

BASHH



BASHH National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People (2021)

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Contents

Abbreviations used

What's new in this guideline?

Summary of key recommendations and good practice points

Scope and purpose

Introduction and Methodology

Methods

Search strategy

Piloting and feedback

Future guidance updating Stakeholder involvement (to be completed post-public consultation)

1.0 Epidemiology of STIs and conceptions in children and young people

1.1 Sexually transmitted infections

1.2 Under 18s conceptions

2.0 Young people's sexual health services: delivery and standards

2.1 Standards

2.2 Access

2.3 Consent and confidentiality issues for young people

2.4 Clinical assessment

2.5 STI diagnostics

2.6 Clinical Management

2.7 Service delivery and design

2.8 Online sexual health e-services

2.9 Information governance

2.10 Staff training

2.11 Referral pathways to other services

2.12 Patient and Public involvement

3.0 Safeguarding children and young people

3.1 Legislative framework and guidance

3.2 Multi Agency Working

3.3 Information sharing

3.4 Safeguarding referrals to children's social care

3.5 Child sexual exploitation

3.5.1 Definitions of CSA and CSE

3.5.2 Prevalence of CSE

3.5.3 Sexually transmitted Infections as a marker of CSE

3.6 Domestic violence

3.7 Local multi-agency safeguarding

3.7.1 MASE panels

3.7.2 MARAC meeting

3.8 Safeguarding training

3.8.1 Staff support and safeguarding supervision

4.0 Management of specific groups

4.1 Looked after children

4.1.2 Management of looked after children

4.1.3 UASC specific considerations

4.2 Children and young people with learning or physical disabilities

4.3 Female genital mutilation

4.3.1 The law relating to FGM

4.3.2 FGM safeguarding

4.3.3 Clinical assessment of FGM

4.4 Lesbian, gay, bisexual, transgender (LGBT) young people

4.5 Young women who have sex with women

4.6 Young men who have sex with men

4.7 Transgender young people

4.6 Young people living with HIV

4.7 Infants and children of parents living with HIV

5.0 The significance of STI diagnoses in children in relation to child sexual abuse

5.1 Risk factors for child or young person acquiring STIs

5.2 *Neisseria gonorrhoeae*

5.3 *Chlamydia trachomatis*

5.4 Bacterial vaginosis

5.5 Genital Mycoplasmas

5.6 Syphilis

5.7 Anogenital warts (HPV)

5.8 Oral warts

5.9 Genital herpes simplex virus

5.10 Hepatitis B

5.11 Hepatitis C

5.12 Human immunodeficiency virus (HIV)

5.13 *Trichomonas vaginalis*

5.14 Summary of the significance of STI diagnoses in children in relation to child sexual abuse

6.0 Screening and testing for STIs in Child Sexual Abuse

6.1 Recommendations for testing for STIs

6.2 Timing of tests

6.3 Testing for STIs in child sexual abuse

6.3.1 Indications for testing for STIs

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

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

6.3.3.1 Gonorrhoea

6.3.3.2 Chlamydia

6.3.4 Testing for STIs in child sexual abuse: good practice points

6.4 Forensic and legal aspects in CSA

6.4.1 Chain of evidence

6.4.2 Forensic and legal aspects in CSA: good practice points

6.5 Recommended STI tests (summarised in the flowcharts in Appendix 3)

6.5.1 Blood samples

6.5.2 STI testing in pre-pubertal females

6.5.3 STI testing in post-pubertal females

6.5.4 STI testing in young males

6.5.5 Presence of genital blisters or ulcers

6.5.6 Presence of ano-genital warts

7.0 Management of specific STIs and STI prophylaxis

7.1 Antibiotic prophylaxis for STIs in children and young people following sexual abuse

7.1.2 Gonorrhoea and Chlamydia

- 7.1.3 Syphilis
- 7.1.4 Hepatitis B
- 7.1.5 Hepatitis C
- 7.1.6 Herpes simplex virus (HSV)
- 7.1.7 Anogenital warts / Human Papilloma Virus (HPV)
- 7.1.8 Human Immunodeficiency Virus (HIV)

8.0 Auditable outcome measures for young people's sexual health services

9.0 Editorial statements

- 9.1 Statement of Editorial Independence
- 9.2 Conflicts of Interest
- 9.3 BASHH CEG Composition

Appendix 1: Writing group and methodology

Appendix 2: Electronic data collection form

Appendix 3: Young people's participation workshop plan and report

Appendix 4 Competency and consent to medical treatment

Appendix 5: STI treatment protocols

Appendix 6: CSE risk assessment

Appendix 7: Safeguarding supervision

Appendix 8: Flow diagrams for STI screening in children and young people

Abbreviations used

BV: bacterial vaginosis
BASHH: British Association of Sexual Health and HIV
CAMHS: child and adolescent mental health services
COE: chain of evidence
CSA: child sexual abuse
CSC: children's social care
CSE: child sexual exploitation
CYP: children and young people
DA: domestic abuse
DV: domestic violence
FGM: female genital mutilation
FSRH: Faculty of Sexual Reproductive Health
GDPR: General Data Protection Regulation
GMC: General Medical Council
HIV: human immunodeficiency virus
HPV: human papillomavirus
LAC: looked after child
LARC: long acting reversible contraception
LGBT: lesbian gay bisexual and transgender
MARAC: multi agency risk assessment conference
MASH: multi agency safeguarding hub
MSM: men who have sex with men
PEPSE: post exposure prophylaxis after sexual exposure
PSHE: personal, social, health and economic
RSE: relationship and sex education
SARC: sexual assault referral centre
SRH: sexual reproductive health

STI: sexually transmitted infections
UASC: unaccompanied asylumseeking children
UKMEC: UK Medical Eligibility Criteria
WSW: woman who have sex with woman
YP: young people

What's new in this guideline?

The updates in this guidance reflect the enormous societal changes for young people (YP) growing up in an increasingly sexualised society through their exposure to social media and internet pornography, the successful prosecution of perpetrators in high profile child sexual abuse (CSA) cases, and the increasing recognition of behaviours which identify children and young people (CYP) vulnerable to sexual abuse and exploitation across the UK. Safeguarding legislation and policies have become more robust in response to the challenging landscape and required the levels of healthcare professional safeguarding training, supervision and workload associated with reporting to multiagencies to increase.

Sexual health services play a key role in fostering positive, healthy attitudes towards YP's sexuality and relationships as part of their normal adolescent development. The provision of good quality sexual health services that are welcoming, friendly and non-judgemental ensures that health care professionals are able to support wellbeing and safeguard YP from harm, whilst balancing YP's rights to confidentiality.

