

**United Kingdom National Guideline  
on the Management of Sexually Transmitted Infections and Related Conditions  
in Children and Young People - 2010**

(updates and replaces 2009 guideline)

**Clinical Effectiveness Group, British Association for Sexual Health and HIV**

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**What is new in this guidance:**

- Confidentiality
- Consent
- HIV testing
- Screening
- Testing
- Treatment
- Evidence of STIs as indicators of sexual abuse
- Prophylaxis
- Out-patient and in-patient settings for provision of care
- Risk assessment form

<b><u>Index of Contents</u></b>	<b><u>Page No</u></b>
Scope and purpose	5
Stakeholder involvement	5
Rigour of development	6
- Levels of evidence - parts 1 and 2	6
- Grading of recommendations	6
- Levels of evidence - part 3	6
<b>Part 1</b>	
Introduction	8
Epidemiology	9
Location and providers of services for children and young people	9
Storage and disclosure of health records	10
Consent, confidentiality and child protection	10
- Legislative framework and guidance	10
- Sexual activity, abuse and exploitation definitions	10
- Consent and access to treatment	11
- Refusal of testing by competent young person	12
- Refusal of testing by parents of a non-competent child or young person	12
- Confidentiality	12
Child protection in practice	13
- Assessing risk of abuse/exploitation	13
- Information sharing and disclosure	14
- Under 13 year olds	14
- Information on sexual partners	15
- Responsibilities of organisation	15
Recommendations	16
<b>Part 2</b>	
Diagnosis and management of sexually transmitted infections (STIs) and related conditions in the <16s	
Risk of infection	17
Screening and testing for STIs	17
- Screening for STIs	17
- Timing of tests	17
- Testing for STIs in child sexual abuse	18
- Sites to be sampled in pre-pubertal and abused post-pubertal children	18
- Test methodology for pre-pubertal children and cases of sexual abuse	19
- Sites to be sampled	19
- Chain of evidence	19
- Testing of contacts	20
Recommended STI tests (Flowcharts in Appendix D)	20
- Blood samples	20
- STI testing in pre-pubertal girls	20
- STI testing in post-pubertal girls	21
- STI testing in boys	21
- Genital blisters or ulcers	21
- Genital warts	21
Risk assessment for pregnancy	22
Contraceptive advice	22

Partner notification	22
Health education/promotion	22
Psychological well-being	22
Management of specific groups	23
- Commercial sex workers	23
- HIV positive young people	23
- Infants of HIV positive parents	23
- Neonates of mothers with STIs	23
- Boys who have sex with boys	24
- 'Looked after' children	24
- Children and young people with learning or physical disabilities	24
- Girls with female genital mutilation	24
Management of specific STIs	24
Prophylaxis for STIs in children and young people following sexual abuse or voluntary sexual activity	24
- Gonorrhoea and Chlamydia	25
- Syphilis	25
- Hepatitis B	25
- Hepatitis C	25
- Genital herpes simplex virus (HSV)	25
- Anogenital warts / human papillomavirus (HPV)	25
- Human immunodeficiency virus (HIV)	26
- Vaccination of voluntarily sexually active young people against hepatitis B and HPV	26
<b>Part 3</b>	27
The significance of infection in pre-pubertal children	27
- <i>Neisseria gonorrhoeae</i>	27
- <i>Chlamydia trachomatis</i>	28
- Bacterial vaginosis	28
- Genital mycoplasmas	29
- Syphilis	29
- Anogenital warts / HPV	29
- Oral warts	30
- Genital herpes simplex virus	30
- Hepatitis B	30
- Hepatitis C	31
- Human immunodeficiency virus (HIV)	31
- <i>Trichomonas vaginalis</i>	31
<b>Part 4</b>	
Summary and recommendations	33
Auditable outcome measures	33
Future research suggestions	34
Acknowledgements	34
Membership of the CEG	34
Editorial independence	34
<b>Appendices</b>	
Appendix A - Legal framework and guidance for consent, confidentiality and child protection	36
Appendix B - Suggested proforma for 'Risk assessment for young people	38

attending sexual health services'	
Appendix C - Child protection contacts	39
Appendix D	
• Flow chart for STI screen for pre-pubertal and pubertal females intolerant of speculum	40
• STI screen for pubertal females tolerant of a speculum	41
• STI screen for pre-pubertal and pubertal males	42
Appendix E - Treatment protocols	43
Chlamydia	
Pelvic inflammatory disease	
Trichomoniasis & bacterial vaginosis	
Gonorrhoea	
Anogenital warts	
Genital herpes	
Anogenital candidiasis	
Congenital syphilis	
Acquired syphilis	
Scabies ( <i>Sarcoptes scabiei</i> )	
Pubic lice ( <i>Pediculosis pubis</i> )	
Appendix F - Individuals who contributed to consultation	49
<b>References</b>	<b>50</b>

## Scope and Purpose

This guideline is appropriate for use in Genitourinary Medicine/Sexually Transmitted Infections (GUM) clinics, and by other NHS or other services providing sexual health advice, management or treatment to young people, e.g. sexual health clinics, young person's clinics, contraceptive clinics, gynaecology/antenatal services, termination services, Sexual Assault Referral Centres (SARCs), paediatric services and general practice in the UK. The principles apply wherever young people are seen for sexual health care or where there are concerns about child sexual abuse (CSA) or where a sexually transmitted infection (STI) has been detected

It includes recommendations on the assessment, examination, diagnostic tests, treatment regimens and prophylaxis for the effective management of children and young persons under 16 at risk of, or who have, an STI. It offers guidance on consent and confidentiality on children and young people presenting to health care professionals working in sexual health services. It is also applicable to young people aged 16-18 who have learning difficulties or who are 'vulnerable'.

Some parts of the guidelines are relevant to all those providing sexual health services, but other parts are only relevant to Level 3 service providers.

Prevention of STIs through health education and one-to-one interventions as recommended by National Institute for Clinical Excellence (NICE)<sup>1</sup> is an integral part of sexual health care of young people but is outside the scope of the guidelines.

## Stakeholder Involvement

The following organisations provided input:

British Medical Association (BMA); Brook, Centre for HIV and Sexual Health; Children's HIV Association (CHIVA); General Medical Council (GMC); HYPNet; National Society for the Prevention of Cruelty to Children (NSPCC); Royal College of General Practitioners; Royal College of Obstetricians and Gynaecology (RCOG) Faculty of Sexual and Reproductive Health; Royal College of Paediatrics and Child Health (RCPCH); Royal College of Physicians (RCP); RCP Faculty of Forensic and Legal Medicine; The Survivor's Trust.

The Survivor's Trust and NSPCC provided patient/non-medical perspectives and input. Whilst contributing to these guidelines, it cannot be assumed that all organisations and individuals necessarily agree with all statements.

This guideline is laid out in specific sections:

### Part 1

Introduction and discussion of issues concerning consent, confidentiality, child protection and basic principles of care.

### Part 2

The diagnosis and management of specific STIs and related conditions in the under 16s.

### Part 3

Significance of sexually transmitted infections in pre-pubertal children in relation to sexual abuse. This section has taken advice from a variety of different experts in the UK and incorporates (with permission) a large amount of guidance produced by the RCPCH in "Physical Signs of Child Sexual Abuse".<sup>2</sup>

#### Part 4

Recommendations, auditable outcomes, additional information, appendices and references.

### **Rigour of Development**

Consultation was undertaken for three months. The levels of evidence and recommendations have been graded as shown below:

#### Levels of evidence - Parts 1 and 2

- Ia evidence obtained from meta-analysis of randomised controlled trials
- Ib evidence obtained from at least one randomised controlled trial
- IIa evidence obtained from at least one well designed controlled study without randomisation
- IIb evidence obtained from at least one other type of well-designed quasi-experimental study
- III evidence obtained from well-designed non-experimental descriptive studies
- IV evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

#### Grading of recommendations

- A evidence at level Ia or Ib
- B evidence at level IIa, IIb or III
- C evidence at level IV

All evidence in parts 1 and 2 unless otherwise stated is Level IV, grade C.

#### Levels of evidence - Part 3

Table 1: Ranking scheme for the security of diagnosis of CSA<sup>2</sup>

<b>Level</b>	<b>Criteria used to define CSA</b>
1	CSA confirmed at case conference/family/civil/criminal court proceedings or admitted by perpetrator
2	CSA confirmed by stated criteria including multidisciplinary assessment
3	CSA defined by stated criteria
4	CSA stated but criteria not given
5	CSA suspected
6	Cannot tell
7	Cannot confidently include the paper but it has some merits

Level 1 indicates the highest level of confidence that child sexual abuse has taken place.

Table 2: Ranking scheme for the security of diagnosis of non-abuse<sup>2</sup>

<b>Level</b>	<b>Criteria used to define non-abuse</b>
1	Newborns or children screened to exclude sexual abuse with a review of past medical records to identify any previous concerns relating to CSA and a structured parent interview and/or a child interview for verbal children
2	Children referred into clinical services for reasons other than suspected CSA or genitourinary complaints where CSA was not actively excluded
3	Children presenting with genitourinary complaints
4	Non-abuse stated and no further details given

Level 1 indicates the highest level of confidence that the population was not sexually abused.

Certain sections of Part 2 and all of Part 3 are taken directly from the 2008 RCPCH guidelines with permission.<sup>2</sup> The search strategy for Part 3 is described in full in the RCPCH guidance. Part 3 is a summary only, and readers should refer to the full text for evidence as required.

When interpreting the significance of a STI in a child, expert advice should be sought. The terms pubertal and post-pubertal are used synonymously in this document. The term her/him are used interchangeably in most instances.

The on-line version of these BASHH guidelines will update RCPCH guidance related to the significance of STIs, as well as the testing prophylaxis and treatment of STIs. The RCPCH guidance will be updated in 2010.

## Part 1

### 1.1 Introduction

Young people need to be able to access sexual health services in order to prevent, diagnose and treat STIs and gain advice to protect against unintended pregnancy. It is essential that these sexual health services are confidential. This encourages young people to come forward for sexual health care and facilitates disclosure of consensual and non-consensual sexual activity.

Many young people enjoy mutually consenting sexual relationships. Although those under 16 years may be involved in consensual sexual activity, they may also be the victims of sexual abuse or exploitation, as may those aged 16-17 yrs. They may not recognise that their relationship is abusive, may have been groomed, or they may be too afraid of the consequences to disclose or acknowledge it. The issue of sexual abuse by other young people is often not recognised.

There is a tension between the right to confidentiality and the need to protect children and young people from sexual abuse and exploitation. However child protection issues must be considered, as highlighted in "Working Together to Safeguard Children".<sup>3</sup> These guidelines should be used in conjunction with statutory guidance and advice from professional bodies. A full discussion of all the issues is not possible within this document and a more detailed document covering issues in more depth is in preparation by BASHH. In particular the issue of overriding refusal to testing by either a competent young person or a parent is an extremely complicated area. Although discussed briefly in the text, a detailed review of this is beyond the scope of this guideline.

The Children Act 1989<sup>4</sup> defines a child as 'a person who has not yet reached 18 years of age'. In these guidelines, children under the age of 16 years will be referred to as 'young people' or 'children' according to the GMC definition.<sup>5</sup>

*Children;* younger children who lack the maturity and understanding to make important decisions for themselves.

*Young people;* older or more experienced children who can make these decisions.

The guidelines are primarily directed at the management and care of young people under the age of 16 years, but those aged 16-17 years may require the same considerations.

