, if unsafe adults come and meet children, children will be flooded with conflicting emotions-love for their parents, but a resistance due to abusive experiences. But a child will start idealising the abusive person because the need for love is greater than that for help.

Therapy also meant that this information the children were taking in was not restricted to them. These children would read out from their journals to their family members and siblings. That way they would also have the skills, even when they weren't at the institute. Therapy led to an understanding of themselves as individuals, and not as damaged goods. It helped them articulate their emotions in an assertive manner, seek help without feeling bad about it, and distinguish safe and unsafe relationships. Most importantly, it gave them hope that life can change.

Manjeer then quoted one such child, who claimed she used to run away from her feelings when she was angry, used to harm herself, and had tried to commit suicide. She did not want to stay in this place. She says, 'before counselling, if someone was angry with me, I was always angry with that person. If now someone is angry with me, I understand it is human.' She further talks of the change she has undergone and how she has been a witness and has contributed to it.

Manjeer ends by saying that today, with a document in hand, we, as a community, have a model that gives us some direction to work with kids in institutions. It gives us a script of doing group sessions and individual therapy, and how organisational policies can be created which are more trauma-informed, but mostly it gives a truckload of hope, that change is possible. She says it also tells us of the limitations and bottlenecks experienced, but we need to hold on and also have faith in children's resilience, because if they have the courage to survive abusive experiences, they have enough resources to overcome that even after the abuse they experience.

'Ishita Manek, Rubaroo, Mumbai

Topic: Relevance of Discourse on Sex and Gender for Prevention of Abuse

Ishita Manek, a former bartender, part time travel coordinator, full time social worker and a few other things. She was present at ASCCSA 2014, sitting in the audience as a simple lay person who had no Social Service-related background. Today, as the co-founder of Rubaroo, she speaks as someone who feels that anyone sensitized can make a difference.

Ishita begins her speech at ASCCSA 2015 with a disclaimer; she requests the audience to hear her out as a simple layperson who has no real background in social work, or counselling. Early last year, she joined Hamara Footpath as a volunteer. It was in conversation with the founder, that it was revealed to her that a conference on CSA was to take place, which is how she came to attend ASCCSA 2014. A presenter at that conference said that 53% of India's children are sexually abused and shared about how she was one of them. Ishita goes on to disclose her abuse by a family member and the reaction of the adults around her on discovery. Since she was silenced and nothing was done about it, the abuse did not stop and she was continued to be subjected to it even till her late teens. Even as a child, if someone would have brought to her notice that what was happening to her was wrong and that it is not her fault, she would have put an end to it herself. However, later Ishita decided to do something about it irrespective of the lack of support. She gathered the courage and confronted her own parents, which was a moment of freedom for her in her life. Ishita now uses her emotions related to her abuse as a rocket fuel to keep going in the positive direction, thus identifying herself not as a survivor but a 'thriver'.

Last year, sitting in the audience, the spark for taking her motivation forward to action was provided by ASCCSA 2014. Her connection with Arpan, training and support, prepared them to go out and do what was needed to be done. She emphasis on that even if someone is not from a psychology or social work background, one can still contribute to work towards making a significant change.

Ishita hopes that some people in the audience are solo attendees, for she believes that one doesn't need experience and qualifications, but just sensitivity to do something about it. Quoting the starfish story, she says: A man passing by the seashore picks up the starfish that have washed up on the shore and flings them back into the sea one by one. Another man passing by expresses that his efforts are futile considering there are thousands of starfishes and even if he puts all his efforts he will be able to help only a few of them. So how is it going to make a difference? To which he replies, "It makes a difference to that one". Similarly, one doesn't need to think that only number can be representative of how significant one's work is. Rubaroo still doesn't have the numbers to go to funders, yet they are significant because they have reached out and started and intend to continue to make a difference.

Ishita was followed by her colleague Lisha who shares Forensic psychologist Valerie Hella's statement about CSA, "we need to recognise it's a form of social conditioning in society. It's not an abnorm, it's a norm. One in two children is a norm and these numbers should not be acceptable. It's a norm because as a society we've let it happen, and been silent about the issue."