Major updates to this guideline include:

- Reference to the Royal College of Paediatrics and Child Health publication: The Physical Signs of Child Sexual Abuse (2nd Edition) 2015
- Updated definitions for child sexual abuse (CSA) and child sexual exploitation (CSE) (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CS_E_Guidance_Core_Document_13.02.2017.pdf)
- All references to children include YP under the age of 18, in line with statutory safeguarding children procedures and policies
- Updates to consent and confidentiality regarding children in line with Health and Social Care Act (2013) and General Data Protection Regulation (2018) (<https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/children-and-the-gdpr/>)
- Includes references to amended Children's Act 2004 (April 2018) <https://www.legislation.gov.uk/ukpga/2004/31/contents>, updated Working Together to Safeguard Children July 2018 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf) reflecting the legislative

changes introduced through the Children and Social Work Act 2017

(<http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted>)

- Updates to the management of vulnerable groups
- Updated version of “You’re Welcome - refreshed standards for piloting.” Quality criteria for making health services young people friendly
(http://www.youngpeopleshealth.org.uk/yourewelcome/wp-content/uploads/2017/02/YoureWelcome_RefreshedsStandards.pdf)
- Brook / BASHH “Spotting the Signs”: a national pro-forma for identifying risk of child sexual exploitation in sexual health services (April 2014) (<https://www.brook.org.uk/our-work/spotting-the-signs-cse-national-proforma>)

Summary of key recommendations and good practice points

Section 2: Young people's sexual health services: delivery and standards (good practice points)

All YP under 18 years should have:

- An holistic sexual risk assessment including history of recreational drug and alcohol use
- A vulnerability assessment for self-harm, mental health and special educational needs and physical disabilities
- A risk assessment completed unless they object, using an assessment tool such as "Spotting the Signs" pro-forma (or a modified version)

All sexual health services should:

- Work towards achieving the "You're Welcome" quality standards to "get it right" for YP with diversity integrated into service design and publicity
- Have a confidentiality policy, which is clearly displayed and routinely discussed with YP at the beginning of their consultation
- Be compliant with General Data Protection Regulation 2018 and patient records management key data protection themes for CYP
- Undertake sexual health consultations for YP including a sexual health risk assessment and a discussion about reproductive health including contraception options for YP involved in heterosexual sex
- Encourage sexually active YP to have asymptomatic STI screening annually, following sex with new sexual partners, and repeat testing at 3 months following a diagnosis of an acute bacterial infection
- Ensure staff working with CYP have Level 3 safeguarding training
- Encourage YP under 18 years to participate in the national HPV vaccination programme, and if missed at school, signposted females to primary care to ensure catch-up and young MSM offered vaccination as part of Sexual Health and HIV services HPV vaccination programme for MSM

Online e-services good practice points

Online services should ensure appropriate screening for safeguarding concerns, including:

- Robust risk assessment for CSA and CSE, with measures in place to respond to allegations
- Follow-up with one to one contact to ensure effective transition from online to face to face interventions
- Use of e-services in those aged 18 years or under should be regularly evaluated including processes for assessment and escalation of safeguarding concerns when they become known.
- GDPR requires consent to the collection and storage of data and proof of capacity could be difficult to prove remotely for individuals under 16 years of age. Therefore it is recommended that under 16s are signposted to face to face services

Section 3: Safeguarding children and young people

Legislative framework and guidance: good practice point

Healthcare professionals should be familiar with key guidance and legislative requirements regarding safeguarding and promoting the welfare of children

Multi-agency working: good practice point

The involvement of health care professionals in multi-agency teams is especially important, as healthcare professionals are more likely to share information with other healthcare professionals such as primary care than with professionals from other agencies

Information sharing: good practice points

- Information sharing is a key factor in safeguarding and promoting the welfare of CYP
- Formal information sharing agreements with multi-agency panels are useful in defining the information governance of shared and stored information on victims and alleged perpetrators of CSA
- Patient identifiable information of sexual partners, provided by a YP under the age of 18 years for the purposes of STI partner notification, should not be shared, unless required by law or justifiable in the public interest or a serious safeguarding concern. Standard procedures using appropriate request forms should be reviewed by Trust / Service Information Governance systems and Safeguarding Leads
- It is suggested that prior to asking for person identifiable information on sexual partners for the purpose of STI partner notification, a YP is advised on the limits of confidentiality
- Prior to asking for person identifiable information on sexual partners for the purpose of STI partner notification, a young person should be advised on the limits of confidentiality

Safeguarding referrals to children's social care: good practice points

- Sexual health services should have a named departmental lead for safeguarding CYP who is able to support MDT safeguarding discussions and decision making for referrals and provide safeguarding supervision (Appendix 2)
- A CSC or MASH referral is always appropriate where sexual activity or diagnosis of an STI involving a pre-pubertal child or child aged under 13 years is suspected or known

- Where a child or young person is known to be under the care of social services, specific MDT consideration and discussion should be taken to inform safeguarding concerns to CSC and involve the social worker in further assessments that may be needed

Child sexual exploitation: key recommendations

- For sexual health services, the recommended CSE assessment tool is Spotting the Signs, a national proforma developed by BASHH and Brook (Grade 1C)
- Presentation with bacterial or protozoal STIs in children aged 13–15 years old may be considered a potential marker for CSE. It would be prudent to consider CSE, perform an in depth assessment and discuss referral to social services with named / designated safeguarding doctor for any children under 16 years old presenting to services with a bacterial or protozoal STI (Grade 1C)
- It is important to consider the possibility of CSE in all sexually active YP, including those aged 16 and 17 years of age, however any information sharing with multi-agencies must be balanced with the risk of undermining the confidentiality of YP in safe, consensual relationships (GPP)

Child sexual exploitation: good practice points

- Sexual exploitation is often linked to other issues in the life of a child or YP and Working Together makes clear the requirements for holistic assessment for heightened vulnerability factors
- Early sharing of information within a multi-agency professional team is key to providing effective help where there are emerging problems

Domestic violence: key recommendation

- Sexual health services should routinely screen YP for DA, including intimate partner violence as part of sexual health consultations (Grade 1C)
- DA training and resources should include increasing sexual health professional's awareness and response to supporting YP experiencing DA (Grade 1C)

Section 4: Management of specific groups

Looked after children: good practice points

- There should be local partnerships and clear pathways between LAC and sexual health services to facilitate ease of access and appropriate timely response to assessment referrals
- Information sharing agreements between multi-agencies should outline when confidentiality can be upheld to ensure that competent LAC and care leavers with capacity have the same rights to access confidential sexual health services as non LAC
- LAC health assessment records should be accessible and the contact details of key workers and professionals involved with the YP should be recorded
- Sexual health services should have pathways into the LAC Health Network Integrated Pathway for UASC
- UASC may be at higher risk of blood borne viruses, via vertical or horizontal transmission, due to the increased prevalence of infection in their country of origin. STI screening must therefore take endemic risk into consideration

Children and young people with learning or physical disabilities: good practice points

- Sexual health services can help to prevent, identify and manage exploitation and abuse in YP with disabilities by ensuring that services are accessible for YP with disabilities and that reasonable adjustments are made such as to accessibility, visual aids and tools to support communication such as sign language
- Sexual health services should provide specific training for staff managing YP with disabilities including those with neurodevelopmental disabilities, and provide facilitated access, easy read materials and offer advocacy and support
- Sexual health services should engage with local YP's learning disability teams to ensure clear pathways between services and share information where indicated to promote safeguarding and improve health outcomes