Those providing a sexual health service for young people must be non-judgemental. Assumptions should not be made about the sexuality of young people, who may be bi- or homosexual, or may be in a period of sexual exploration.

The care of the young person should be holistic taking into account other relevant factors such as drug and alcohol use, mental health issues, chronic disease, adverse social circumstances, school and family issues. The role of parents, other family members, friends, social networks, teachers and social workers are all important in the care of young people. Whilst usually supportive, any of these may also be, or perceived by the young person to be, a negative influence in his/her life.

### 1.2 Epidemiology

All GUM clinics in the UK collect and return to the Health Protection Agency data on the number of cases of sexually transmitted infections by sexual orientation and age. Annual reports are published and may be accessed via [www.hpa.org.uk](http://www.hpa.org.uk).<sup>6</sup> For the purpose of data collection, young people are divided into the age groups 16-19 years and under 16 years of age. Data for those under 16 therefore include sexually active adolescents, victims of child sexual abuse, neonates and infants. The report does not differentiate for most STIs between vertical infection, sexual and non-sexual transmission.

### 1.3 Location and providers of services for children and young people

The location of services should be the most appropriate for that individual based on their age, vulnerability, reason for attendance, special needs, personal choice (of the individual and parent/carer) and local resources.

- Pre-pubertal children are normally seen in “specialist children’s” services.
- Pre-pubertal children who are being assessed for CSA or assault would normally be seen by community paediatricians/forensic physicians, usually in their dedicated premises or in a children’s Sexual Assault Referral Centre (SARC).
- Post-pubertal children under 16 years are seen in either in a children’s or adult’s SARC or Paediatric Unit, and examined by Forensic Physicians and/or Community Paediatricians or may attend a Department of Genitourinary Medicine (if forensic examination is not being performed), according to their preference and the local expertise. If previously sexually active, consideration should be given to referral on to GUM services and if contraception needed to their GP/community contraceptive service.
- Young people 16-18 years old who are victims of sexual assault are seen in adult SARCs or a Department of Genitourinary Medicine (if forensic examination is not being performed), according to their wishes.
- Post-pubertal young people requiring sexual health services can be seen either in mainstream adult services or dedicated youth clinics according to their preference. If the young person is thought to be particularly vulnerable or distressed, arrangements should be made for them to wait in a separate area. Although there is no evidence that young people attending sexual health services are targeted for exploitation whilst in waiting areas, separate waiting rooms if available for males and females, or for under or over 18 years, would theoretically prevent proximity to predatory adults of the opposite sex. It would not protect them from those adults of the same sex or other young people. The Children’s National Service Framework<sup>7</sup> recommends separate services for those under 18 but this would probably be detrimental for most of those attending sexual health services as it may prevent couples attending together; limiting choice and access to services. The service should be young-people friendly. The waiting areas should be visible to staff so that no young person is at risk whilst attending the service. Departments should participate in trust-wide audits based on national audits to ensure their service meets recommended standards for young people. Services should refer to “You’re Welcome” Guidance<sup>8</sup> on young peoples’ services and the Children’s National Service Framework.<sup>7</sup>

## 1.4 Storage and disclosure of health records

Health records for young people must be kept until the patient's 25<sup>th</sup> birthday, or 26<sup>th</sup> if the young person was aged 17 at conclusion of treatment.<sup>9</sup> Where CSA has been disclosed, whether a retraction is later made or not, then the records should be kept in accordance with child protection procedures.

Local Trusts have policies for the storage of child protection records. Disclosure of records raises specific issues with young people under 16 years and parental/guardian rights. Records of competent young people should not be disclosed to parents or others without their explicit consent or a court order. Where the request is from police or social workers in relation to child protection issues, it is advisable to seek advice from the Trust's solicitors, regulatory bodies and defence associations.

## 1.5 Consent, confidentiality and child protection

### Legislative framework and guidance

The legal framework on child protection, consent and confidentiality with particular relevance to children and young people is covered by the General Medical Council publication '0-18 years: Guidance for all doctors'.<sup>5</sup> This should be referred to for full references which include England, Wales, Scotland and Northern Ireland, and more detailed explanation. The following is a summary of key issues for sexual health providers (see also Appendix A).

### Sexual activity, abuse and exploitation

- In England, Wales, Scotland and Northern Ireland the legal age for heterosexual and homosexual sex is 16 years.
- Under the Sexual Offences Act 2003 (England)<sup>10</sup> sexual activity under 16 years old is illegal. Those under the age of 13 are considered unable to give consent, and that penetrative sexual activity is therefore rape. In Scotland, the law on sexual offences is currently under review. Information on laws is updated on the UK website.<sup>11</sup>
- The Government publication, "Working Together to Safeguard Children (2006)"<sup>3</sup>, defines CSA:
 

*Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.*
- "Working Together"<sup>3</sup> indicates the need to consider CSA in those under 18 years old who are sexually active, and perform a risk assessment on under 16 year olds. It states that there is a presumption of reporting under 13s to social services and the police. It does not advocate mandatory reporting. "Working Together" also

states that where more information is known about a sexual partner, the national police database (PND) should be checked.

Although child sexual abuse encompasses both contact and non-contact activities, in the RCPCH publication<sup>2</sup>, the term 'CSA' is used to describe only those activities which could cause anogenital injuries or result in the diagnosis of a sexually transmitted infection in a child under 18 years of age.

- Sexual abuse can be perpetrated by male and female adults, and teenagers as well as older children.
- Young people may suffer from more than one type of abuse; sexual, physical, emotional and neglect.
- Sexual abuse and consensual sexual activity may co-exist.
- Young people may present in a variety of ways with a wide range of symptoms.
- The signs of sexual abuse in young people are rarely diagnostic. A diagnosis should be made considering the whole picture.
- The possibility of sexual abuse needs to be considered in any young person attending a sexual health service.

### Consent and access to treatment

Young people under the age of 16 years can consent to medical examination, investigation and treatment if they have sufficient maturity and judgement to enable them fully to understand what is proposed and its implications (Fraser Ruling when applied to contraception, Gillick competence when applied to wider aspects of care, management and consent<sup>12</sup>). The Axon ruling<sup>13</sup> upheld this right of young people.

The more serious the medical procedure proposed, a correspondingly better grasp of the implications is required.

- If a young person is not competent, consent from one parent or carer with parental responsibility is necessary for examination and treatment. There is similar provision in Scotland by "The Age of Legal Capacity (Scotland) Act 1991".<sup>14</sup> In Northern Ireland, although separate legislation applies, the then Department of Health and Social Services Northern Ireland stated that there was no reason to suppose that the House of Lords' decision would not be followed by the Northern Ireland Courts. If a clinician is aware of parental disagreement, the GMC guidance<sup>5</sup> should be consulted.
- If someone under 16 is not judged mature enough to consent to treatment, the consultation itself can still remain confidential.
- The Mental Capacity Act<sup>15</sup> and the Code of Practice to the Mental Health Act 2007,<sup>16</sup> may help guide professionals for those 16-17 years with regards to a young person or their parent's consent or its refusal.

- Under the Sexual Offences Act 2003,<sup>10</sup> sexual health care providers are deemed to be protecting a child if they are preventing STIs or pregnancy, whether the child is under 16 or under 13 years old.

### Refusal to test by competent young persons

This is a difficult area and varies according to country in the UK. In Scotland, parents cannot override a refusal to test by a competent young person. In England, Wales & Northern Ireland, the law on parents overriding a competent young person's refusal to testing is complex. The clinician must weigh up the harm to the rights of the child against the benefits of testing and treatment, so that decisions can be taken in the child's best interests. The advice of other members of the multi-disciplinary team, an independent advocate or named/designated doctor for child protection may be helpful. Legal advice should be sought about whether to apply to the court, if testing is thought to be in the best interests of a competent child who refuses.

### Refusal of testing by parents of a non-competent child or young person

If parents refuse testing that is clearly in the best interests of a non-competent child or young person then the clinician should involve other members of the multi-disciplinary team, an independent advocate or named/designated doctor for child protection before seeking legal advice. This also applies if both a young person with capacity and their parents refuse testing. Consideration must be given to the fact that the parent who is declining consent may be an abuser.

### Confidentiality

It is important to maintain confidentiality so that young people access services<sup>17, 18</sup> and engage in partner notification. A confidential service may also provide an environment where they can feel safe to disclose sexual abuse or exploitation (whether perceived as such or not) in order that help can be offered.

- Young people are covered by the "NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) directions 2000".<sup>19</sup> This prevents disclosure about anyone examined or treated for an STI except for the treatment or prevention of an STI.
- "Best practice guidance for doctors and other health professionals on the provision of advice and treatment for young people under 16 on contraception, sexual and reproductive health" produced by the Department of Health<sup>20</sup> upholds the right of young people to confidentiality
- BMA response to the revised edition of "Working Together to Safeguard Children (2006)"<sup>21</sup>: '*Without an underlying presumption of confidentiality, young people will refuse to access such services and their interests could therefore be seriously harmed..... Where health professionals believe that children may be subject to coercion or exploitation, existing child protection guidelines must be followed.*'
- GMC "0-18 years: guidance for all doctors"<sup>5</sup> reaffirms the right to a confidential service. It states that clinicians can disclose relevant information when this is in the public interest. Although this would be normal practice if a child or young person is involved in abusive or seriously harmful sexual activity, it indicates each case should be considered on its merits, taking into account behaviour, living

circumstances, maturity, serious learning disabilities, and other factors affecting vulnerability. Information on under 13s should usually be shared, but if a decision is made not to disclose there should be discussion with a named or designated doctor for child protection, with a record of the decision stating the reasons.

- The National Children's Information Database<sup>22</sup> requires information to be entered wherever a child/young person accesses care. An exemption has been made for sexual health services, where information on attendance at the service should be entered **only** with their **express consent**. There is wide access available to the database, which is maintained until the age of 21 years; therefore in most cases it is unlikely to be in the young person's best interest to have data recorded.

Although it is preferable that a young person attending a sexual health service has the support of a parent or carer with parental responsibility, often they do not wish their parents or carers to be informed of a medical consultation or its outcome. Attempts should be made to encourage the young person to inform their parents. However establishing a trusting relationship between the young person and the healthcare professional at this stage will do more to promote health than to refuse to see the young person without involving the parents, or carers with parental responsibility.<sup>5</sup>

## 1.6 Child protection in practice

Sexual health service providers must be aware of child protection issues and take very seriously the possibility that a young person is being exploited or abused. Advice and guidance on child protection is available in "Working Together"<sup>3</sup> and "What to do if you are worried a child is being abused".<sup>23</sup> All sexual health clinics should:

- have guidelines in place for risk assessment and management for child sexual abuse;
- use a standardised proforma<sup>24</sup> for risk assessment (Appendix B) for all under 16 year olds and those 17-18 where there is a cause for concern or learning difficulties. The proforma can be amended according to local need;
- be aware of local child protection procedures.

### Assessing risk of abuse/exploitation

Issues that should be considered include:

- competency, as currently assessed using Fraser guidelines
- emotional maturity
- psychological wellbeing
- physical development, e.g. pre- or post-pubertal
- drug or alcohol abuse
- age of partner(s)
- number of partners (current and lifetime)
- disclosure of current or previous sexual abuse or exploitation
- other young people who may be at risk, e.g. siblings/other family members, friends, vulnerable adults etc
- social networks and support
- age of young person, with decreasing age causing higher concern.
- homelessness
- out of school

- other, e.g. commercial sex work, internet grooming etc
- physical disability affecting communication
- learning difficulties
- presence of an STI or pregnancy

### Information Sharing and Disclosure

Although young people have the same right to confidentiality as adults, the need to break confidentiality may exceptionally arise. The service should have an established process for cases of concern and access to a network of colleagues.