To work towards making a difference, Rubaroo started working with communities they were associated with through Hamara Footpath and conducting personal safety education workshops. On their journey, they were approached by parents and teachers requesting them to talk to children about sex, sexual health, and gender. Lisha goes on to sharing about how genders as a social construct exist to keep society function smoothly but it becomes a debilitating experience for us when one has to abide by the rules and stereotypes related to it. This is one of the reasons why boys feel more hesitant to report the abuse they have faced and women feel hesitant to report because of the burden laid on them of family's honour. Hence, at Rubaroo, they want to incorporate talking about sex, sexuality and gender into their personal safety education programme. They wish to take on a three-pronged approach: talk to the children, talk to abusers or potential abusers, and the adults, or society at large, because ultimately the responsibility of protecting the children lies with them. Finally, Lisha too ends by thanking the Foundation for being the catalyst behind Rubaroo, and subsequently, this positive change.

Sangeeta Rege, CEHAT, Mumbai

Topic: Implementing a comprehensive response to sexual violence: Learnings from the collaborative program between the MCGM hospitals and CEHAT

The idea of CEHAT was conceived 20 years ago when a group of researchers and healthcare professionals decided to create an alternative health research institution which is at the interface of activism and academics. CEHAT comprises of a multi-disciplinary team such as doctors, lawyers, social workers, public health experts and counsellors. CEHAT through its research, intervention, education and advocacy, has been addressing issues of right to health care for all; investigating and combating violence; and caring for survivors. CEHAT has pioneered a comprehensive healthcare model in 3 public hospitals in Mumbai, based on standards set by the World Health Organization for sexual assault survivors. Since 2008, the services have extended to over 250 women and children.

At ASCCSA 2015, SangeetaRege begins her presentation by giving an overview of the experience of implementing a comprehensive healthcare response in 3 Municipal MCGM hospitals in Bombay since 2008, which pre-dates POCSP and both the CCA. The presentation aims to present a profile of children, the nature of violence they are reporting, different kinds of health consequences that prompt survivors to reach the hospital for treatment, share the experience related to CEHAT's interface related to police, judiciary and prosecution as well as Child Welfare Committees, as well as components of medico-legal evidence and its limitations.

The comprehensive healthcare response is a collaborative program between CEHAT and Municipal Corporation that entails the training of a carder of health professionals to be able to provide and obtain informed consent and creating documentation of a detailed kind about the history of sexual violence. This means that doctors are trained to write what sexual violence means, as opposed to the ambiguous terms "alleged assault." They are further trained to conduct a gender sensitive examination and collection of evidence, which implies doing away with the two-finder test and commenting on the hymen and status of children. Next, there is a provision of first contact psychological aid, moving away from doctors' preoccupation with forensic evidence only, which entails a clear and fool-proof chain of custody. Lastly, is the referral to appropriate agencies.

Moving to evidence on the profile of survivors of sexual violence: From 2008-14, CEHAT has received 580 rape survivors, of which they've been divided into adults and children. 64% of the figure (370 cases) is children. Disaggregating this information, since cases of elopement and false promise of marriage do not fall under the category of sexual violence, leaves 321 children-this constitutes 87% as victims of forced, non-consensual sex. Sangeeta takes these 321 cases to show the pattern of reporting. From 2008, since CEHAT started working in a collaborative fashion with the hospitals, it was seen that almost 37% of children were being brought in by caregivers (mostly parents) for

health complaints emerging out of sexual violence. Post-POCSO there is seen a large drop in this, and an increase in reporting to the police, which could be due to changed government policies and norms about reporting, increasing confidence to report after the Nirbhaya case, or other reasons that are unclear. However, it certainly indicates a jump in the nature of reporting.

Another important factor is the disclosure of CSA. It is seen that 31% of the children have immediately reported the sexual violence to a caregiver, depending on the rapport shared between child and parent. 15% of the perpetrators have been caught in the act by a family member. 14% have reported health consequences to the hospital, which has been discovered to be a result of sexual violence. Coming to the relationship with the perpetrator, of 238 cases, 74% are known to the victim, with 46 instances of incest (family members, step-fathers). Others include neighbours, acquaintances, boyfriend and partner.