Female genital mutilation: good practice points

- Health care practitioners should offer psychosocial support to CYP affected by FGM, including referral to specialist FGM services
- Referral to CSC is indicated if there are concerns or suspicion that a child under 18 is at risk of FGM. If there is an imminent risk, the police should be alerted immediately by calling 999
- Confirmation that FGM has been carried out maybe required as part of a safeguarding or criminal investigations
- To maximise the opportunity to confirm the diagnosis of FGM and related injuries and reduce the need for repeated examinations, clinical assessment should be performed by an experienced clinician

Young LGBT people: good practice points

- All staff working in sexual health services should have appropriate equality and diversity training which includes accurate and appropriate information about gender diversity, supported by equality, diversity and inclusion policies and a transparent complaints procedure
- Young LGBT people should be signposted to specialist services, where they can access expert guidance and support, individually tailored to their mental health well being and healthcare needs
- STI screening tests for young LGBT people should be based on a sensitive risk assessment, should include extra genital sampling from exposed sites, be non-invasive and include serological testing for blood borne viruses
- Reproductive health, including contraception and LARC options should be discussed given that young WSW have higher rates of unplanned teenage pregnancy
- Contraception should be explored in young trans men where there is a risk of pregnancy and advice can be sought from FSRH guidance around hormonal drug interactions
- Manangement for young LGBT people should include STI prevention strategies such as vaccination against Hepatitis B, Human Papillomavirus (in MSM 45 years and under) and Hepatitis A (in outbreaks), support in negotiating safer sex and risk assessment for PEPSE and PrEP

- The risks and benefits of providing PrEP for YP should be weighed carefully in the context of UK laws and judgements about autonomy in healthcare decision-making and by assessing competency and capacity, balanced against protecting YP from harm
- There are limited data on the use of PrEP in YP under 18 years. Use should be on a case by case basis taking into consideration vulnerabilities, competency and capacity to consent to treatment and ongoing high risk sexual activity
- When discussing PrEP, it is important to ascertain the types of sex YP are engaged in, to advise appropriate timing of drug dosing schedules to ensure adequate drug tissue penetration in genital sites such as the vagina
- In young transgender people who are having only anal sex, following a careful risk assessment on-demand PrEP could be used as it is likely to have the same biological efficacy as seen in older MSM populations

Young people living with HIV: good practice points

- Transition from paediatric to adult HIV services should centre on the individual and YP should have a documented transition plan in line with national guidance
- Young people should have multidisciplinary team support for antiretroviral drug adherence and should include peer support if available
- Young people should be made aware of the important TaSP and U=U public health promotion messages to support ongoing optimal drug adherence

Section 5: The significance of STI diagnosis in pre-pubertal children in relation to child sexual abuse

Summary statements taken from “The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice (2nd Edition)” 2015

- There have been relatively few studies where children with a particular STI have been evaluated for the possibility of CSA. This has resulted in a limited base to determine whether a particular STI is a marker of CSA
- Only two included studies across all STI infections were conducted on UK populations. Most of the studies have been undertaken elsewhere and prevalence rates from these may not be applicable to UK populations
- Sexual contact was demonstrated in at least one third of children infected with *Neisseria gonorrhoea*, *Chlamydia trachomatis* and anogenital warts, suggesting that abuse should be strongly considered in children with these infections. A high prevalence of abuse was also found in studies on *Trichomonas vaginalis*, genital herpes and HIV although population numbers were small
- The evidence base for syphilis, hepatitis B and C was too limited to offer any information on the association between the presence of infection (which can be sexually transmitted in adults) and abuse. In adults, syphilis is virtually always sexually transmitted
- The evidence reviewed does not provide guidance on the age at which perinatal transmission of a particular STI can be excluded. In general, studies did not rigorously consider and exclude alternative modes of transmission. Attributing infection to perinatal transmission is difficult in very young children who are pre-verbal and cannot disclose abuse, and the possibility of sexual abuse should always be considered
- For *N. gonorrhoea*, *C. trachomatis*, anogenital warts and *T. vaginalis*, the likelihood of a STI in sexually abused children increased with the child's age. However, the interpretation of this finding is complicated by a lack of consideration of consensual sexual activity in adolescents, the difficulties in obtaining an allegation of abuse in young children and incomplete information about how other modes of transmission were excluded

- Penetrative sexual contact is associated with an increased risk of infection by *N. gonorrhoeae*, *C. trachomatis*, *T. vaginalis* and HIV
- The possibility of abuse in children with an STI should be considered and thoroughly investigated in all cases, given the wealth of research on the pathogenicity and sexual transmission of STIs in adults. Trained and experienced sexual health clinicians have a key role as expert witnesses in CSA medico-legal cases and in supporting clinical pathways for STI testing and screening in children and adults in child protection cases as part of a multidisciplinary team

Section 6: Screening and testing for STIs in relation to child sexual abuse

Good practice points taken from “The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice (2nd Edition)” 2015

Testing for STIs in child sexual abuse

- Examination of a pre-pubertal child should be undertaken by an experienced paediatrician either as a single or a joint examination with a complementary suitably qualified forensic clinician or genitourinary medicine physician with the appropriate expertise, skills and knowledge as the case demands
- Consideration should be given to the clinical environment and setting for the examination to minimise distress and put the child or YP at ease
- 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, should be understood. It is recommended that interpretation of positive bacterial and protozoal STI NAAT results should be done in collaboration with genitourinary medicine and microbiology specialists

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

- Where there has been an allegation of any abuse, then triple site sampling 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, vulvo-vestibular swabs inside the labia minora but avoiding the hymen should be used. Trans-hymenal sampling should only be taken in exceptional circumstances with the smallest ENT swab by a senior experienced clinician, if it is possible to pass a swab without causing distress ie there is a wide hymenal opening diameter or the child is being examined under anaesthesia. Urine NAATs can be used as screening tests in young females if swabs are not feasible, but have lower sensitivity compared with vulvo-vaginal swabs in adults
- First-pass urine for NAAT testing should be undertaken in young males

- Self-sampling can be considered where age appropriate and the child or young person has a preference. However in the case of a positive STI test result, sampling may need to be repeated by a clinician in order that the result's validity is not challenged in medicolegal proceedings

Forensic and legal aspects in CSA

- Services undertaking Paediatric Sexual Offence Medicine should comply with the service standards required for training, workplace based supervision, CPD, to enable CYP up to the age of 18 years to be seen by clinicians for single and joint paediatric forensic assessments depending on the availability, skills and competences of individual examiners
- A child protection examination should only be carried out if it is necessary and appropriate in the circumstances and it is clear whether the outcome is likely to affect the proposed course of action. Consideration should be given to the child or YP having the option of having another adult present during the examination (this might be a parent, or an independent chaperone, as appropriate). Repeated examinations should be avoided as these may be harmful to the child or YP
- If the presence of an STI is to be used in medico-legal proceedings then services should ensure that pathways are in place for COE samples to be taken. Ideally, a COE should be in place in all CSA cases and positive samples stored. However, if an infection is found but there was no COE performed, the test should be repeated with a COE in place

Scope and purpose

This is an update of the 2010 BASHH guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People. This guideline is designed for use in UK Genitourinary Medicine (GUM) clinics and sexual health services, where children and YP under 18 years are seen for sexual health care, there are concerns about child sexual abuse (CSA), or where a sexually transmitted infection (STI) has been detected. The law relating to CYP is complex and differs across the UK. Healthcare professionals should have some understanding of the law as it applies where they practise and should seek up-to-date legal advice in individual cases.¹

These recommendations may also apply in other UK health care settings providing sexual health advice, management or treatment to YP, such as general practice, sexual assault referral centres (SARCs), contraception and sexual health clinics (CASH), child and adolescent mental health services (CAMHS), and gynaecology, antenatal, abortion, emergency and paediatric services.