Information sharing outside the team should usually be done with the consent of the young person. The young person's view on the sharing of information is essential.

In considering the need to share information, the overwhelming issues are the care of that young person and the need to act in her/his best interests to protect their emotional and physical health. When a practitioner has any concern, or if possible or actual abuse is disclosed, information must be shared within the multi-disciplinary team in order to facilitate decision-making. Working with the young person usually allows disclosure to be made with their consent, thus preventing a breakdown in the healthcare professional/patient relationship. When the decision is made that no immediate action is taken, the young person should be offered a follow-up appointment. If it is decided to work with the young person on future visits regarding disclosure, they should be advised that action may need be taken if they fail to attend or respond to communications.

Where consent is refused and there may be/is a risk to the young person or others, the case should be discussed with the nominated practitioner for child protection within the team. Multi-disciplinary discussion should occur to assess whether disclosure is in the best interests of that person or others. Informal discussions, without breaking confidentiality by naming the young person, with a colleague with expertise, the Trust's named/designated professional, with a specialist in community paediatrics or a senior member of the local child protection team are helpful (First Access Team in Wales). Where information is to be disclosed against a young person's wishes they should be advised this will happen, unless doing so would put them at risk.

Each young person should be assessed on a case-by-case basis. It should be remembered that all factors need to be taken into consideration when deciding whether or not to disclose without consent. For example a physically and emotionally immature 15 year old may be far more at risk than a younger person with greater emotional intellectual and physical development.

The reasons and decision whether or not to disclose information should be summarised and documented.

### Under 13 year olds

Although "Working Together"<sup>3</sup> states that there should be a presumption of reporting under 13 year olds who are sexually active to social services and the police, reporting is not mandatory. Each case must be considered on its own merits following the process. The GMC states that you should usually share information, but again does not advocate mandatory reporting. Although sexual activity in someone under the age of thirteen will always be a cause for concern, the need to share information without consent to protect

the young person must be balanced against the need to provide a service that encourages young people to seek help when they need it.<sup>5</sup> In all decisions, the focus of attention must be on promoting the best interests of the child or young person.

In some areas the Local Safeguarding Children Board (LSCB) guidance may state mandatory reporting, whilst the national guidance in “Working Together”<sup>3</sup> does not. This is very difficult for clinicians. Where this occurs, the clinician would be justified in following the national guidance as set out above, acting in the child’s best interests, which is supported by the GMC<sup>5</sup> and BMA.<sup>21</sup> Even if it is not necessary to report to the police or social services, it is helpful to consider what support needs the young person has, and what other agencies may be able to provide this support in the local community, and facilitate referral to these services if appropriate.

### Information on sexual partners

As a result of the Bichard Inquiry Report (2004)<sup>25</sup> “Working Together”<sup>3</sup> advises that where the identity of sexual partners is known they should be checked on the National Police Database (PND). This information may be stored long-term as soft evidence, and human rights groups have expressed concern that young people involved in normal consensual sexual activity could appear years later as potential sex offenders on an enhanced Criminal Records Bureau (CRB) check. The possibility of this issue requires further clarification.

Additionally it is important to separate the role of STI services in partner notification, from police duties to detect a crime. Therefore checks on partners via the PND, where the information has been obtained as part of partner notification, should not be done routinely. If information is being requested in order to check the PND, the young person should be informed why the information is being requested and how it will be used. If there is cause for concern about a partner it is more appropriate to refer the young person to social services who can consult the PND on information given to them by the young person themselves.

### Responsibilities of organisations

All Sexual Health Clinics should have:

- guidelines on management of young people under 16 years;
- copies of Local Safeguarding Children Boards procedures and protocols;
- a regularly updated list of child protection contacts (see Appendix C);
- access to child protection training for staff;
- members of staff who have some training in adolescent health (e.g. through the e-Learning for Healthcare Adolescent Health and Sexual Health and HIV Projects<sup>26</sup>);
- regular audit and review of compliance with these guidelines and compatibility with Standard 4 of the National Service Framework for Children, Young People and Maternity Services<sup>7</sup>;
- a nominated consultant physician to take the lead for young people and children who is part of a multi-disciplinary team in the department, consisting of a nurse and health adviser and others who have received training in child protection issues. Small departments may consider being part of a clinical network to discuss issues of concern;
- procedure for chain of evidence<sup>27</sup> or care pathway for onward referral

- links with local specialist sexual violence and abuse support services including Independent Sexual Violence Adviser services, where these are established, and fast track referral protocols to specialist support services

## **1.7 Recommendations**

Under 16s accessing sexual health services (and those 16 and 17 if indicated) should:

- be assessed for risk factors for Child Sexual Abuse (CSA) and exploitation using an 'under-age attender proforma' (see Appendix B for suggested proforma);
- be given the opportunity to be seen without a parent or carer;
- be encouraged to involve a parent or carer with parental responsibility in their care;
- be referred to a Health Adviser or equivalent health care professional;
- have a care plan which includes diagnosis, treatment, STI prevention advice/one-one intervention, contraceptive advice, and decision on whether disclosure to other agencies is needed;
- have competence and risk factors re-assessed at each visit with a new problem.

## Part 2

### Diagnosis and Management of STIs and related conditions in the under 16s

#### 2.1 Risk of infection

The risk of a child or young person acquiring a sexually transmitted infection (STI) is dependent on several factors including:

- the prevalence of STIs within the local population.
- maternal STI during pregnancy leading to vertical transmission to the infant.
- the type of sexual activity, e.g. penile-vaginal or penile-rectal penetration is more likely to lead to infection than other types of sexual activity.
- injuries of the genital tract. Trauma increases the susceptibility to infection.
- the sexual maturity of the young person. A young person has an increased biological susceptibility to carcinogens and STIs due to physical and immunological immaturity of the genital tract.
- the lack of use of barrier contraception.
- age at first intercourse and previous sexual activity as these may lead to a longer period of exposure to transmissible agents and an increased number of partners.
- co-existence of other risk behaviours such as drugs or alcohol misuse.

#### 2.2 Screening and testing for STIs

##### Recommended when

- sexual history suggests it
- symptoms/signs which could be caused by an STI
  - o including vaginal or penile discharge, genital ulceration and vulvitis, anal lesions/discharge or genital lesions e.g. warts
  - o for all who have been found to have one STI

##### Considered when

- sexual abuse is suspected or proven,
  - o according to local STI prevalence
  - o circumstances/type of abuse

##### Offered to

- parents of child/young person with an STI to assess vertical transmission as appropriate
- the subject's siblings if also being assessed for sexual abuse or vertical transmission
- other young people/adults in the household/close contacts if suggested by the history.

##### Timing of Tests

The scheduling of examinations should depend on the history of voluntary sexual activity, abuse/assault and incubation periods of STIs. These should be determined on an individual basis taking into account the young person's (and their parent/carer's) psychological and social needs. A single examination may be sufficient if the young person has been abused over an extended time period by the same person/people or if the last episode of abuse was at least three months previously.

A general guide for assessment and examination timing is as follows:

- tests for STIs should be performed at baseline;
- tests for *Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT) should be repeated two weeks after the last penetrative contact if necessary;-
- tests for HIV, syphilis and Hepatitis B and C at baseline with final test at three months (14 weeks if oral HIV test) and six months in some cases. If post-exposure prophylaxis for HIV following sexual exposure (PEPSE) given the final HIV test should be performed three months after finishing the course (i.e. at four months). If high risk for HIV then blood tests done earlier than three months should be undertaken.<sup>28, 29</sup>

### Testing for STIs in child sexual abuse

This section refers to testing in cases of sexual assault or abuse of children and young people under 18 years. For information on testing/screening in post-pubertal teenagers in consensual relationships refer to the BASHH STI Testing Guidelines via [www.bashh.org.uk](http://www.bashh.org.uk).

Examination of a pre-pubertal child should normally be undertaken by an experienced paediatrician or suitably qualified forensic practitioner, or a GUM physician with appropriate expertise. A second adult/professional, who could attend primarily to the welfare of the child, should be present to provide explanation and support.

In cases of CSA, a patient-sensitive and pragmatic view should be taken with regard to sites and methods of STI sampling. Non-invasive samples may be more appropriate, however the limitations of such samples, in terms of sensitivity, specificity and positive/negative predictive values, should be understood. It is recommended that interpretation of positive NAAT results should be done in collaboration with specialists in GUM and microbiology.

Reasons for testing include:

- to detect an infection which may require treatment.
- to reassure the child and parent(s)/carer.
- to gain additional evidence which can then be used in child protection/legal proceedings. In pre-pubertal children, a STI may be of medico-legal significance in supporting diagnosis of CSA. Results need to be interpreted based on the limitations of the tests used.
- in pubertal children, a STI may only be of medico-legal significance in the child who has not been voluntarily sexually active.
- an STI can be used to help link a perpetrator to a victim.

### Sites to be sampled in pre-pubertal and abused post-pubertal children

The genital organs of female infants, children, adolescents and adults have important anatomical and physiological differences. These differences influence the microbiological flora of the genital tract and the sampling sites for tests. Deciding which sites to sample can be difficult; abuse of a particular orifice may not be disclosed even when abuse elsewhere has been established. It is suggested that where there has been disclosure of any abuse then sampling of all sites should be considered. Where there is only suspected abuse then decisions should be made on a case-by-case basis including factors such as symptoms, signs, and probability of abuse. For pre-pubertal girls, introital swabs inside

labia minora but avoiding the hymen should be used. Trans-hymenal swabs (ENT swabs are smaller than traditional swabs) can be used if it is possible to pass a swab without causing distress. First-pass urine for NAAT testing to detect GC and CT should be undertaken in boys. Urine NAATs can be used as screening tests in girls if swabs are not feasible.

### Test methodology for pre-pubertal children and cases of sexual abuse

This is a rapidly changing field. The latest online version of these guidelines and the most up-to-date version of the STI Testing Guidelines should always be accessed via (<http://www.bashh.org>).

**Gonorrhoea.** Culture for *Neisseria gonorrhoeae* (GC) is currently the method of first choice in GUM clinics in the UK. Ideally, there should be direct plating onto culture medium, but Amies swabs (or equivalent) are acceptable when this is not possible, providing there is prompt transport to the laboratory. Nucleic acid amplification tests (NAATs) for *N. gonorrhoeae* are more sensitive than culture and can also be used as diagnostic/screening tests on non-invasively collected samples (urine and self-taken vaginal swabs). NAAT technology is a rapidly changing field and current guidance<sup>30</sup> should be sought in interpreting results (for example, the PCR assay has poor sensitivity on female urines). If a GC NAAT is positive then current recommendation<sup>30</sup> is to confirm this result with culture, although this may not always be possible. Microscopy for gonorrhoea in CSA is inconclusive, as it cannot differentiate between *N. gonorrhoeae* and *N. meningitidis*.