This information, coming from a health system perspective, as the analysis from medico-legal and counselling reports, is critical as it deals with critical issues, the first of these being the Nature and Circumstances of Sexual Violence. Because of the broadened definition of POCSO, this constitutes more than penile penetration. 44% of children reported non-penile penetrative sexual violence, while 15% reported penetration by finger. Since violence through penile penetration isn't the largest category, there is a need to advocate for the role of health professionals to communicate with little children to elicit this kind of information, and subsequently carry out treatment. The second issue discussed is What Prompted Sexual Violence, which discusses ways in which grooming takes place. 17% children reported that they were lured by promises of TV, chocolates, money, toys, and time to play with the child. 5% were misled into believing they'd be given a job, etc. Others were kidnapped and blackmailed, while 70% were not lured. This is important information to convey how sexual violence occurs in the first place, and this, in turn, needs to be connected to medical evidence that can or cannot be found in cases of CSA. The third major category is What Comprises Medical Evidence. This is mostly understood as only comprising physical injury, which is why the definition needs to be expanded. First, it includes trace evidence such as semen, spermatozoa, blood, hair, dust, paint, grass, faecal matter, body fluid, saliva, etc. Second is injury, which includes blunt trauma, abrasions and lacerations. The third is health consequences, which includes HIV, Hepatitis, STI, and unwanted pregnancy, pain in urination and defecation, and trauma. Finally, the fourth category is medico-legal documentation carried out by doctors-often, as children come to hospitals only much after the abuse; this is the only evidence of sexual violence. Although 71% of the children have reported within 4 days, less than 1/4th has sustained genital injury, and even lesser have sustained physical injury. Therefore, other evidence needs to be looked at as medical evidence.

Taking from this, Sangeeta discusses the various limitations of medical evidence: First, medical evidence rapidly erodes with time with activities such as bathing, douching, urinating and defecating.

Second, there is a possibility in penetrative sexual violence that a condom was used, or semen wasn't emitted. Thirdly, despite the expanded definition of POCSO, medical evidence will not be found in each and every case, such as with masturbation. Lastly, mucosal injuries, which are thin membrane-related injuries, may heal quickly. Even if the child is brought in on the same day, there may not be any redness- this doesn't mean that sexual violence hasn't taken place.

Coming to the learning from the field, the first was that despite putting healthcare response in hospitals, the police, CWCs and courts haven't awakened to the limitations of medical evidence. The current perception is that without forensic evidence, there hasn't been rape. Moreover, the police themselves aren't in tune with the law; there is very little awareness that a survivor can be brought into a hospital directly without police requisition. Secondly, the nature of the police requisition itself is unscientific, and questions often asked to the examining doctors are ones that are impossible to answer, such as 'was she a virgin?', 'was she habituated to sexual intercourse?' and 'was she capable of sexual intercourse?' Moreover, when dissatisfies with the medico-legal report, children are subjected to medico-legal examinations, which is illegal, invasive and essentially unethical. Third is the question of mandatory reporting. The Central Government Guidelines of 2013 empower the examining doctor to record "Informed Refusal". When a child under 12 years is brought in and the doctor is convinced that the parent is not interested in reporting, and provided the doctor does not suspect any foul play, informed refusal can take place; wherein the incident is recorded in medico-legal records, and treatment is offered. At the month-end, a report goes to the police with the aggregate data of victims, but details of the child not reporting are not revealed.

Sangeeta goes on to discuss the efforts made to interface with the police and its limitations, as well as the various Child Welfare Committees in Bombay. There has been observed a tendency towards first institutionalisation post-reporting, which can be detrimental as it punishes the child for coming forth. Hence, other methods of monitoring the child's progress are required. But there are limitations in the manner CWCs are functioning, with a moralistic attitude and a lack of awareness regarding the law. Therefore, it needs to be determined whether mandatory reporting should take place to the protection services (CWCs) that seem to be biased and anti-children, or to law enforcement.

Another pressing issue is that putting the health sector in order is not enough. Having undertaken an analysis of 14 case judgements of children and adults, there are questions regarding what happens at the level of courts and what leads to conviction. In numerous cases, there is an absence of trace evidence, and doctors need to be able to explain why. Hence, doctors need to be able to explain injuries, and an interpretation of a lack of them, as in the cases of lubrication and non-penetrative sexual violence. Doctors are often regarded as expert witnesses, and yet are not treated this way, often being asked to answer only in 'yes' or 'no', which can be demoralising. So, efforts need to be made at the court and public prosecutor level to be able to present this kind of evidence.

Lastly, Sangeeta discusses the various factors leading to acquittal: First, doctors are not called to court. Second, there is a gap at the level of the public prosecutor who is supposed to engage with the doctor; third, there is not clear interpretation for a lack of injuries. Often, trace evidence is left unexplained, and sometimes in the case of non-penetrative sexual violence, evidence of semen and spermatozoa is being asked by the court. Lastly, as a social factor, children around the age of 14-16 years often withdraw their case, following which courts are not interested in prosecuting, and the case dies down.