The guidance includes recommendations on the assessment, examination, and diagnostic tests for the effective management of children and YP at risk of, or who have, an STI. It offers guidance to healthcare professionals working in sexual health services on consent and confidentiality issues when managing CYP as part of the wider multiagency safeguarding partnership.

Many of the principles in this guidance may also apply to YP aged under 25, who have special educational needs, or who are vulnerable young adults leaving social care, however the approach and law regarding consent, confidentiality and responding to safeguarding needs will differ for adults depending on their decision-making capacity.

The document is designed primarily to provide guidance on the direct clinical care of CYP but also makes reference to the delivery of services with the aim of supporting clinicians and commissioners in providing effective services for CYP.

This document does not provide guidance on the treatment of individual conditions or sexually transmitted infections where this is covered in the British Association for Sexual Health and HIV (BASHH) guidelines, but outlines best practice in multiple aspects of the sexual health care of CYP.

¹ General Medical Council: 0–18 years: guidance for all doctors. Updated April 2018. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years>

Introduction and Methodology

Methods

A writing group with expertise in working with CYP were invited to undertake a review and agree updates to the 2010 BASHH guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People. Writing group members were assigned topics relating to their expertise and specialist knowledge, agreed updates and frequent queries to the BASHH Adolescent Specialist Interest Group (see Appendix 1: writing group and methodology). The writing group was asked to follow the methodology as outlined in the search strategy and provide an audit trail regarding their search strategy (see Appendix 2: electronic data collection form).

Search strategy

This document was produced in accordance with guidance set out in the BASHH Clinical Effectiveness Group (CEG) document 'Framework for guideline development and assessment' published in 2015 at <http://www.bashh.org/guidelines>. The GRADE system for assessing evidence was adopted and recommendations made accordingly. Where there was a lack of evidence to underpin recommendations or if guidance was based on other best practice documents, then good practice points (GPP) were adopted.

Article titles and abstracts were reviewed by the working group. Priority was given to randomised controlled trial and systematic review evidence, and recommendations made and graded on the basis of best available evidence. Medline and PubMed searches from 1998 – 2015, using search terms child and STI, safeguarding, CSE, sexual, exploitation, testing and diagnostics were documented on audit trail.

Given the wide scope of this guidance document and rapidly changing safeguarding CYP landscape of statutory legislation and resulting policies, the grey literature, third sector and expert opinion were used for some sections of the guidance.

The STI section of the RCPCH Physical signs of child sexual abuse (2015), an evidence based review and guidance for best practice, was adapted for use (with permission). This document reviews the significance of sexually transmitted infections and sexual abuse in girls and boys younger than 18 years of age. The evidence statements in this section are based on the best available evidence up to 31st March 2014, using search strategies run on MEDLINE database (Jan 2007 to March 2014) and EMBASE databases (January 2007 to March 2014) using the OVID interface. For each topic area, abstracts were

independently reviewed by at least one member of the working group and a member of the research team. For the STI section, studies were included if they met the predefined criteria:

- Any primary study reporting STIs in children or young persons under 18 years of age where CSA has been confirmed in the study group
- Any primary study reporting an STI in newborns or children under 18 years of age where CSA had been rigorously excluded.

The data extraction and quality standards form [[https://www.rcpch.ac.uk/sites/default/files/2018-02/physical signs of child sexual abuse - data extraction and quality standard forms.pdf](https://www.rcpch.ac.uk/sites/default/files/2018-02/physical_signs_of_child_sexual_abuse_-_data_extraction_and_quality_standard_forms.pdf)],

included studies in the evidence base section by chapter

[[https://www.rcpch.ac.uk/sites/default/files/2018-02/physical signs of child sexual abuse - included studies in the evidence base section by chapter.pdf](https://www.rcpch.ac.uk/sites/default/files/2018-02/physical_signs_of_child_sexual_abuse_-_included_studies_in_the_evidence_base_section_by_chapter.pdf)] and literature searches

[[https://www.rcpch.ac.uk/sites/default/files/2018-02/physical signs of child sexual abuse - literature searches.pdf](https://www.rcpch.ac.uk/sites/default/files/2018-02/physical_signs_of_child_sexual_abuse_-_literature_searches.pdf)] can be found on RCPCH website.

Piloting and feedback

The first draft was produced by the writing group, with input from a young people's participation workshop in partnership with Brook, BASHH Patient Public Involvement panel and Adolescent Specialist Interest Group. Young peoples perspectives on sexual health services, confidentiality and consent to disclose information were also drawn from other resources (see Appendix 3: young people's participation workshop plan and report). The draft was then circulated to BASHH CEG for review using the AGREE appraisal tool. The second draft was piloted on BASHH website for wider consultation and simultaneously reviewed by the BASHH Patient Public Involvement panel and external stakeholders. The final draft was presented to the CEG for review and piloting in the clinics.

Future guidance updating

To ensure the contents remains applicable and up to date, a review and updating of the document is intended five years after publication.

Stakeholder involvement (to be completed post-public consultation)

- YP input / workshop facilitated by Brook (August 2017)
- Brook
- Invited professionals to the writing group
- BASHH Adolescent Specialist Interest Group input

Section 1: The epidemiology of STIs and conceptions in children and young people

1.1 Sexually transmitted infections

Data regarding STI diagnoses in the UK are collated by public health bodies from a number of sources, including data supplied by sexual health services Genitourinary Medicine Clinical Activity Dataset (GUMCAD) and from the National Chlamydia Screening Programme (NCSP).^{1,2} These data do not distinguish between STIs acquired in consenting sexually active adolescents and victims of child sexual abuse, though all individuals aged less than 13 years should be considered in the latter group.