**Chlamydia.** NAATs for *Chlamydia trachomatis* (CT) are widely used. In females, a cervical swab or self-taken vulvovaginal swab are specimens of choice.<sup>31</sup> If these are not possible, a first-catch urine specimen may be utilised. In males, a first-catch urine is reported to be as good as a urethral swab. Confirmation of positive NAAT results should be undertaken locally or via the Health Protection Agency by using a different NAAT platform or using culture (direct immunofluorescence may be acceptable if expertise is available). NAATs are currently unlicensed for use with oro-pharyngeal, rectal and genital tract specimens.<sup>31</sup> Culture for CT can be used in addition to a NAAT, although availability of a validated test is now extremely limited, if available at all. When CT culture from the pharynx is performed, the laboratory must be able to distinguish between *C. trachomatis* and *C. pneumoniae*. In a child with rectal symptoms who is found to have a positive rectal CT swab, the swab should be forwarded to the Health protection Agency (HPA) for testing for lymphogranuloma venereum (LGV). Chlamydia culture although mentioned below is rarely available in practice.

### Chain of evidence

If the presence of a STI is to be used in medico-legal proceedings then there should be a chain of evidence (COE) for the samples taken. Ideally, a COE should be in place in all cases and positive samples stored. If an infection is found, but there was no COE performed, the test should be repeated with a COE in place. The COE requires that the origin and history of any exhibit to be presented as evidence in a Court of Law must be clearly demonstrated to have followed an unbroken chain from its source to the Court. It is initiated by the physician taking the samples, who must seal the sample, label it fully and hand it to the next person in the chain.

Sample labelling should identify that the patient is a young person and include:

- the name of the examinee

- description and site of the sample
- the date and time (24-hour clock)
- signatures
  - physician initiating the chain
  - subsequent custodians

All persons handling the sample along with the places and conditions of storage must be documented with the date, time, place and signatures of custodians.

Whilst a chain of evidence for STI samples might be desirable in some circumstances, it is acknowledged that it might not always be achievable in some settings; if a chain of evidence cannot be performed, referral to a centre where this can be undertaken is usually required for medico-legal samples.

National guidance on COE and specimen storage is available from the Royal College of Pathologists website.<sup>27</sup>

### Testing of contacts

Testing and treatment of any consensual and non-consensual sexual contacts (if consent is given) should be addressed if a STI is detected. Parents should be tested where the possibility of vertical transmission is relevant.

## **2.3 Recommended STI tests (summarised in the flowcharts in Appendix D)**

### Blood samples

Consider testing for HIV, syphilis, Hepatitis B and C in all cases depending on the risk factors. Further information on risk factors is available in BASHH guidelines on post exposure prophylaxis for HIV<sup>32</sup> and the joint guidelines on HIV testing.<sup>28</sup> HIV serology should be repeated at three months post assault and at four months post assault if PEPSE for HIV is given.<sup>29</sup> Saliva sampling (not validated in children) can be performed for HIV, repeated 14 weeks after assault if blood testing declined or not appropriate. Those with positive samples need re-testing using venous blood.

### STI testing in pre-pubertal girls

The following tests are recommended according to the needs of the individual child:

#### *Vulval or trans-hymenal swabs:*

##### Essential

- GC culture (+/- microscopy)
- NAAT for CT +/- GC
- CT culture if available

##### Optional if discharge present

- Microscopy for *Trichomonas vaginalis* (TV)/candida/bacterial vaginosis (BV) and/or culture for TV/candida/anaerobes/aerobes. May also request testing for other organisms.

#### *Urine sample:*

If child/carer declines examination

- NAAT for CT +/- GC

*Rectal swab*

If anal assault is disclosed or suspected

- NAAT for CT +/- GC
- GC culture
- CT culture if available

*Pharyngeal swab*

If oral assault is disclosed or suspected

- NAAT for CT +/- GC
- GC culture
- CT culture if available

STI testing in post-pubertal girls

As for pre-pubertal girls, but use endo-cervical swabs in preference to vulval or trans-hymenal swabs if speculum tolerated.

STI testing in boys*Meatal swab (pre-pubertal) or urethral swab (post-pubertal)*

If urethral discharge then meatal swab

- Microscopy for pus cells
- GC culture
- CT culture if available

*Urine sample*

- NAAT for CT +/- GC

*Rectal swab*

If anal assault is disclosed or suspected

- NAAT for CT +/- GC
- GC culture
- CT culture if available

*Pharyngeal swab*

If oral assault is disclosed or suspected

- NAAT for CT +/- GC
- GC culture
- CT culture if available

Genital blisters or ulcers

- Swab for herpes simplex virus (HSV) culture or PCR (more sensitive than culture).
- HSV serology for IgM and IgG, paired sera required at 3-week interval (consider according to circumstances). At the current time, HSV2 serology is not reliable for under 14 years old. Interpretation needs expert advice.
- Swab for bacterial culture (consider).
- Dark ground microscopy for *Treponema pallidum* should be considered. PCR swab for syphilis is increasingly available

Genital warts

- The value of HPV typing of surgically removed warts is controversial. It is not justified as routine at the current time for evidential purposes, although in specific cases it may be considered.

## **2.4 Risk assessment for pregnancy**

All young women who are post-pubertal should be assessed regarding the possibility of pregnancy. Pregnancy testing and emergency contraception should be available at the initial point of care. Mechanisms should be in place for referral to termination of pregnancy advice or to a midwifery service specialising in teenage pregnancy.

## **2.5 Contraceptive advice**

Access to the full range of contraceptive methods and emergency contraception advice should be available either by the service or by referral. Condoms should be readily available.

## **2.6 Partner notification**

If a young person is diagnosed with an STI, then partner notification should be undertaken by a trained practitioner as occurs with adults (see Part 1, Information on sexual partners).

## **2.7 Health education/promotion**

It is imperative that all young people receive health education and some understanding of the principles of negotiating safer sex. The NICE guidelines on the “Prevention of STIs and under 18 conceptions”<sup>1</sup> set out some of the behavioural interventions which may be effective. Details of training on one-to-one interventions can be obtained by contacting BASHH.

## **2.8 Psychological well-being**

Depression, suicidal ideation and severe mental health problems are becoming more prevalent in young people, and drug and alcohol abuse are increasing. Clinicians should be aware of these issues, and training and establishment of links with local Children and Adolescent Mental Health Services (CAMH) may be considered. If any concerns are raised then prompt referral to their General Practitioner or CAMH should be made.

Information should be provided to the child/young person and their parents as appropriate on:

- contact details for local third
- sector specialist sexual violence and abuse support services;
- Sexual Assault Referral Centres (where these exist);
- Independent Sexual Violence Adviser services (who generally work with young people from the age of 11, although some work with younger children). They will

also provide counselling and support for parents, family members and partners and can potentially act as advocates.

## **2.9 Management of specific groups**

### Commercial sex workers

Young people involved in prostitution should be treated primarily as the victims of abuse. They require careful assessment in the GUM setting to provide them with STI screening, treatment of STIs detected, vaccination against hepatitis B, and possibly human papillomavirus (HPV), advice on prevention of acquisition of HIV and other STIs and advice on contraception. There must be a multi-disciplinary approach. They must also be provided with strategies to assist them in exiting prostitution. Clinicians should encourage the young person to involve carers and work with them to encourage voluntary disclosure to an appropriate agency. All practitioners should be aware of the issue of trafficking of young people and the referral mechanisms and resources for them.

### HIV positive young people

There are increasing numbers of young people with vertically acquired HIV diagnosed prior to adolescence, or who are diagnosed for the first time during adolescence. These young people may have acquired infection vertically or through sexual transmission, either sexual abuse or consensual sex. The sexual health needs of these individuals are complex. Transitional care arrangements should be in place for those infected in early childhood to enable seamless transition of care from paediatric to adult services.<sup>33</sup> Education regarding safer sexual practices, disclosure and post-sexual exposure prophylaxis for partners is warranted. Contraceptive advice that takes into consideration HIV drug therapy should be provided by someone with appropriate expertise.<sup>34</sup> Pre-pubertal children should be cared for in a paediatric setting/family clinic. Older children, and young people diagnosed in sexual health settings, may prefer to have their care in adult services, e.g. GUM clinics/HIV clinics with liaison with paediatricians as required. The young person with HIV should be involved in decisions about where their care for HIV and sexual health is delivered, and may prefer separation of the two. Any adult service caring for young people should ensure they conform with guidance on young people.<sup>8</sup> Transitional care arrangements should be in place for children to move between child and adult services.<sup>35</sup>

### Infants and children of HIV positive parents

Testing of infants born to HIV positive parents, and issues of consent and non-consent for testing are covered in Appendix 5 of the 2008 Guidelines for HIV Testing.<sup>28</sup> When a known positive mother or very high-risk mother refuses testing of the neonate/child, specialist advice should be sought. The decision must be made in the best interests of the child. As evidence accumulates of previously undiagnosed vertically infected children surviving into adolescence, all children or young people of infected mothers should be offered testing, and this must be done pro-actively. This causes difficulties if the parents refuse testing, and the child may not be aware of the mother's diagnosis. Specialist advice should be sought if testing is refused. Joint CHIVA/BASHH/BHIVA guidelines recommend testing of children of HIV positive patients irrespective of their age if they may be at risk<sup>36</sup>.

### Neonates of mothers with STIs

Infants of mothers with STIs need to be tested for STIs and treatment given as appropriate. Prophylactic treatment or vaccination should be considered and given. Refer to individual BASHH guidelines on [www.bashh.org.uk](http://www.bashh.org.uk).

### Boys who have sex with boys

Additional support and advice is required. Management should include vaccination against Hepatitis B. Risk of certain STIs is greater and wider number of tests is necessary. Specialist expertise should be sought.

### 'Looked after' children

A significant number of children are 'looked after' and have special risks and needs. They are at particular risk of sexual exploitation. Additional time and assessment may be required. The issue of who has parental responsibility needs to be considered if the young person is not competent to give consent for testing and treatment.

### Children and young people with learning or physical disabilities

Some children and young people are unable to communicate partially or fully due to learning or other disabilities. Consideration should be given to the use of independent advocates (accessed via specialist sexual violence and abuse support services) for these children if they require sexual health services, as it is possible that their carer could be an abuser.

Accessing specialist sexual health services may be difficult for those with physical or other disabilities and alternative methods of providing a service to them may be required.

### Girls with female genital mutilation

Girls who have suffered female genital mutilation are considered as having been physically abused. Other girls in the family may also be at risk. Specialist advice should be sought.

## **2.10 Management of specific STIs**

The treatment guidance should be read in conjunction with the appropriate BASHH UK National Guideline and information from the latest edition of BNF for Children (BNFc). As far as possible, medicines should be prescribed within the terms of the marketing authorisation however, many children may require medicines not specifically licensed for paediatric use. Prescribing unlicensed medicines or medicines outside the recommendations of their marketing authorisation alters (and probably increases) the prescriber's professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines.<sup>37</sup>

The treatment for specific STIs in young people is shown in Appendix E.

## **2.11 Prophylaxis for STIs in children and young people following sexual abuse**

This is a rapidly changing field. For the most up-to-date information, refer to the most recent online version at <http://www.bashh.org>. Overall, the risk of acquiring a STI is low. Risk varies according to the type of abuse, whether violence was involved, whether anogenital injuries with bleeding were present, the characteristics of the abuser and number of perpetrators, the prevalence of a particular STI in the community and the transmissibility of a particular STI. Once medication is given, any problems with specimens and chain of evidence cannot be rectified. As more sensitive tests are being used and issues of specificity become more problematic, then the opportunity to repeat tests for confirmation becomes more important. If prophylaxis is to be given, chain of evidence for GC and CT tests should be used if there are likely to be medico-legal issues.