Sangeeta concludes her presentation by stressing on an increased need not only on the forensic aspect, but on the therapeutic role of healthcare providers. Moreover, health consequences need to be interpreted as evidence, and finally, there is a need to understand the role of medical evidence in this sphere and simultaneously building an awareness of the limitations of such medical evidence.

Dr. Klaus Michael Beier, University of Berlin

Topic:The German Dunkelfeld Project: Proactive Strategies to Prevent CSA and the Use of Child Abusive Images

Dr. Klaus Michael Beier's began his medical studies in 1979 and in 1980 additional studies in philosophy at the Freie Universität, Berlin. In 1986 he got a doctorate in medicine, two years later in philosophy. His habilitation for Sexual Medicine took place in 1994, he became a specialist in 1996 as a psychotherapist and psychoanalyst and professor of sexology / sexual medicine at the Charité and head of the Institute for Sexology and Sexual Medicine. In 2005 he initiated the "Prevention Project Dunkelfeld" which offers professional help to self-identified undetected pedophiles and hebephiles in order to prevent child sexual abuse. He is one of the principal investigators of the research consortium "Neural Mechanisms Underlying Pedophilia and Sexual Offending against Children."His last English book publication was "Sexual Medicine in Clinical Practice" (together with K. Loewit, Springer: New York, 2013)

Dr. Beier has been working in the field of sexual medicine for more than 25 years. At ASCCSA 2015, Dr. Beier presents a sexological view on the primary prevention approach towards sexual offending against children focusing on paedophiles.

At the outpatient clinic in Berlin they deal with the whole spectrum of sexual and gender identity disorders. From a clinical perspective there is one significant basic concept of sexuality which applies to all these disorders. Sexuality incorporates three core dimensions fulfilling quite different functions. The dimension of desire that is the importance of sexuality and all its possibilities for increasing desire by sexual stimulation and this dimension is always the focus of public perception. Then the reproductive dimension and last but definitely not the least, the dimension of attachment. Attachment is the important one for the fulfillment of basic psycho-social needs of acceptance, closeness, security, bisexual communication.

The bonding program in every human exists from the very beginning up to the end of our lives. It is dependent on the fulfillment of psychosocial basic needs which determines the quality of life and protects us from emotional disturbances and psychosomatic disorders. These basic attachment factors are important for the understanding of sexual behavior, the outcome of sexual traumatization as well as understanding of atypical sexual behaviour and damages caused by the latter.

Recent research shows that the history of childhood abuse is capable of irritating this bonding dimension thus creating unfavourable conditions for entering into relationships, for sexual involvement within relationships, possibly for the development of disorders of sexual function. So the potential long-term effects can disrupt the very areas of personal life. In women, for instance, immeasurably low concentration of oxytocin in the liver has been found in the aftermath of a history of childhood sexual abuse.

Coming to the incidence of child sexual abuse in the general population, in Germany approx. 10% of the children are affected, 3 times more girls than boys. According to Indian Ministry data from 2007, incidence of child sexual abuse is much higher and more boys are affected than girls. It is a public health issue as well as a global health issue.

Child sexual abuse can be prevented via two possible approaches: one way is to focus on potential victims and another way is to focus on potential offenders. If it were possible to reach those who might be liable to cause child sexual abuse and to influence their behavior, that would be primary prevention because there would be no offence and no harm done to others. This goal can be achieved through specialized knowledge about the different kinds of offenders.

Concerning sexual offending against children two groups can be distinguished. The first one consists of those showing a sexual preference disorder namely paedophilia which is an erotic preference for prepubescent minors, prepubescent body scheme. This group accounts for approximately 40% of officially known offenders. The other group shows no sexual preference disorder but who for different reasons sexually abuse children which serve as a surrogate or a substitute for a sexual relationship with partners of similar age. These are sexually inexperienced adolescents, mentally retarded persons, those with personality disorders and perpetrators with general traumatizing family conditions. This group accounts for approximately 60% of officially known offenders.

Further Dr. Beier highlighted an important fact concerning sexual preferences arising from clinical and empirical findings. Sexual preference does not change during a lifetime. It is fate and not choice. The preferences for gender, body type, age of the partner and favourite practices manifest during puberty and remain stable. Hence they endure and are not changeable. They are an expression of a fixed structure. This applies to sexual orientation in general.

Considering recidivism, there is a big difference between the paedophilically-inclined and the surrogate-type. Between 50% and 80% paedophilically-inclined reoffend while only 10% - 25% surrogate-type reoffend.