Combined data from Public Health England and Health Protection Scotland indicate that between 2009-2014 an average of 6394 individuals aged under 16 were diagnosed with a STI each year, a very small percentage of whom were aged under 13 years (1.5% in England and 0.8% in Scotland).^{3,4,5} The prevalence of STIs was much higher in the 16-19 cohort, with a mean of 93,713 individuals being diagnosed with a STI in this group per annum. The vast majority (87%) of STIs in under 16s were in females; however, this gender difference was less pronounced in under 13s (62% female and 38% male). The Public Health Agency data sharing policy for GUMCAD STI surveillance in Northern Ireland ensures that STIs with cell values of 1-4 are masked, such that very limited information on new STI diagnoses is available in the under 16-years age group. On average, 11 STIs in children aged <16 years were diagnosed each year between 2015-2017, with 80% of STIs in females and the majority of the infections being chlamydia.⁶

Chlamydia remains the most commonly diagnosed STI in England, with more than 128,000 diagnoses among YP aged 15-24 years of age in 2016 followed by genital warts, HSV, and gonorrhoea.⁷ Since the introduction of the UK HPV vaccination programme in 2008 for adolescent girls, surveillance data suggest that the programme has contributed to a significant decrease in rates of the two main cancer causing human papillomaviruses in women.⁸ The high vaccine effectiveness and herd-protection in lowering HPV prevalence among females and males who are not currently vaccinated has seen a 62% reduction in the rate of first episode genital warts in young men in England since 2009 and a 72% decrease in young women.⁹ Data from integrated sexual health services in Wales indicate that, between 2015 and 2017, an average of 89 individuals aged under 16 were diagnosed with a STI* each year.¹⁰ In the same period, an average of 2552 individuals aged 16-19 were diagnosed with an STI annually in Wales. The majority of all STIs diagnosed in under 16s in this period were in females (92.5%), however this gender difference was less pronounced in 16-19 year olds (70% in females). Higher STI diagnoses in females in these age groups is likely due to a similar difference in STI testing seen at sexual health

services, where 72% of all 16-19 years olds tested in sexual health services are females, compared to males of the same age. Chlamydia remains the most commonly diagnosed STI in YP in Wales, with 4,459 diagnoses amongst people aged 15-24 years of age in 2016, followed by genital warts, HSV, and gonorrhoea.

Further data regarding the prevalence of STIs in children are available from prospective studies conducted by the British Paediatric Surveillance Unit (BPSU; <http://www.rcpch.ac.uk/bpsu>). The BPSU monitored STIs including chlamydia, gonorrhoea, syphilis and trichomonas, reported in under 13s between January 2010-12 and demonstrated an overall incidence of 0.075 cases per 100 000 children per year.¹¹ Most were identified because they presented with symptoms and child sexual abuse was confirmed or suspected in 10 of these 15 cases. A number of studies looking at the prevalence of STIs in child sexual abuse victims have reported rates of between 0.4–7.5%, with the majority of cases being found in female victims.^{12,13,14,15,16}

Limitations impacting on the ability to establish the true prevalence of STIs in YP include:

- Access to appropriate services, which may be particularly relevant to victims of child sexual abuse
- Not all YP with an STI will have a diagnosis made, particularly relevant in asymptomatic individuals
- Young people's lack of knowledge regarding STI transmission and the need to test for STIs particularly in asymptomatic individuals
- STI data collection may be affected by recording errors including incorrect dates of birth (adults wrongly coded as children and vice versa; this may be important in those using on-line STI testing services)
- Cases where an infection has been diagnosed which was not sexually transmitted (i.e. through autoinoculation or ante/perinatal transmission)
- STI datasets may not include information about STIs diagnosed outside the setting of sexual health services

1.2 Under 18s conceptions

The Office for National Statistics (ONS) reports for women aged under 18 in England and Wales in 2018, there were 16.8 conceptions per 1,000 women aged 15 to 17 years, a reduction of 62.7% since 1998, the baseline year of the Teenage Pregnancy Strategy. The rate of under-16s conceptions is 2.5 conceptions per 1,000 women a decrease by 69.9% since 1999 ¹⁷ Similarly, in Scotland, teenage pregnancies are at their lowest level since reporting began in 1994, with rates for under 18s and under

16s are 16.9 and 2.7 conceptions per 1.000 women respectively in 2018.¹⁸ Teenage pregnancy rates have reduced across all levels of deprivation in recent years, with rates in the most deprived areas falling more.¹⁹

Factors explaining the recent reductions in under-18 conceptions in the UK include:

- Programmes to improve relationship and sex education, access to contraceptive services and contraceptive publicity²⁰
- Shift in aspirations of young women towards education and the perceived stigma associated with being a teenage mother (although for some young women, pregnancy may be planned and a positive life choice)^{21,22}

However, YP continue to be at highest risk of unintended or unplanned pregnancy, and teenage births remain higher than comparable Western European countries with a strong correlation with socioeconomic deprivation and teenage pregnancy.

England, Scotland and Wales have highlighted the need for further progress on reducing teenage pregnancy and published evidence-based guidance.²³

¹ GUMCAD data set; Available at: <https://www.gov.uk/government/collections/sexually-transmitted-infections-stis-surveillance-data-screening-and-management> (accessed 29th August 2018)

² NCSF data set; Available at: <https://www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp> (accessed 29th August 2018)

³ Freedom of information request response, Public Health England; March 2018

⁴ STI data tables, Public Health England. Available at :

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/534555/2015_Table_2_New_STI_diagnoses_rates_by_gender_sexual_risk_age_group_2011-2015.pdf (accessed 29th August 2018)

⁵ Personal Communication, Dr Lesley Wallace, Health Protection Scotland; March 2018

⁶ Personal communication, Dr Neil Irvine, Consultant in Health Protection, PHA Northern Ireland; Feb 2018

⁷ Public Health England STI data tables, 2016. Available at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables> (accessed 29th August 2018)

⁸ Mesher D, Panwar K, Thomas SL, et al Continuing reductions in HPV 16/18 in a population with high coverage of bivalent HPV vaccination in England: an ongoing cross-sectional study *BMJ Open* 2016;6:e009915. doi: 10.1136/bmjopen-2015-009915

⁹ Cameron RL, Kavanagh K, Pan J, et al. Human Papillomavirus. Prevalence and Herd Immunity after Introduction of Vaccination Program, Scotland, 2009–2013. *Emerging Infectious Diseases*. 2016;22(1):56-64. doi:10.3201/eid2201.150736.

¹⁰ Personal communication, Caroline Harris, Public Health Wales (16th Jan 2019)

¹¹ Gonorrhoea, Chlamydia, syphilis and trichomonas in children under 13 years of age: national surveillance in the UK and Republic of Ireland; Reading et al: *Archives of Disease in Childhood*; Volume 99, Issue 8 (<http://adc.bmj.com/content/99/8/712.long>)

¹² Sexual Assault and Abuse of Children: Hammerschlag M; *Clin Infect Disease* (2011) 53 (<https://academic.oup.com/cid/article-lookup/doi/10.1093/cid/cir700>)

¹³ The epidemiology of sexually transmitted infections in suspected child victims of sexual assault: Girardet et al: *Paediatrics*, 2009, vol 124 (pg79-86) (<https://www.ncbi.nlm.nih.gov/pubmed/19564286>)

¹⁴ Sexually transmitted infections in alleged sexual abuse of children and adolescents: Kelly et al: *J Paediatric and Child Health*, 2006, Jul-Aug 42 (7-8) (<https://www.ncbi.nlm.nih.gov/pubmed/16898881>)