### Gonorrhoea and Chlamydia

Prophylaxis is not recommended as routine. It may be considered where:

- testing for GC and CT is not performed/is declined;
- child is unlikely to return for treatment if a STI is detected;
- risk of infection is high, e.g. perpetrator has infection.

### Syphilis

Prophylaxis should be considered if a perpetrator is known to have infectious syphilis. A balance is needed between gathering forensic evidence (seroconversion in child) with the need to prevent infection and the long-term stigma of positive syphilis serology.

### Hepatitis B

Hepatitis B vaccination should be considered if the child presents within six weeks of the last assault, as there is some evidence in adults that it can prevent infection following exposure. It is more likely to be of value after a single episode of assault.

- Vaccination schedule can be an accelerated course of 0, 7, 21 days or 0, 1, 2 months with a booster at 12 months, or standard course of 0, 1 and 6 months.
- Hepatitis B immunoglobulin should be considered if the perpetrator is Hepatitis B eAg/sAg positive and the child presents within 48-72 hours, but can be used up to seven days.

### Hepatitis C

There is no evidence for prophylaxis in children. In adults, there is some evidence that after a high-risk incident (e.g. parenteral exposure from an HCV-positive source) if infection is detected, early therapy may be effective. Vaccination is not currently available.

### Genital herpes simplex virus (HSV)

No vaccine or prophylactic medication is currently available.

### Anogenital warts / Human Papilloma Virus (HPV)

Two vaccines to prevent some oncogenic strains of HPV are licensed for use:

- Cevarix<sup>®</sup> (administered in the national UK vaccination programme), and
- Gardasil<sup>®</sup> (also protects against HPV types 6 and 11 which cause external genital warts).

The role of vaccination with either type in the management of victims of sexual abuse has not been determined.

### Human Immunodeficiency Virus (HIV)

Overall risk is very low. Post exposure prophylaxis (PEPSE) should be considered for every case presenting within 72 hours of the most recent abuse, if unprotected anogenital penetration has occurred, taking into consideration risk factors. The majority of children will not require it. There is no evidence base for its use in children. A decision should be made according to criteria in the appropriate National BASHH guidelines for adults<sup>32</sup> and the Children's HIV Association (CHIVA).<sup>38</sup> The decision to treat must balance the risk of acquiring infection with the risks of therapy and the likelihood of compliance. Factors to consider are type of sexual activity, violence, HIV status of assailant (if known) or according to prevalence rate in assailant's 'community'. Treatment must be initiated as soon as possible, ideally within one hour but at least within 72 hours, with close monitoring for toxicity and compliance while on therapy, with input from paediatric and HIV specialists. Antiretroviral therapy requires three drugs given for four weeks. Serology for HIV must be obtained before starting treatment, although the results are not needed before treatment begins. Serology must be repeated at three months after treatment has ended. Dosage and drugs suitable for children are available online.<sup>37</sup>

### Vaccination of voluntarily sexually active young people against Hepatitis B and HPV

Vaccination of all sexually active young people is not routine although Hepatitis B vaccination is given to children or young people in most Western European countries.

There is a case for considering vaccination against genital and oncogenic HPV types in those young people who have recently initiated sexual activity, but who have not already been immunised with either HPV vaccine type. Vaccination to protect against HPV types 6, 11, 16 and 18 may be particularly relevant to those girls who have been sexually abused, work in the sex industry or are attending a sexual health clinic, who are at higher risk of sexually transmitted infections and risky sexual activity, or who are HIV positive. It may be appropriate to also consider vaccination with the quadrivalent vaccine for boys in the same circumstances and/or who are involved in same sex relationships. The issue of HPV vaccination in specific risk groups has not been researched and therefore practitioners should consider each case on its own merits, in the light of evidence as it becomes available.

Hepatitis B vaccination should be considered for all vertically infected HIV children and young people.

## Part 3:

### 3.1 Significance of STIs in pre-pubertal children in relation to sexual abuse

The significance of an STI requires careful interpretation. The presence of any STI in young people may indicate that sexual abuse has taken place, but other methods of transmission should be considered.

- An STI can be used as corroborative evidence and indicate a high probability of sexual abuse. Rarely, it can be conclusive evidence of abuse and confirm identification of a perpetrator, for example when the same STI is identified in the alleged perpetrator and the young person, and other sources of infection have been excluded (e.g. perinatal from the mother). Specialist advice essential and other alternatives must be considered.
- Accidental transmission (e.g. fomite, close physical contact or autoinoculation) varies according to the STI. Whereas it can never be completely ruled out there is minimal evidence of this as a mode of transmission for most STIs.
- Vertical transmission is a possibility. There is no research indicating a definitive cut-off age after which it cannot occur.
- Sexual abuse can occur at any age including in neonates.
- The presence of one STI indicates the need to look for others.

The following statements on specific STIs are taken from the RCPCH evidence based guidelines pages 95-114.<sup>2</sup> This should be referred to for further information on the statements. An updated version is likely in 2010.

#### Neisseria gonorrhoeae

##### *Key messages*

- Gonorrhoea is not often seen in sexually abused pre-pubertal and pubertal children.
- When children with gonorrhoea have been evaluated for sexual abuse, a significant number were found to have been abused suggesting that sexual contact was the mode of transmission in these cases. However, the possibility of vertical transmission was not rigorously excluded or confirmed in any study.
- Gonorrhoea is more likely to be proven to be due to sexual abuse in older children.
- Limited evidence suggests that most abused children with GC had a history of vaginal or anal penetration.

##### **Evidence statement**

**Sexual abuse is the most likely mode of transmission in pubertal and pre-pubertal children with gonorrhoea. The evidence does not help to establish the age at which the possibility of vertical transmission can be excluded.**

##### *Issues for clinical practice*

- *If a child presents with confirmed non-ophthalmic gonorrhoea, the possibility of previous sexual contact should always be considered unless there is clear evidence of perinatal transmission (i.e. confirmed maternal infection at the time of delivery).*
- *When a child is diagnosed with gonorrhoea in the absence of a confirmed maternal infection, it is likely that the child has been sexually abused.*

*Consensual sexual activity should be considered.*

- *A positive diagnosis in the mother does not exclude child sexual abuse.*
- *The diagnosis of gonorrhoea necessitates an urgent referral to child protection services.*

## Chlamydia trachomatis

### *Key messages*

- Chlamydial infection is not often seen in sexually abused children.
- When children with *C. trachomatis* have been evaluated for sexual abuse, a significant number were found to have been abused suggesting that sexual contact was the mode of transmission in these cases. However, the possibility of vertical transmission was not rigorously excluded or confirmed in any study.
- *C. trachomatis* is more frequent in pubertal than pre-pubertal sexually abused girls, although the result may have been confounded by consensual sexual activity and/or younger children less likely to disclose abuse.

### **Evidence statement**

**Penetrative sexual contact is the most likely mode of transmission in pre-pubertal children with genital infection caused by *C. trachomatis*. The evidence does not help to establish the age at which the possibility of vertical transmission can be excluded.**

### *Issues for clinical practice*

- *If a child presents with a confirmed *C. trachomatis* infection, the possibility of previous sexual contact should always be considered unless there is clear evidence of perinatal transmission (i.e. confirmed maternal infection at the time of delivery).*
- *When a child is diagnosed with *C. trachomatis* in the absence of a confirmed maternal infection, it is likely that the child has been sexually abused. Consensual sexual activity should be considered.*
- *A positive diagnosis in the mother does not exclude child sexual abuse.*
- *The diagnosis in a pre-pubertal child necessitates an urgent referral to child protection services.*

## Bacterial vaginosis (BV)

### *Key messages*

- When studies have screened all rather than just symptomatic girls, the prevalence of BV in sexually abused 1-12 year olds is extremely low. Slightly higher rates are found when abused pre-pubertal girls with a discharge are screened.
- In pubertal girls, BV is found in both girls who are virgins and sexually active.
- There are no agreed criteria for diagnosis of BV in pre-pubertal girls.

### **Evidence statement**

**The prevalence of BV in asymptomatic sexually abused pre-pubertal girls is extremely low. BV is seen slightly more often in sexually abused girls who have a discharge. There is insufficient data in children to determine the significance of BV in relation to CSA.**

### *Issues for clinical practice*

- *The finding of BV is currently not helpful in indicating whether abuse has*

*occurred.*

## Genital Mycoplasmas

### *Key messages*

- In the only study of sexually abused children aged 1-12 years, genital mycoplasmas have been reported in 2-9% depending on the site of the swab.
- In sexually abused children aged 1-18 years, genital mycoplasmas have been isolated in between 4% and 36%.
- Three studies of girls have reported an increase of genital mycoplasmas with age.
- One study has reported the majority of girls with *Ureaplasma urealyticum* and/or *Mycoplasma hominis* had evidence of penetrative abuse.

### **Evidence Statement**

**The evidence does not help to establish whether or not genital mycoplasmas are sexually transmitted in children.**

### *Issues for clinical practice*

- *Research is needed on the prevalence and significance of *Mycoplasma genitalium* in children.*

## Syphilis

### *Key Messages*

- Syphilis has been reported in less than 1% of sexually abused children.
- A small single case series of nine South African children with syphilis, suggests that sexual abuse is likely although vertical transmission was not considered.
- Syphilis in adults is almost exclusively a sexually acquired disease but the evidence in relation to syphilis in abused children is extremely limited. No study was found which differentiated between congenital or acquired disease.

### **Evidence statement**

**There are very few published studies on sexually abused children with syphilis. As a result, the literature cannot help in establishing whether sexual contact is a likely route of transmission in children with syphilis.**

### *Issues for clinical practice*

- *In a child presenting with syphilis, history, examination and syphilis serology in both the child and mother are needed to determine acquired or congenital disease.*
- *Despite the lack of evidence and in view of the fact that syphilis is almost exclusively a sexually transmitted disease in adults, sexual abuse should always be considered if vertical, perinatal or blood contamination has been excluded.*
- *A positive diagnosis in the mother does not exclude child sexual abuse.*

## Anogenital warts (HPV)

### *Key messages*

- Four studies have reported anogenital warts in less than 2% of sexually abused children.

- Six studies have reported sexual transmission to be the cause of infection in 31% to 58% children with anogenital warts.
- Two small studies have shown that anogenital warts in young children have been sexually transmitted even in the presence of maternal infection.
- Older children are more likely to have sexual transmission confirmed or proven.
- There is a lack of evidence to support a cut-off age below which vertical transmission can be assumed to occur.
- The evidence base does not help to clarify whether HPV typing is of value in the diagnosis of sexual abuse, due to poor quality of data.

**Evidence statement**

**A significant proportion of children with anogenital warts have been sexually abused. Sexual abuse is more likely to be confirmed in older pre-pubertal children. The evidence does not help to establish the age at which the possibility of vertical transmission can be excluded.**

*Issues for clinical practice*

- *Sexual abuse must be considered in any child presenting with anogenital warts.*

Oral warts

**Evidence statement**

**There is insufficient evidence to determine the significance of oral warts in relation to child sexual abuse at the current time.**

Genital herpes simplex virus

*Key messages*

- Genital herpes has been reported in <1% of sexually abused children.
- Two studies suggest sexual contact to be the source of transmission in most children with genital herpes although numbers of cases are very small (1/2 and 6/8).