It's important to stress the difference between sexual preferences and sexual behavior. A paedophilic inclination in an individual does not mean that the inclined person will necessarily act out his preferences. There are paedophilic people who manage to restrict desires for sexual contact with children. For men with this inclination, it means since puberty they have been living with these fantasies about children's bodies and have had to control these impulses in order to not become an offender and traumatize children, not even on the internet by using child abusive images. Furthermore, most of the sexual assaults are not registered/reported.

The paedophilic inclination perseveres and remains stable during lifetime and thus clinically significant distress occurs. Men with paedophilic inclination are at greater risk to reoffend. The preference

of paedophilia in Germany is 1% of the male population based on an epidemiological study. This should shift our focus on primary prevention. Paedophilic men are considered the most important target group of primary prevention of CSA and child pornography offences which means consumption of child abusive images, especially those coming voluntarily from the unreported category or Dunkelfeld. This belief was the basis of starting the Prevention of child sexual abuse clinic at the Institute of sexology in Berlin, 10 years ago.

Dr. Beier goes on to describe the functioning of the Berlin project. The first step was to design a media campaign to get paedophilically inclined people to come to the clinic. This was done by interviewing real offenders for their recommendations. Based on those interviews, it was concluded that the campaign should be non-medical, non-judgemental, non-threatening, empathic, professional, and authentic. The placement of the ad should be in street media, while not labelingthe concerned persons as child molester. The media campaign was designed to communicate the following messages: empathy for the particular situation, no discrimination due to the sexual preference, confidentiality and anonymity, no augmentation of the feelings of guilt and shame.

Ads were placed in street media, TV spot was shown about 80 times in several public and private tv stations. Since July 2012, through Google Adwords potential consumers of child abuse of images are guided to the therapeutic offer of the Dunkelfeld project by typical search keywords. Respondents to the media campaign can contact the research team unanimously by telephone and Internet. The staff is specifically trained to build a trust-worthy and empathic relationship. Each caller is assigned a personal identification number to each respondent. Ongoing legal activities in connection to the sexual offences are a exclusion criteria. Those respondents interested and able to attend a consultation are questioned about their criminal and sexual history, sexual fantasies, behaviour, demographic data, and former experiences with health professionals.

In a specialized one-year treatment program, participants learn to ensure impulse control by using cognitive-behavioural techniques, sexological tools, integrating the attachment dimension in terms of an increase of social functioning as well as pharmaceutical options mostly androgen deprivation. This is followed by an after-care offer.

Since 2014, the prevention work has been extended to reach adolescents with an erotic preference towards children's body schemes. Criminal statistics in Germany shows that nearly 25% of sexual offending against children can be allocated to children under 18 years old. Our clinical experience shows that sexual preference particularities could arise and are noticed by the individual during adolescence.

The clinic is now doing scientific research on neurobiological factors and meanwhile we have become very near to the ability of assessing paedophilia using hemo-dynamic brain response to sexual

stimuling with neuroimaging techniques. However, assessing paedophilia is not the same as assessing the risk of paedophilia. So what are we trying to do is differentiate offenders from non-offenders and we found neurobiological difference between those groups.

The efforts in this field need to be combined at an international level for two reasons. Firstly, paedophilia is a part of human sexuality and it is found in every culture and country. Second, child pornography is a topic of international concern because of World Wide Web and its accessibility in nearly every country. While in Germany there are systems and laws with an advantage, even in countries with mandatory reporting one can focus on potential offenders. Paedophilia as diagnosed in ICT 10 from WHO is not a crime and it becomes a crime when acted out. It is possible to offer therapy anonymously. The use of child abusive images is a strong indicator for paedophilic inclination. Taking into consideration that 1% of the male population is paedophilically inclined and that the next generation of paedophilically inclined will began their career on child abusive images, doing nothing is not the answer. It will affect every country and the availability of material online will not be stopped unless efforts are combined.

Paula Sellars, Author and Director of Stewards of Children, Darkness to Light

Topic: Bystanders Protecting Children from Boundary Violations and Sexual Abuse

Darkness to Light (D2L) is a nonprofit organization founded in 2000 with the mission to empower people to prevent child sexual abuse. Their work is guided by a vision to create a world for children where child sexual abuse does not exist. They believe protecting children is an adult responsibility and that education is the first critical step, as well as the catalyst for larger cultural change. Using an evidence-informed platform, D2L programs teach adults to prevent, recognize, and react responsibly to child sexual abuse. Till date, they have trained over 8,000 Authorized Facilitators who teach the program in 50 states and 16 international locations, and more than 980,000 copies of Stewards of Children have been distributed to communities around the world.