¹⁵ Bacterial colonization in suspected sexually abused children: Kohlberger et al, *J Paediatric and Adolescent Gynaecology*, 2007, vol 20 (pg289-92) (<https://www.ncbi.nlm.nih.gov/pubmed/17868895>)

¹⁶ Simmons et al. Child sexual abuse examination: is there a need for routine screening for N gonorrhoeae and C trachomatis? *J Paediatric and Adolescent Gynaecology*, 2005, Oct 18 (5) (<https://www.ncbi.nlm.nih.gov/pubmed/16202938>)

¹⁷ Office for National Statistics, 2018. Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/datasets/conceptionstatisticsenglandandwalesreferencetables> (accessed 29th August 2018)

¹⁸ Public Health Scotland. Teenage Pregnancies. Available at: <https://beta.isdscotland.org/find-publications-and-data/population-health/births-and-maternity/teenage-pregnancies/> (accessed 10th March 2021)

¹⁹ Wellings K et al. 2016. Changes in conceptions in women younger than 18 years and the circumstances of young mothers in England in 2000-12: an observational study. *Lancet* 388 (10033), 586-595. 6 August 2016.

²⁰ Kaye Wellings, Melissa J Palmer, Rebecca S Geary et al. Changes in conceptions in women younger than 18 years and the circumstances of young mothers in England in 2000–12: an observational study. *Lancet* vol 388: 10044; 555-623.

²¹ Stijn Broecke and Joseph Hamed. *Gender Gaps in Higher Education Participation: An Analysis of the Relationship between Prior Attainment and Young Participation by Gender, Socio-Economic Class and Ethnicity*, Department for Innovation, Universities and Skills; HM Government, 2008. Available at:

https://webarchive.nationalarchives.gov.uk/20121106153906/http://www.bis.gov.uk/assets/biscore/corporate/migratedD/publications/D/DIUS_RR_08_14 (accessed 29th August 2018)

²² Kyla Ellis-Sloan, Teenage Mothers, Stigma and Their 'Presentations of Self', *Sociological Research Online*, 19(1):9 (2013). Available at: <http://www.socresonline.org.uk/19/1/9.html> (accessed 29th August 2018)

²¹ Personal communication Public Health Wales, 16th Jan 2019, Caroline Harris

²³ PHE Teenage pregnancy prevention framework: Supporting young people to prevent unplanned pregnancy and develop healthy relationships: May 2018 <https://www.gov.uk/government/publications/teenage-pregnancy-prevention-framework>; Pregnancy and Parenthood in Young People Strategy 2016-2019, March 2016 <https://www.gov.scot/publications/pregnancy-parenthood-young-people-strategy/>

Reducing Teenage Conception Rates in Wales: Project Report March 2016

<http://www.wales.nhs.uk/sitesplus/documents/888/Teenage%20conceptions%20in%20Wales%20%20FINALv1.pdf>. (Accessed 10th March 2021)

Section 2: Young people’s sexual health services: delivery and standards

2.1 Standards

This section should be read in conjunction with the BASHH 2019 Standards for the Management of STIs, 2019 FSRH/BASHH standards for Online and Remote Providers of Sexual and Reproductive Healthcare services, 2016 FSRH service standards for Sexual and Reproductive Healthcare, 2018 DHSC / PHE Integrated Sexual Health Services A suggested national service specification and National Chlamydia Screening Programme (NSCP): standards.^{1,2,3}

Young people’s service standards should ensure patient safety and ensure services are effective, well led and accountable.^{1,3} Services should monitor their performance using key performance indicators and have a clinical governance framework.³ Sexual health services contribute to measures in the Public Health Outcomes Framework, which includes under 18 conceptions and chlamydia detection (15-24 year olds).

As part of a wider multiagency whole system approach to sexual health delivery, young people’s services should partner with local authority public health teams to deliver flexible services across a joined-up network, and work alongside voluntary, health and education sectors to provide integrated services where need is greatest.

Sexual Health services should recognise the diversity of YP and the impact that equality issues have on their health and well being. Services should work towards achieving the “You’re Welcome” quality standards to “get it right” for young people.⁴

There are seven quality standards each split into essential as selected by YP as key to making a health service YP friendly which need to be met and at least two additional criteria: In addition, there is a specialist service subheading for providing high quality health services for sexual and reproductive health [SRH] services:

- Involving YP in their care and in the design, delivery and review of services
- Explaining confidentiality and consent
- Making YP welcome
- Providing high-quality health services
- Improving staff skills and training
- Linking with other services
- Supporting young peoples changing needs

The You're Welcome refreshed standards were piloted in 2017 and publication of an updated self assessment tool is awaited.

2.2 Access

Young people with sexual health needs should have access to a range of local confidential services for STI testing and treatment and contraception provision.^{1,3} Services should be advertised via various media, including online and social media platforms and should be accessible at convenient times for YP, such as after school and college and at the weekend. Marginalised YP who may not be effectively reached by existing services or through traditional health channels should have high quality outreach services commissioned in community settings.

2.3 Consent and confidentiality issues for young people

Open access sexual health services should be aware that YP may register under a pseudonym and need to work with YP to gain confidence to disclose their correct personal identifiers. All sexual health service users should be made aware of their rights to confidentiality.^{1,3}

The limits of confidentiality should be discussed with YP at the beginning of their consultation and the need to share information with multiagency support partners, when a clinician has concerns about the wellbeing or safety of the young person or others.⁵ If confidentiality is breached, YP should be informed of what, who and why information is being shared. Consent should be sought from the YP to share information in their best interests, unless there is a compelling reason not to, for example, as required by law or justifiable in the public interest or a serious safeguarding concern.⁶

2.4 Clinical assessment

Young people accessing services should have a comprehensive medical and sexual history taken, elicited in a holistic sensitive and non-judgmental manner.^{1,2} A YP's competency and capacity to consent should be assessed and documented, be based on their emotional and intellectual maturity and their ability to understand the proposed treatment [see Appendix 4: competency and consent to medical treatment]. Gillick competency⁷ is applied to under 16's and the Mental Capacity Act to 16 and 17 year olds and presumes capacity to consent to surgical, medical and associated procedures unless it is established the person lacks capacity.⁸ It has specific relevance in YP with learning disabilities and in circumstances where there is impaired decision making eg substance misuse including alcohol.⁹

All YP under the age of 18 should have a risk assessment completed unless they object, by using an assessment tool such as the Brook / BASHH “Spotting the Signs”¹⁰ to identify vulnerability and safeguarding issues.

Young people have the right to be involved in their healthcare and receive relationship and sex education (RSE) information as part of personal, social, health and economic (PSHE) education appropriate to their age, maturity and understanding to support healthy choices in negotiating safer sex.