**Evidence statement**

**There are very few published studies to inform whether sexual abuse is likely to be the mode of transmission in children with genital herpes. However where infected children have been evaluated 1/2 and 6/8 were found to have been abused.**

*Issues for clinical practice*

- *In children with genital herpes, CSA should always be considered.*
- *Autoinoculation needs to be considered.*

Hepatitis B

*Key messages*

- Two studies have reported Hepatitis B in less than 3% of sexually abused children.
- No studies have rigorously evaluated children with Hepatitis B for the possibility of sexual abuse.
- Sexual transmission has been reported in 4 of 6 children with Hepatitis B although this evidence is from a single study and vertical transmission was not excluded.

**Evidence statement**

**There is insufficient evidence to determine the significance of Hepatitis B in relation to sexual abuse in children.**

*Issues for clinical practice*

- *Despite the lack of evidence, in view of the fact that Hepatitis B can be sexually transmitted in adults, sexual abuse should be considered in a child with Hepatitis B if vertical, perinatal or blood contamination has been excluded.*
- *A positive diagnosis in the mother does not exclude child sexual abuse.*

Hepatitis C**Evidence statement**

**There is insufficient evidence to determine the significance of Hepatitis C in relation to sexual abuse in children.**

*Issues for clinical practice*

- *Hepatitis C can be sexually transmitted in adults. Therefore, despite the lack of evidence in children, sexual abuse should be considered in children with Hepatitis C if vertical, perinatal or blood contamination has been excluded.*
- *A positive diagnosis of Hepatitis C in the mother does not exclude child sexual abuse.*

Human immunodeficiency virus (HIV)*Key messages*

- Two studies have reported HIV in <1% (41/5622) and 34% (24/71) of sexually abused children. The prevalence of HIV in abused children will reflect the prevalence in the local adult population and the highest frequency was reported in a study on a West African population. HIV is unlikely in sexually abused children outside of areas with high infection rates in adults.
- In children with non-vertically or parenterally transmitted HIV evaluated for the possibility of abuse, sexual transmission has been confirmed/proven in most cases.
- Three studies have suggested an association between genital-genital/anal contact or penetration and HIV infection.

**Evidence statement**

**Published studies suggest that sexual abuse is a likely source of infection in children with HIV in whom the possibility of mother-child transmission or blood contamination has been excluded.**

*Issues for clinical practice*

- *In a child with HIV with an uninfected mother, the possibility of sexual abuse is highly likely.*
- *HIV infection in the mother of a child with HIV does not exclude the possibility of sexual transmission.*

Trichomonas vaginalis

### Key messages

- *T. vaginalis* has been reported in less than 3% of pre-pubertal and pubertal sexually abused children.
- Studies have reported a considerable proportion of children with *T. vaginalis* to have been sexually abused.

#### **Evidence statement**

**Published studies suggest that sexual abuse is a likely source of *T. vaginalis* infection in girls. The evidence does not help to establish the age at which the possibility of vertical transmission can be excluded.**

#### *Issues for clinical practice*

- *In girls with a confirmed infection of *T. vaginalis*, sexual abuse is likely. Consensual sexual activity should be considered.*
- *Although there is no evidence to inform the age at which vertical transmission can be ruled out, *T. vaginalis* in girls younger than two months may be a result of a perinatal infection maintained by maternal oestrogen, although sexual abuse should still be considered in these children.*

## Part 4

### Summary and recommendations

All young people accessing sexual health services should have care guided by the following principles:

- An expectation of confidentiality.
- Trust and confidence in the service.
- Be consulted and have choices.
- Remain in control of the process, wherever possible.
- Be seen in the most appropriate site for optimal care and 'fast-tracked' according to local facilities, resources, demand and Trust regulations.
- A risk assessment performed on all under 16 year olds using a standardised proforma. The latter should be used if they re-present as a new case.
- Whenever possible the young person should be seen by an experienced senior member of staff. When this is not possible the case should be discussed with a senior member of staff either immediately or subsequently.
- Be assessed for competency according to Fraser guidelines.
- Any under 13 year old must be discussed with a nominated professional either within the clinic or in the Trust and should normally be referred but a decision made on a case-by-case basis. There should not be automatic referral to child protection services of all cases
- Information sharing on any young person should be individualised and undertaken in the best interests of the child. The best interests of the child should include all aspects of their wellbeing – physical, psychological and social.
- 16-18 year olds should have risk assessments if there is cause for concern.
- There should be clear documentation on whether disclosure to child protection services is or is not to be undertaken
- If disclosure is to be undertaken without consent, the young person should be informed unless to do so would put them in danger.
- The young person should not routinely be entered on the Children's database. If this is done express consent must be obtained.
- Information on partners obtained for partner notification purposes should not be checked on the police data base as a routine.
- Follow up appointments should be given to under 16 year olds whenever possible as further information may come to light subsequently.
- All under 13 year olds, and preferably under 16 year olds, should be given an appropriate follow up appointment.
- Training should be provided for all staff at induction and on a regular basis thereafter, at an appropriate level. The quality of training should be reviewed at intervals to ensure it is in line with current good practice. Training should include child protection and the management of children and young people.
- Chain of evidence procedures or pathways of care for them should be available.
- Vaccination and/or prophylaxis should be considered where appropriate.
- STIs should be managed according to BASHH guidelines and British National Formulary for Children (BNFc)
- There should be national service reviews.<sup>39</sup>

### Auditable outcome measures

- Offer of full STI screen (CT/GC/HIV/STS), including Hepatitis B and C serology where appropriate, to sexually active young people under 16 years: (90%)
- The percentage of above who accepted the offer of the STI screen: (90%)
- Guidelines in place on management of children and young people: (100%)
- Number of young people under 16 years of age having a risk assessment proforma completed: (100%)
- The documentation of a decision whether or not to refer to child protection services: (100% under 13years, 90% under 16 years)

### **Future research suggestions**

- Data collection as disaggregates or in defined age ranges, e.g. 0-3 years, 3-12, 13-15 years and number seen for possible abuse.
- Rates of STIs in pre-pubertal young people.
- Use of non-invasive screening methods for the diagnosis of STIs in young people and children.
- The rate of clinical anogenital warts and HPV infection in children and young people born to mothers with present/previous anogenital HPV infection.
- The prevalence of genital herpes in pre-pubertal young people and adolescents.
- Diagnosis and management of PID in early puberty.
- The incidence of Hepatitis B, Hepatitis C and HIV infection acquired through sexual abuse/assault.
- The diagnosis and significance of BV in pre-pubertal children.
- Significance of *Mycoplasma genitalium* in children and young people.

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M Talbot;

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### **Membership of the Clinical Effectiveness Group**

Clinical Effectiveness Group: Keith Radcliffe; David Daniels; Mark FitzGerald; Margaret Kingston; Neil Lazaro; Gill McCarthy; Guy Rooney; Ann Sullivan.

### **Editorial Independence**

This guideline was commissioned and edited by the BASHH Clinical Effectiveness Group, without external funding being obtained. All authors and group members have declared conflicts of interest if any.

Parts of this guidance have been reproduced from STI sections of the RCPCH Evidence Based Guidelines of Physical Signs of Child Sexual Abuse.<sup>2</sup> The authors of these sections are co-authors in these guidelines. Permission has been given by the RCPCH for the reprinting of parts of these sections.

## Appendix A

### Legal Framework and Guidance for Consent, Confidentiality and Child Protection

Refer to GMC guidelines “0-18 years: guidance for all doctors”<sup>5</sup> for full summary and references and [www.opsi.gov.uk](http://www.opsi.gov.uk).<sup>11</sup>

- NHS (Venereal Disease) Regulations 1974 and NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) directions 2000.<sup>19</sup> This prevents disclosure about anyone examined or treated for an STI except for the treatment or prevention of an STI. A government consultation on this is currently being undertaken.
- The Sexual Offences Act 2003 (England and Wales).<sup>10</sup> Under the Sexual Offences Act 2003, sexual activity under 16 years old is illegal. Those under the age of 13 are deemed not capable of giving consent to sexual intercourse, and such sexual activity is therefore rape. The act states that sexual health care providers are protecting a child if they are preventing STIs or pregnancy, whether children are under 16 or under 13 years old.
- Fraser guidelines. Young people under the age of 16 can consent to medical treatment if they have sufficient maturity and judgement to enable them fully to understand what is proposed (Gillick vs. West Norfolk and Wisbech AHA & DHSS 1985). There is similar provision in Scotland by The Age of Legal Capacity (Scotland) Act 1991.<sup>14</sup> In Northern Ireland, although separate legislation applies, the Department of Health and Social Services Northern Ireland stated that there was no reason to suppose that the House of Lords' decision would not be followed by the Northern Ireland Courts. The Fraser guidelines specifically refer to consent for contraception, but the principles are deemed to apply to other treatments (Gillick competence). If someone under 16 is not judged mature enough to consent to treatment, the consultation itself can still remain confidential. The Axon ruling<sup>13</sup> also upholds this right of young people. The Fraser guidelines are:
  - the young person understands the professional's advice;
  - the young person cannot be persuaded to inform their parents;
  - the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment;
  - unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer
  - the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.
- “Best practice guidance for doctors and other health professionals on the provision of advice and treatment for young people under 16 on contraception, sexual and reproductive health” produced by the Department of Health in 2006 upholds the right of young people to confidentiality.<sup>20</sup>
- “Working together to safeguard children”<sup>3</sup> paragraph 5.8 indicates the need to consider child sexual abuse in those under 18 year olds who are sexually active, and perform a risk assessment on under 16 year olds. It states that there is a presumption of reporting under 13s to social services and the police. There is no mandatory reporting even for under 13s. All cases should be looked at individually. Local safeguarding children boards (LSCBs) should produce local guidelines based on this.

- “Safeguarding Children and Young People from Sexual Exploitation. Supplementary guidance to Working Together to Safeguard Children” provides extra advice where exploitation is detected<sup>40</sup>.

## Appendix B

### Suggested proforma for 'Risk assessment for young people attending sexual health services'

Name/ID: ..... Age: .....

ESSENTIAL			ADDITIONAL INFORMATION
Age	Under 13	13-15	
Parental awareness of sexual activity	No	Yes	
Involuntary sexual activity			
Current	Yes	No	
Previous	Yes	No	
More than 1 partner	Yes	No	
Partners ages (specify)			
Partner in position of trust	Yes	No	
Alcohol use	Yes	No	
Drug abuse	Yes	No	
Pre-puberty	Yes	No	
Intellectual understanding	No	Yes	
Other young people/children at risk	Yes	No	
ADDITIONAL			
Involvement of other services	Yes	No	
Home circumstances of concern (e.g. in care/looked after)	Yes	No	
Out of school	Yes	No	
Aggression / coercion / bribery / grooming	Yes	No	
Mental health issues	Yes	No	
FRASER COMPETENCY FOR TREATMENT			
Understands advice given	No	Yes	
Cannot be persuaded to inform parent(s)	Yes	No	
Is likely to have intercourse	No	Yes	
Physical and/or mental health likely to suffer if care not given	No	Yes	
Best interest is care with or without parental consent	No	Yes	
ACTION			
Need to disclose	Yes	No	
Reasons			
Consent to disclose	Yes	No	
Discussed with/seen by senior doctor	Yes	No	
Action			
Referred to Health Adviser	Yes	No	
Follow up	Yes	No	
Name of Doctor/Nurse/HA			
Date:			

## **Appendix C**

### **Child Protection Contacts**

#### **Health services**

- Named Doctor for clinic
- Named Nurse for clinic
- Named Health Adviser for clinic
- Designated Doctor Child Protection
- Designated Nurse Child Protection
- Named Doctor Child Protection (Local NHS Trust)
- Named Doctor Child Protection (Local Primary Care Trust)
- Named Nurse Child Protection (Local NHS Trust)
- Named Nurse Child Protection (Local Primary Care Trust)
- Young Adult Learning Disabilities Team
- Child & Adolescent Psychiatry
- Drug Addiction Unit

#### **Other Children's Services**

- Child Protection Co-ordinators
- Local Area Offices
- Emergency Duty Team
- Learning Disabilities Team
- First Access Team (Wales)

#### **Police**

- Local Child Protection Unit/s

#### **Education**

- Child Protection Co-ordinator

#### **Sexual Assault Service (SARC)**

- Children's SARC
- Adult SARC

#### **Voluntary sector**

- The Survivors Trust
- National Association for People Abused as Children
- Rape Crisis England and Wales

Access databases of above for local services information on contact details, opening hours, services offered and specific client groups served.