The D2L presentation is based on a video on a 20-minute video on Bystander intervention

At ASCCSA 2015, Paula Sellars and Cindy share the principles behind the work of D2L especially the Stewards of children module as well as the supplementary modules used by D2L in training adults to react responsibly in protecting children. The Stewards of Children program is a premier training program for the adult general public in a docu-training format which is a documentary style film that documents the stories of survivorsand the sort of the guiding principles that experts can provide in teachingpeople prevention of child sexual abuse.

The strategic pillars of D2L are education, activation to promote change, partnerships. Some of the achievements of D2L program are top five nominees from the United Nations Foundation in the child rights category and the only program listed as a model program by the office of Juvenile Justice and Delinquency Prevention in the US, trainedover one million people in the United States. D2L plans to embark on a 3-phase project in India. In the first phase in June 2015, the aim was to check the potential of the stewards of children program in India, phase two is to train facilitators to go out and offer a Training of Trainers. The trainers will offer the training to others and come back with feedback. The final stage is to film a culturally adapted-version with survivor stories and experts from India.

They further go on to sharing one of their supplemental trainings at ASCCSA 2015 on bystander intervention. Bystander is a person who is not directly involved in a boundary violation but (s)he is observing it. We are all often bystanders when we see something that doesn't look or feel right between an adult and a child or an older youth and a child. One way of preventing CSA is by getting bystanders involved in sort of inserting themselves when theysee something that looks like it could be breaching the boundaries of a child. Oftentimes, offenders groom children before abuse takes place. A lot of grooming behaviourlooks a lot like healthy normal behavior. For instance, the adult

spending time with children, giving gifts, etc. The goal is to identify grooming behaviors and intervene before abuse takes place.Thus bystandersare engaged through awareness about sexual abuse and then pushed into getting involved when they see those kinds of behaviors. The involvement is through intercepting them and not in aggressive, offensive ways but in a gentle assertive manner. The intervention is through describing the behavior, setting a limit, and then moving on to the next activity.

D2L looks at a five-step model while teaching adults. The first step is awareness-building including basics such as statistics and impact of sexual abuse on survivors. Second step looks at one –on-one adult-child isolated situations and how to prevent those in various setting. The third step looks at the component of talking with children about various topics such as safety and sanctity of their bodies, protecting themselves, etc. The fourth step looks at knowing the signs, recognizing the signs of abuse both in children who are displayingsigns of abuse but also in adults who may be offending. The final step is reacting responsibly by knowing how to report and understanding what the system is around reporting as also intervening as a bystander. Thus the first three steps are in a sense primary prevention meaning intercepting abuse before it takes place while the last two steps are a form of secondary prevention – identifying children affected by sexual abuse and engaging the system in protecting these children.

Cindy further goes on to describe the ideal way of measuring the effectiveness of their prevention program. She refers to the use of proxy variables. Proxy variables in prevention of CSA are people changing their behavior. The best way to measure this is to teach them how to create a safe situation and intervene and then determine if they do these things after leaving the room through post-tests. The entire process is scientifically evaluated by independent parties through randomized controlled trials. The stewards of children program is evaluated in this manner.

Dr. Anjan Bhattarcharya, Paediatrician

Topic: Child Protection in the UK: Learning objectives for India

Dr.Anjan Bhattacharya is a renowned Developmental Paediatrician based at Child Development Centre, Apollo Gleneagles Hospital, Kolkata with a vast experience of 25 years. Dr. Anjan Bhattacharya has worked in Newham University Hospital and Primary Care Trust, London in the past and has expertise in leading multidisciplinary assessment and management of children with complex disabilities. He was awarded Pioneer Award by East Zone IAP and Bharat Jyoti Award by India International Friendship Society.

He aspires to bring the scientific professional training in the arena of child protection in Paediatric practice in India to highest available international standards. He is the immediate past national secretary of Medicolegal Group of Indian Academy of Pediatrics and was instrumental in spreading awareness about Protection of Children against Sexual Offenses Bill (14th Nov, 2012) amongst the members.

At ASCCSA 2015, Dr. Anjan Bhattacharya begins his presentation by introducing the importance of dealing with the topic of CSA with fun and positivity, as it the culture of fear that is holding people back from openly exploring and discussing the topic in order to move forward. He identifies the importance that doctors hold as stakeholders in the implementation of the POCSO Act. As the Secretary of the Medicolegal Group of Indian Academy of Paediatrics, he put forth a session on the POCSO Act in the Golden Jubilee Pedicon, where an entire panel discussion was held on this act. Yet, he says, 2-3 years later, Paediatricians are still reluctant to talk about CSA, and this is due to the fear surrounding the topic.