Young people attending sexual health services do not require an intimate genital examination unless indicated by medical concerns raised in their consultation. Asymptomatic YP should be offered non-invasive STI screening including sampling from extra genital sites as indicated by their risk assessment, to reduce barriers to the uptake of STI tests. If a genital examination is required, verbal consent should be sought and an appropriately trained chaperone offered. The offer, identity of chaperone and outcome should be documented in the patient’s medical record.¹¹

2.5 STI diagnostics

Services offering STI testing in YP should ensure sexual health service standards are met by:

- Following the latest BASHH guidelines for the testing of individual STIs
- Meet the recommended STI turnaround times from testing to results to ensure rapid access to STI treatment
- Achieve STI partner notification standards for untreated contacts

2.6 Clinical Management

Treatment of STIs should be managed in accordance to the latest BASHH guidelines. In under 16s, consideration should be made to appropriate dosing according to age and weight and paediatric licensing of antimicrobials (see Section 7 and Appendix 5: STI treatment protocols).

It is the responsibility of all sexual health providers to provide access to healthcare for sexual contacts who may be at risk of infection from an individual (index case) diagnosed with a sexually transmitted infection (STI). The STI partner notification process includes providing access to advice, testing and if appropriate treatment for known sexual contacts.

2.7 Service delivery and design

When considering service delivery and design, a “one-stop” model of integrated SRH is preferred by YP.

Contraception and sexual health needs should be met, adhering to FSRH guidance for contraception provision and choice for females.¹² An assessment of pregnancy risk, need for emergency contraception and ongoing contraceptive needs should form part of routine evaluation. Young people should have access to all methods of contraception including LARC. Choice of contraception should consider FSRH UK Medical Eligibility Criteria (UKMEC) recommendations,¹³ noting that considering age alone, the UKMEC for all contraceptive options are either a category 1 or 2.

Sexual health services should include teenage pregnancy support and advice for both females and males,¹⁴ with pathways for abortion services and antenatal care.

Sexually active YP should be encouraged to participate opportunistically in the National Chlamydia Screening Programme (NSCP) with asymptomatic STI screening annually, with new sexual partners and retesting at 3 months following a diagnosis of an acute bacterial infection.¹⁵

Young people under the age of 18 years should be encouraged to participate in the HPV vaccination programme offered to females and males (aged 12-13 years) in school year 8. If missed at school, YP should be signposted to the catch up programme in primary care for females under 18 years and for young MSM to specialist Sexual Health Services and HIV clinics offering the HPV vaccination programme for MSM.¹⁶

Young people under the age of 18 years should be offered STI prevention strategies such as against Hepatitis B and A (in outbreaks) vaccination, PEPSE and PrEP, with tailored and individualised clinical decisions, based on risk assessment on their sexual behaviour and the sexual behaviour of their partners.

2.8 Online sexual health e-services

Sexual health services are increasingly offered online, providing sexual health care to individuals aged 16 years and over in many parts of the UK. Online services may provide access to care for marginalised and vulnerable groups, and allegations of child sexual exploitation (CSE) and or other safeguarding concerns may be supported by the anonymous nature of the service.^{17,18,19}

Online sexual health services should provide a comprehensive approach to risk identification and assessment as well as support of CSE disclosures in remote consultations². Effective transition from online to clinic services after disclosure is an essential element of this process and YP aged <16 years should be offered face to face consultations with clear pathways in place to signpost them.²⁰ Sexually

active YP aged between 16-18 years should have a risk assessment for CSE using a tool such as 'Spotting the signs' by an appropriately trained healthcare professional (see Appendix 6: CSE risk assessment).¹⁰ Pathways should also be in place for a physical examination if indicated.

Staff who consult with YP via online clinical services should be compliant with Level 3 Safeguarding CYP training and have the same clinical skills and competencies needed for similar face to face consultations. Providers should ensure that policies for safeguarding are available to all staff and that there is a designated Safeguarding Lead within the service. Services must comply with national and local policies on safeguarding YP and have systems in place for escalation of safeguarding concerns when they become known. They should regularly assess and review any limitations of communicating via online methods.

The General Data Protection Regulation (GDPR) 2018²¹ states that:

- "Children require specific enhanced protection with regard to their personal data as they may be less aware of the risks, consequences and safeguards concerned and their rights in relation to the processing of personal data."
- Children have the same rights as adults over their personal data and this includes rights to access their data, request correction, object to processing and have their data erased. Children aged <13 years cannot consent in an online setting.

GDPR and data protection laws expect services to demonstrate that individuals aged under 16 years have the capacity to consent to their data being collected and processed remotely. Legally this is difficult to prove through an online service without confirming age and identification, and therefore it is recommended that individuals aged under 16 years are signposted to face to-face services.

2.9 Information governance

Sexual health services should ensure that health information collected about YP complies with standards for record keeping and management^{22,23}. Information should only be shared with other professionals if it is in the service users' best interest, such as for safeguarding or for Public Health reporting purposes. Sexual health services, where patients do not have to provide their personal information to access care are excluded from reporting to the Health and Social Care Information Centre (HSCIC) Female Genital Mutilation (FGM) Enhanced Dataset in England.²⁴ However, services do have responsibilities to share information to ensure an appropriate safeguarding response. Services must report FGM to the police in females under 18 years (see Section 4.3).

The duration of retention for children's health and social care records is until the 25th birthday (or if

the patient was 17 years at the conclusion of the treatment, until their 26th birthday).²² Records should be reviewed prior to destruction for any serious incidences that could extend the retention, or where an implant or device has been inserted (in which case the records retention period is 10 years). The Independent Inquiry into Child Sexual Abuse (IICSA) has requested that the health and social care sector do not destroy any safeguarding and incident reports or complaints and enquiries that are, or may fall into, the remit of the inquiry. The retention schedule applies to electronic patient record systems.

Where sexual health information is shared for public health reporting, data should be anonymised. Caution should be exercised with Freedom of Information requests as the number of case reports in YP are small and individuals may be identifiable.²⁵ Staff should be trained in the legal requirements the Freedom of Information Act 2000 as they apply to health services.

2.10 Staff training

Staff should be appropriately trained for their role according to BASHH and FSRH recommended standards and competencies.^{1,2} All clinical staff should be compliant with Level 3 CYP safeguarding training and have opportunities for safeguarding supervision (see Appendix 7: Safeguarding supervision). All clinical staff should be aware of the legislation regarding sexual activity in YP, risk indicators for CSE and follow local safeguarding policies.

2.11 Referral pathways to other services

Young Peoples services should have referral pathways to other local statutory and allied clinical services, such as Child and Adolescent Mental Health services [CAMHS], Drug and Alcohol services, children's social care (CSC), abortion care, Paediatric, and Sexual Assault centres (SARC)], to facilitate care pathways as needed.^{1,2}

2.12 Patient and Public involvement

Services should provide evidence that user and public involvement is integral to service development, monitoring and evaluation.^{1,2} Young people should be consulted about the development and delivery of local young people's services. Services should consider innovative methods including using social media platforms to gain young people's views.