**Appendix D: Flow diagrams for STI testing**  
**STI Screen for Pre-pubertal and Pubertal Females Intolerant of Speculum<sup>+</sup>**  
<sup>+</sup> (This flow chart should be used in conjunction with the text).

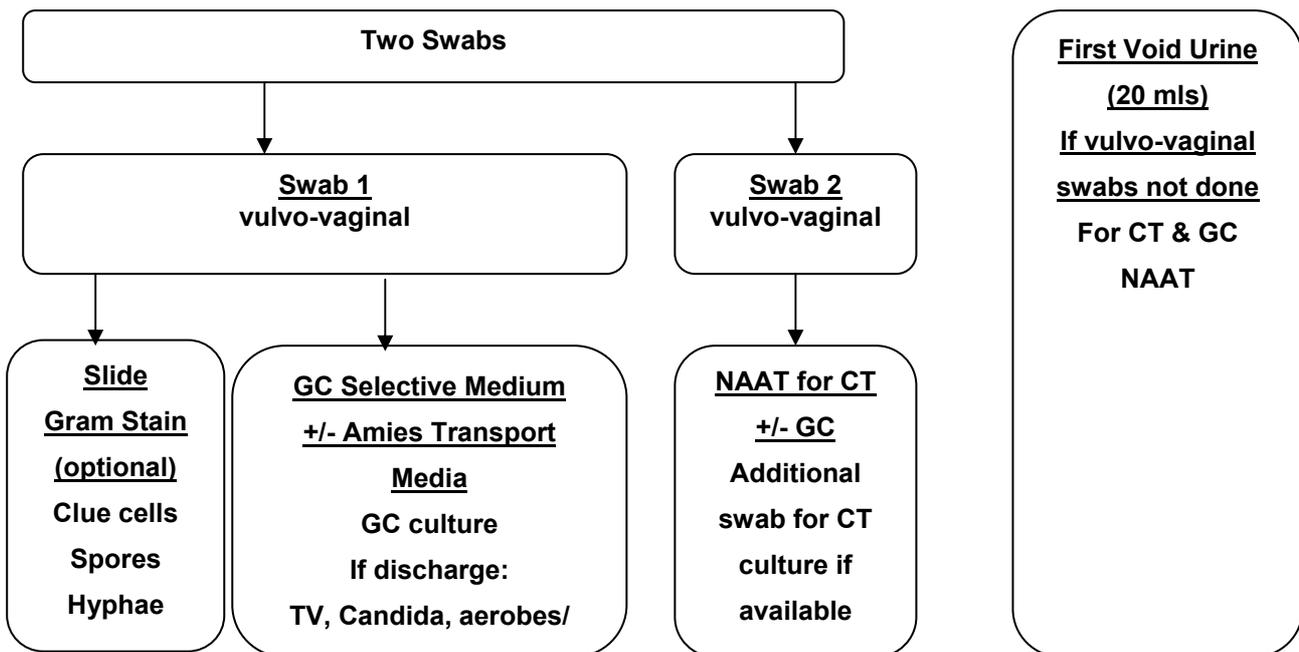
**Criteria for screening**

- Disclosure of penetrative sexual abuse.
- Physical signs of penetrative sexual abuse.
- Consensual sexual activity.
- Genitourinary symptoms, e.g. vaginal discharge.

**Screening schedule**

- Immediate: Serology (HIV, HepB&C, syphilis). Samples as below.
- 2 weeks\*: Samples as below.
- 3 weeks: Results.
- 3 months\*\*: Serology.
- 6 months: Consider serology.

\* If initial sample within 2 weeks of last assault; \*\* To be done at 3 months following last assault.



**Other tests if indicated:**

- Oral penetration:** 2 oropharyngeal swabs, 1 selective medium +/- Amies transport media for GC & 1 NAAT for CT +/- GC. CT culture if available.
- Anal penetration:** 2 anal swabs (preferably by proctoscope), 1 selective medium +/- Amies transport media for GC & 1 CT +/- GC NAAT. CT culture if available.
- Open sore:** 1 swab HSV (PCR or culture). Dark ground microscopy/PCR for *Treponema pallidum*.

## STI Screen for Pubertal Females Tolerant of a Speculum<sup>+</sup>

<sup>+</sup> (This flow chart should be used in conjunction with the text ).

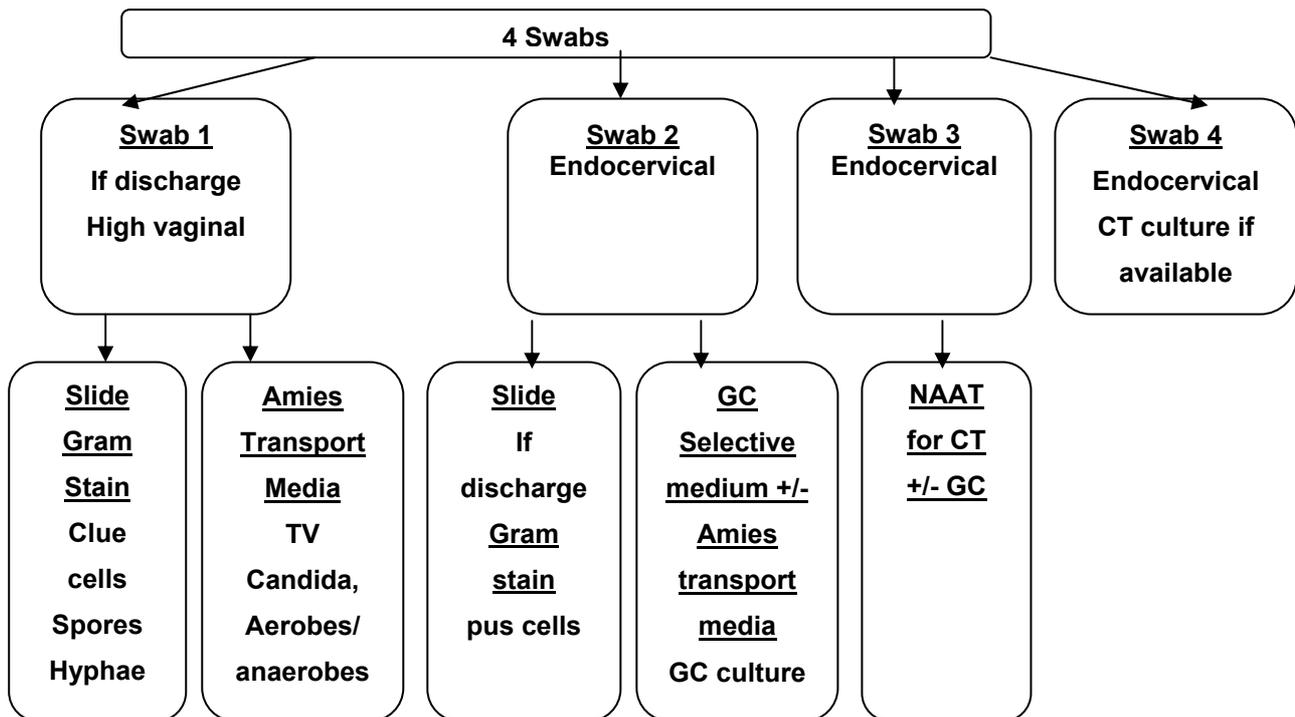
### Criteria for screening

- Disclosure of penetrative sexual abuse.
- Physical signs of penetrative sexual abuse.
- Consensual sexual activity.
- Genitourinary symptoms, e.g. vaginal discharge.

### Screening Schedule

- Immediate: Serology (HIV, HepB&C, syphilis).  
Samples as below.
- 2 weeks\*: Samples as below,
- 3 weeks: Results.
- 3 months\*\*: Serology.
- 6 months: Consider serology.

\* If initial sample within 2 weeks of last assault; \*\* To be done at 3 months following last assault.



### Other tests if indicated:

**Oral penetration:** 2 oropharyngeal swabs, 1 selective medium +/- Amies transport media for GC & 1 NAAT for CT +/- GC. CT culture if available.

**Anal penetration:** 2 anal swabs (preferably by proctoscope), 1 selective medium +/- Amies transport media for GC & 1 CT +/- GC NAAT. CT culture if available.

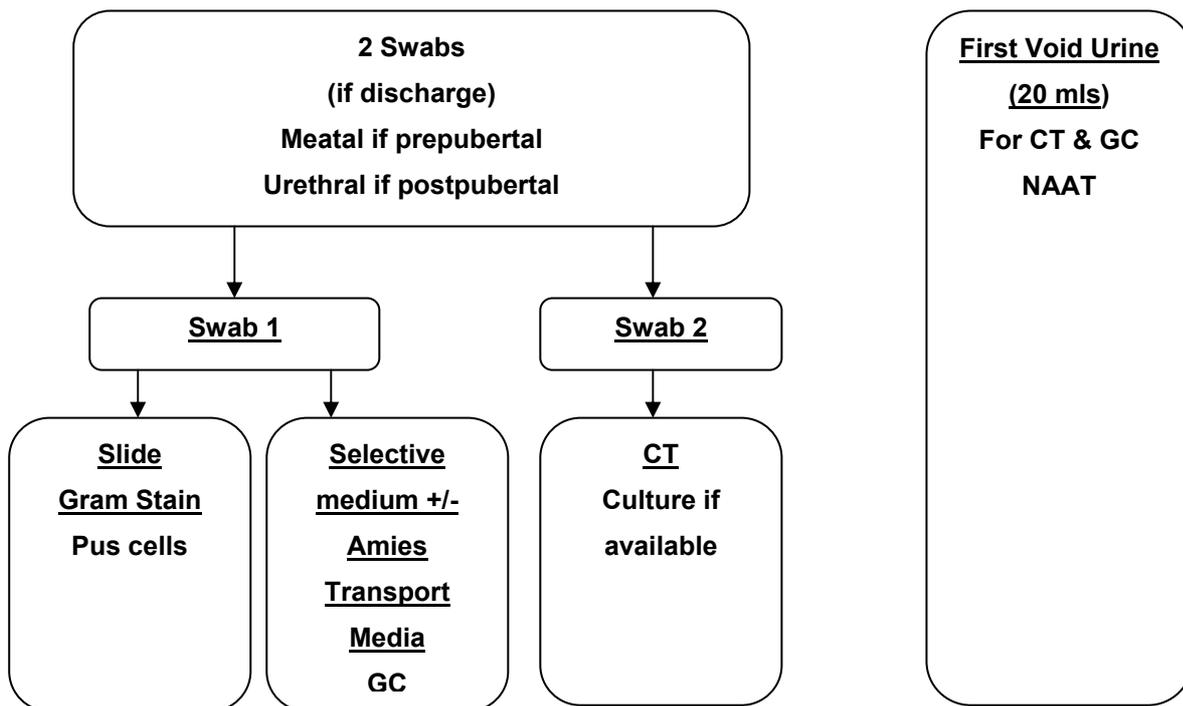
**Open sore:** 1 swab HSV PCR or culture. Dark ground microscopy/PCR for *Treponema pallidum*.