Coming to the central question of how one can practice taking the process forward in a modular format, Dr. Bhattacharya draws on his experience with patients in the UK to explore the difference in experience and practice and also training modules for doctors in both the UK and in India. While working in Newham University Hospital, Dr. Bhattacharya was visited by a 13 year-old girl with her father, who complained of recurring abdominal pain. Even after a thorough physical examination, the source of the pain could not be identified. However, during the process of examination, the doctor observed a hint of inappropriateness in the father's behaviour with his daughter. For him, this was a warning sign, which he chose to act upon. Looking at this possible situation in the Indian context, he discusses how someone with no formal training would probably be unable to find anything wrong with the situation, and this problem arises from ignorance. Also, the topic of how to deal with such an issue practically is not taught in the undergraduate curriculum in India or abroad.

Returning to the case of the 13-year old girl, Dr. Bhattacharya highlights the complexities a doctor faces in the UK to arrive at such a conclusion without getting any psychosocial handle, as a misstep

could result in him being sued. Keeping this in mind, he also cites a line from the POCSO Act that says that if there is a possibility, the doctor has a duty of care. So he retains the daughter in the presence of his secretary who acts as a witness, speaks with her, and then calls the father back in to tell him that although there is the possibility that there is nothing wrong, it is his duty as a doctor to refer them to the Social Services. Dr. Bhattacharya explains that his duty as a doctor is not entirely fulfilled until he follows it through, and that this attitude can be imbibed by doctors everywhere with appropriate training.

In comparison to this, he cites a case in India. An 8-year old child is brought in for experiencing vaginal discharge of recent onset, accompanied by itchiness. Her parents are advised remedies like applying a certain cream and wearing cotton undergarments. However, this is problematic, because it essentially meant washing off crucial evidence. Dr. Bhattacharya maintains that at this time, doctors in India cannot be held entirely responsible, as they lack adequate training. Hence, the solution isn't punishment, but education and sensitization in training, in order to work alongside the police. However, this time frame for training needs to be put down on paper, after which doctors will need to face action for negligence.

Dr. Bhattacharya goes on to describe the role of this training, stressing on the importance of procedure. It is necessary to tell the parents (sometimes the very perpetrator) why the child is being referred to Social Services. By not giving a reason for it, one can damage the process. Next, doctors need to be trained to handle the negative reactions that may come from the child and parents, as they undergo a huge loss of empowerment, and also inform them that these reactions are being recorded and can be used against them. Often, a child might not even know what has been happening, especially in India, with such importance placed on "family honour". Therefore, in order to encourage greater awareness through training of doctors, the Joint Commission International (JCI) is gradually increasing the stakes in hospitals, such that the professional group of doctors are adequately prepared to deal with the situation rather than shying away from it, and the focus remains on child welfare. Hence, it is necessary to take up this question in post-graduate studies; an international course, with situations very similar to India, has been introduced, which has now spread over 14 countries in 24 years. Moreover, portals like the DCH (Diploma of Child Health) and MRCPCH treat doctors that deal with children, as 40% of GPs' workload is paediatrics, but they don't know how to deal with them.

Finally, there is a lack of competence-based training in India, and doctors need to acknowledge the truth in order to move forward. Therefore, in order to gain this experience, a fellowship in Developmental Paediatrics has been started, which is new in India, on psychological vaccines. This, along with prevention, is essential to move forward. Dr. Bhattacharya ends with a need for pro-active behaviour that comes from the training of doctors, a culture that is prevalent in the UK, and needs to, and will, soon, come to India as well.

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ANNUAL STAKEHOLDERS CONFERENCE ON CHILD SEXUAL ABUSE

Uma Subramanian & Siddharth Pillai, Aarambh, Mumbai

Topic: Making An Aarambh: Creating India's First Online Resource Portal against CSA

Aarambh is an Initiative by Prerana & ADM Capital Foundation in supporting communities to safeguard children from CSA. Uma has over 9 years of experience of working with children at risk across India. She is a professional social worker and trained in the International Break the Silence module by the Philippine based Stairway Foundation.
For the last 9 years, Siddharth has worked with non-profits across India managing communications. He has worked on several successful online campaigns and petitions on variety of human rights issues in India.
Their insights and passion to create an impact in child protection in India led to the creation of Aarambh. The duo put together www.aarambhindia.org – India's first online resource portal against child sexual abuse & exploitation.

At ASCCSA 2015, Uma Subramaniam begins her presentation by conveying the meaning of the word 'Aarambh'. In Hindi, the word means 'to begin', or 'to start.' Discussing Aaambh's partners, Prerna and the ADM Capital Foundation, she presents a video of last year's ASCCSA conference, where Project Aarambh was first announced.

She first tackles the question of why an online resource portal is even needed. Drawing from her personal experiences, she describes her experience of being trained in the module abroad by the Philippines-based Stairway Foundation. While extremely enthusiastic about taking this training to India, she first wanted to take stock of the options locally available at that point in time. While the initial assumption was that there is a lack of information at all, it was eventually found that there was a lot of information from many different sources, both online and offline, but this information was very scattered with no single guide to help process it. For example, Googling the phrase "Child Sexual Abuse in India", would be met with a plethora of random links with no comprehensive source. The material that was present was very complex and often obtuse, especially in reference of medical protocols, the law, GRs- essentially being the exact opposite of easily accessible. To read about the recently drafted law on child sexual abuse, one would have to go searching for a scanned image of POCSO, which was barely readable and could not be indexed for any further use. There was no single resource one could look to, say, as a confused parent, to help process this information. This, she feels, was limiting engagement with the subject in this country. She also acknowledges that a few organizations have been working towards this purpose since the 90s, the information was undigitized, and hence very limited in its reach.

She foregrounds the fact that a problem as complex as CSA needs to be addressed with multiple perspectives. To address this, there is a need to go local. Content needs to be available in local lan-

guages, adapt it to the local audience, and reach if not the rural areas, then at least tier-II and tier-III cities, and not just be concentrated on the metropolitan ones.

She addressed the crisis of representation – and emphasized on the fact that it is important to move beyond petty dialogue and misunderstandings among humans, to a comprehensive collaboration among all the stakeholders in CSA.

Uma also emphasizes on the need to move away from the existing fear-based approach existing both online and offline. She gives the example of a few common images that accompany the idea of "child sexual abuse in India", with dark, depressing portrayals of children who are alone, in the dark, feeling unsafe, and often with illustrative indicators of having faced abuse. Such images and ideas perpetuate the taboo nature of child sexual abuse, and make it harder to talk about in a society which already shies away from breaching the topic. Hence, she emphasizes the need for a positive, help-based approach for an information portal, emphasizing on a protection as a collective responsibility.

Therefore, she realizes the need for a centralized resource portal that aggregates the information already available, along with creating content. A portal that fills the gaps in the chain of information around CSA in India, and dresses it up in a palatable manner. One that simplifies and demystifies concepts and jargon, and address all stakeholders involved in this issue. Essentially, a platform that connects the smaller bodies fighting the cause against CSA to the bigger, pre-existing ones, that can aid the former in establishing a strong base from which to begin working. Also, there is a need to counter the "bad stuff" so easily available online by "good stuff" that can educate these people alongside, that will lead to increased awareness. Moreover, after the training, with an online resource portal, one can stay updated and have something to go back to.

At this point, Siddharth Pillai joins the presentation, explaining how he has joined the project very recently. To him, it was abundantly clear that in this digital age, the content Aarambh created had to simple, linear, and able compete with viral images and videos. The platform also had to be dynamic, constantly updated with the latest information and happenings, so that people could count on a centralized platform to reliably inform them at any point in time. Moreover, it needs to be a conversation, promoting collaboration.

Siddharth thanks several collaborators and sources that they worked with, or have taken inspiration from. He walks through the process of the incubation of the website, the different forms it took, and finally shows a video guided tour of the final project. In the 11 months since it's been launched, he announces that they have 18 new organizations already registered with the website, and using their resources. They have also organized online training for these organizations, after which they've been using the resources even more. The website gets around 3000 visitors per month, with around 30% return traffic – that is, users who check back regularly, for new updates

and content on the website. Hence, they've been able to provide support to smaller organizations in Maharashtra, Chennai, Tamil Nadu, by organizing an online training for them to understand how to use the website.

Siddharth runs through how to use the website- it is a linear process, with a simple understanding of the subject, with links to more complex processes. There is also a page called 'Simplifying POCSO', to effectively make sense of the more complex document. Siddharth ends the presentation with a plea for collaboration – emphasizing that with an issue as complex and layered as Child Sexual Abuse, progress can only be made with heavy collaboration to centralize the information, and putting it out there for people to use.

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