**STI Screen for Pre-pubertal and Pubertal Males<sup>+</sup>**  
<sup>+</sup> (This flow chart should be used in conjunction with the text ).

- Criteria for screening**
- Disclosure of penetrative sexual abuse.
  - Physical signs of penetrative sexual abuse.
  - Consensual sexual activity.
  - Genitourinary symptoms, e.g. penile discharge.

- Screening Schedule**
- Immediate: Serology (HIV, HepB&C, syphilis).  
Samples as below
  - 2 weeks: Samples as below
  - 3 weeks: Results.
  - 3 months: Serology.
  - 6 months: Consider serology.

\* If initial sample within 2 weeks of last assault; \*\* To be done at 3 months following last assault.



- Other tests if indicated:**
- Oral penetration:** 2 oropharyngeal swabs, 1 selective medium +/- Amies transport media for GC & 1 NAAT for CT +/- GC. CT culture if available.
- Anal penetration:** 2 anal swabs (preferably by proctoscope), 1 selective medium +/- Amies transport media for GC & 1 CT +/- GC NAAT. CT culture if available.
- Open sore:** 1 swab HSV PCR or culture. Dark ground microscopy/PCR for *Treponema*



<b>Chlamydia</b>	<p><b>Neonate</b> Erythromycin 12.5 mg/kg orally qds x 14 days * or Azithromycin 20 mg/kg/day orally, 1 dose daily x 3 days</p> <p><b>Child weight &lt;45 kg</b> Erythromycin 50 mg/kg/day orally divided into 4 doses daily x 14 days</p> <p><b>Child aged ≥2-12 years</b> Erythromycin 250 mg qds x 7days or bd x 14 days</p> <p><b>Child &gt;12 years</b> Azithromycin 1g orally in a single dose or Doxycycline 100 mg orally bd x 7 days or Erythromycin 500 mg orally qds x 7 days or Erythromycin 500 mg orally bd x 14 days <b>*Erythromycin in neonates under 2 weeks increases risk of hypertrophic pyloric stenosis</b> <b>** Azithromycin 1g recommended in CDC guidelines for children over 8 years or who weigh more than 45Kg</b></p>
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<b>Pelvic inflammatory disease</b>	<p>There are no randomised controlled trials of antimicrobial therapy for PID in children. The following recommendations are based on the evidence from adult trials modified for paediatric use.</p> <p>Quinolones cause arthropathy in the weight-bearing joints of immature animals and are therefore generally not recommended in children and growing adolescents. However, the significance of this effect in humans is uncertain and in some specific circumstances short-term use of a quinolone in children may be justified. Quinolones should not usually be used to treat PID caused by gonorrhoea.</p> <p><b>Child 2-12 years</b> Ceftriaxone (if gonorrhoea) 125mg intramuscularly single dose in children less than 45 kg followed by oral Erythromycin 250mg bd plus oral Metronidazole both x 2 weeks</p> <p><b>Child &gt;12 years</b> Ceftriaxone (if gonorrhoea) 250mg IM single dose followed by oral Doxycycline 100mg bd plus oral Metronidazole both x 2 weeks</p>
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<b>Trichomonas and Bacterial Vaginosis</b>	<p><b>Child 1-3 years</b> Metronidazole 50 mg orally tds x 7 days</p> <p><b>Child aged 3yrs to &lt;7 years</b> Metronidazole 100 mg orally bd x 7 days</p> <p><b>Child aged 7 years to &lt;10 years</b> Metronidazole 100 mg orally tds x 7 days</p> <p><b>Child &gt;10 years</b> Metronidazole 400 mg orally bd x 7 days or Metronidazole 2g orally in a single dose</p> <p><i>NB: Metronidazole gel 0.5% and clindamycin cream 2%, are not licensed for use in children.</i></p>
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<b>Anogenital Warts</b>	<p>Observation period for minimum of three months unless symptoms of pain, bleeding or irritation.</p> <p>Cryotherapy +/- local topical anaesthetic</p> <p><i>NB: Podophyllotoxin and Imiquimod are not licensed for use in children. Can be used 2-18 year olds with specialist advice off-licence.<sup>41</sup></i></p> <p>Excision/electro surgery under general anaesthesia – consider if all other treatment modalities failed</p>
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<b>Genital Herpes</b>	<p>First episode Treat if within 5 days of start of episode or while new lesions are still developing.</p> <p><b>Child 1 month–2 years</b> Aciclovir 100 mg orally five times a day for 5 days</p> <p><b>Child &gt;2 years</b> Aciclovir 200 mg orally five times a day for 5 days</p> <p>Recurrence If episodic or suppressive therapy is required see adult guideline.</p> <p><i>NB: Valaciclovir and famciclovir are not licensed for use in children.</i></p>
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<p><b>Anogenital candidiasis</b></p>	<p><b>Child &lt;16 years</b>  Clotrimazole cream 1% topical application 2-3 x daily</p> <p><i>NB: Oral triazoles are not licensed in this age group for genital candidiasis.</i></p> <p>Intravaginal treatment is not recommended for younger girls and oral treatment may be more appropriate</p>
<p><b>Congenital Syphilis</b></p>	<p>Refer to BASHH UK National Guidelines on the Management of Syphilis 2008<sup>42</sup></p> <p>Benzyl penicillin sodium 100,000 to 150,000 units/kg daily IV (in divided doses given as 50,000 units/kg 12 hourly in the first 7 days of life and 8 hourly thereafter) for 10 days (III, B)</p> <p>or</p> <p>Procaine penicillin G 50,000u/kg daily IM x 10 days (III,B)</p> <p>In children, intravenous therapy (option 1 here) may be preferable due to the pain associated with intramuscular injections.</p> <p>Treatment is based on studies using procaine penicillin G which is available as Jenacillin A [3ml contains both procaine penicillin G 750 mg/750,000iu and benzyl penicillin sodium 300mg]. Although there are no studies on the use of Jenacillin A in the treatment of congenital or acquired syphilis, both types of penicillin in Jenacillin A are effective against congenital syphilis.</p>

<p><b>Acquired Syphilis</b></p>	<p><b>Child &lt;12 years</b>  IV Benzyl penicillin sodium 200,000 to 300,000 mg/kg/day (50,000 units/kg every 4-6 hours) x 10 days.  or  IM Procaine penicillin G 50,000iu/kg [Jenacillin A 0.2ml/kg] daily in a single dose x 10 days up to a maximum daily dose of 750,000 units [Jenacillin A 3ml daily maximum] (units in full see BNFC<sup>36</sup>)</p> <p><b>Child &gt;12 years</b>  Treatment should take into account the circumstances of infection, i.e. is it epidemiological treatment or for incubating, early (primary/secondary/early latent) or late syphilis. Expert advice should be sought, and reference made to BASHH syphilis guidelines<sup>42</sup> and the BNFC.<sup>37</sup></p> <p>IV Benzyl penicillin sodium 200,000 to 300,000 units/kg/day (50,000 units/kg every 4-6 hours) x 10 days.  or  IM Procaine penicillin G 50,000iu/kg [Jenacillin A 0.2ml/kg] daily in a single dose for 10 days up to a maximum daily dose of 750,000 units [Jenacillin A 3ml daily maximum]  or  Benzathine penicillin single dose (early); or weekly x 2 weeks (i.e. 3 doses) (late)</p> <p><b>Penicillin Allergy</b>  Consider Penicillin desensitisation  or  Doxycycline 100mg orally bd x 14 days (early); x 28 days (late)  or  other treatments as recommended in BASHH guidelines<sup>41</sup> and BNFC.<sup>37</sup></p>
<p><b>Scabies</b></p>	<p>Permethrin 5% dermal cream  Apply over whole body [including face, neck, scalp and ears in children aged &gt;2 years]; wash off after 8-12 hours.  Do not use more than once a week for three consecutive weeks.  Medical supervision of treatment required in children aged two months to two years  or  Malathion liquid 0.5% in aqueous base.  Apply over whole body [including face, neck, scalp and ears in children aged &gt;2 years]; wash off after 24 hours.  Do not use more than once per week for three consecutive weeks.  Medical supervision of treatment required in children aged less than six months.</p>

<b>Pediculosis pubis</b>	<p>Malathion liquid 0.5% in aqueous base Apply over whole body, allow to dry naturally, wash off after 12 hours or overnight. Repeat after 1 week.</p> <p>or</p> <p>Permethrin 5% dermal cream (not licensed for &lt;18 years) Apply over whole body, wash off after 12 hours. Repeat after 1 week.</p>
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<b>Hepatitis B vaccines</b>	<p>See BNFC for more details<sup>37</sup></p> <p><b>Engerix B<sup>®</sup></b> Neonate (except if born to HbsAg +ve mother*) - 3 doses of Engerix B<sup>®</sup> 10 micrograms at 0, 1 and 6 months *If born to HbsAg +ve mother: 4 doses of Engerix B<sup>®</sup> 10 micrograms at 0 (along with Hep B immunoglobulin at a separate site) and then at 1, 2 and 12 months</p> <p>Child 1 month-16 years - 3 doses of Engerix B<sup>®</sup> 10 micrograms at 0,1 and 6 months</p> <p>Child 16-18 years - 3 doses of Engerix B<sup>®</sup> 20 micrograms at 0,1 and 6 months</p> <p>NB:</p> <ul style="list-style-type: none"> <li>- Accelerated schedules at 0, 1, 2 and 12 months may be given in all age groups</li> <li>- Ultra rapid schedule in children over 16 years old: Engerix B<sup>®</sup> 20 micrograms at 0, 7 days, 21 days and 12 months</li> <li>- Alternative '2 dose' schedule for children aged 11-15 yrs: 2 doses of Engerix B<sup>®</sup> 20 micrograms at 0 and 6 months (not suitable if high risk of infection between doses or if compliance with 2<sup>nd</sup> dose uncertain)</li> </ul> <p><b>Fendrix<sup>®</sup></b> - Licensed in renal insufficiency</p> <p><b>HepBvaxPRO<sup>®</sup></b> Neonate (except if born to HbsAg +ve mother*) - 3 doses of 5 micrograms at 0, 1 and 6 months *If born to HbsAg +ve mother: 4 doses of HepBvaxPRO<sup>®</sup> 5 micrograms at 0 (along with Hep B immunoglobulin at a separate site) and then at 1, 2 and 12 months.</p> <p>Child 1 month-16 years - 3 doses of HepBvaxPRO<sup>®</sup> 5 micrograms at 0, 1 and 6 months</p> <p>Child 16-18 years - 3 doses of HepBvaxPRO<sup>®</sup> 10 micrograms at 0, 1 and 6 months - Accelerated schedule: 4 doses of HepBvaxPRO<sup>®</sup> 10 micrograms at 0, 1, 2 and 12 months</p>
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## Appendix F

### Responses to Consultation and Additional Input/Advice

Thanks to:

M Erooga  
A Sullivan  
F Boag  
C Sonnex  
A De Burgh  
E Foley  
D Rogers  
C Carne  
S Forsyth  
K Forbes  
C Foster  
S Stilwell  
J Sheather  
J O'Brien  
H Lacey  
K Radcliffe  
C Thompson  
S Blake  
D Kellock

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