- ¹ BASHH Standards for the Management of STIs in Outreach Settings (2016). Available at: <https://www.bashh.org/about-bashh/publications/sti-outreach-standards/> (accessed 29th August 2018)
- ² FSRH/BASHH Standards for Online and Remote Providers of Sexual and Reproductive Health Services (2019). Available at: <https://www.fsrh.org/standards-and-guidance/documents/fsrhbashh-standards-for-online-and-remote-providers-of-sexual/> (accessed 31st October 2019)
- ³ FSRH Service standards for Sexual and Reproductive Healthcare September 2016. Available at: <http://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare>. (accessed 29th August 2018)
- ⁴ "You're Welcome" Quality criteria for making health services young people friendly. Available at: http://www.youngpeopleshealth.org.uk/yourewelcome/wp-content/uploads/2017/02/YoureWelcome_RefreshedsStandards.pdf (accessed 29th August 2018)
- ⁵ GMC: Protecting children and young people. The responsibilities of all doctors. Available at: http://www.gmc-uk.org/Protecting_children_and_young_people___English_1015.pdf_48978248.pdf (accessed 29th August 2018)
- ⁶ HSCIC Guide to Confidentiality (2013). Available at: <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/a-guide-to-confidentiality-in-health-and-social-care> (accessed 29th August 2018)
- ⁷ Gillick vs West Norfolk & Wisbech Area Health Authority 1985. Available at: <http://www.bailii.org/uk/cases/UKHL/1985/7.html>. (accessed 29th August 2018)
- ⁸ Mental Capacity Act 2005. Available at: <http://www.legislation.gov.uk/ukpga/2005/9/contents> (accessed 31st October 2019)
- ⁹ GMC ethical hub: Learning disability. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-hub/learning-disabilities> (accessed 10th March 2021)
- ¹⁰ Brook / BASHH Spotting the Signs: A national proforma for identifying risk of child sexual exploitation in sexual health services [April 2014] Available at: <https://www.brook.org.uk/our-work/spotting-the-signs-cse-national-proforma> (accessed 29th August 2018)
- ¹¹ General Medical Council Intimate examinations and chaperones April 2013. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/intimate-examinations-and-chaperones> (accessed 10th March 2021)
- ¹² FSRH Clinical Guidance: Contraceptive Choices for Young People (March 2010, amended 2019) Available at: <https://www.fsrh.org/standards-and-guidance/documents/cec-ceu-guidance-young-people-mar-2010/> (accessed 29th August 2018)
- ¹³ FSRH. UKMEC. UK medical eligibility criteria for contraceptive use. 2nd edition update. 2016. Available at: <https://www.fsrh.org/ukmec/> (accessed 29th August 2018)
- ¹⁴ Teenage Pregnancy Prevention Framework; HM Government (2010) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/673458/TP_Prevention_Framework.pdf (accessed 29th August 2018)
- ¹⁵ Public Health England. National chlamydia screening programme standards. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759846/NCSP_Standards_7th_edition_update_November_2018.pdf (accessed 10th March 2021)
- ¹⁶ Public Health England. HPV vaccination programme for men who have sex with men (MSM) Clinical and operational guidance. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/697362/HPV_MS_M_clinical_and_operational_guidance.pdf (accessed 10th March 2021)
- ¹⁷ Brennan DJ1, Lachowsky NJ, Georgievski G, Rosser BR, MacLachlan D, Murray J; Cruising Counts Research Team. Online Outreach Services Among Men Who Use the Internet to Seek Sex With Other Men (MISM) in Ontario, Canada: An Online Survey. J Med Internet Res. 2015 Dec 9;17(12):e277. doi: 10.2196/jmir.4503.
- ¹⁸ Baraitser P, Syred J et al. How online sexual services could work; generating theory to support development. BMC Health Services Research (2015) 15: 540
- ¹⁹ Spencer-Hughes, Victoria, et al. "Screening for child sexual exploitation in online sexual health services: an exploratory study of expert views." Journal of Medical Internet Research 2017 (Feb 14); 19(2):e30
- ²⁰ Spencer-Hughes V, Syred J, Allison A, Holdsworth G, Baraitser P. Screening for Child Sexual Exploitation in Online Sexual Health Services: An Exploratory Study of Expert Views. J Med Internet Res. 2017;19(2):e30. Published 2017 Feb 14. doi:10.2196/jmir.5911
- ²¹ GDPR Regulations (2018). Available at: <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/children-and-the-gdpr/what-should-our-general-approach-to-processing-children-s-personal-data-be/> (accessed 29th August 2018)
- ²² Records Management Code of Practice for Health and Social Care 2016. Available at: <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016> (accessed 29th August 2018)
- ²³ Service standards for record keeping in sexual and reproductive healthcare services <https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-record-keeping-july-2019/>. Health and Social Care Records Management Code of Practice – reference 17
Wales - <http://www.wales.nhs.uk/governance-emanual/standard-20-records-management>
Scotland - <https://www.informationgovernance.scot.nhs.uk/wp-content/uploads/2020/06/SG-HSC-Scotland-Records-Management-Code-of-Practice-2020-v20200602.pdf>
Northern Ireland - https://www.publichealth.hscni.net/sites/default/files/good-mangement-good-records_0.pdf
- ²⁴ FGM Prevention Programme. Understanding the FGM Enhanced dataset – updated guidance and clarification to support implementation. [September 2015]
- ²⁵ BASHH advice regarding FOI requests in children (2016) Available at: <https://www.bashh.org/news/news/bashhphe-advice-regarding-freedom-of-information-request-for-clinic-level-data-on-stis-in-children/> (accessed 29th August 2018)

Section 3: Safeguarding children and young people

3.1 Legislative framework and guidance

Child protection is underpinned by the principles set out in the United Nations Convention on the Rights of the Child¹ and the European Convention on Human Rights.² These principles emphasise the child as an individual, as part of a family and a community who has rights, which should be recognised and upheld.

The legal framework on child protection, consent and confidentiality is covered by General Medical Council guidance.³ It states that doctors must safeguard and protect the health and well-being of CYP. Well-being includes treating CYP as individuals and respecting their views, as well as considering their physical and emotional welfare. All practitioners should be familiar and apply the principles using their judgment.

The Nursing and Midwifery Council has standards for children's nurses. It states that nurses must act as advocates for children and their families, understand the laws relating to consent and recognise that children have a right to be safe and be able to reach their full potential.⁴

Child protection guidance from across the UK includes:

England:	<i>Working together to safeguard children (2018)</i> ⁵
Scotland:	<i>National guidance for child protection in Scotland (2014)</i> ⁶
Wales:	<i>Working Together to Safeguard People Social Services and Well-being (Wales) Act 2014</i> ⁷
Northern Ireland:	<i>Co-operating to Safeguard Children (2017)</i> ⁸

Working Together to Safeguard Children (2018) covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children including in relation to child sexual exploitation.

All NHS Trusts, as well as other key organisations commissioned to provide health services have a duty under section 11 of the Children Act 2004⁹ to have arrangements in place to safeguard and promote the welfare of children.

The legal age for heterosexual and homosexual sex is 16 years. Under the Sexual Offences Act 2003 (England)¹⁰ sexual activity under 16 years old is illegal, and those under 13 are considered unable to

give consent. Even where a young person is old enough to legally consent to sexual activity, the law states that consent is only valid where they have the freedom and capacity to make that choice.

3.2 Multi Agency Working

The need for effective multi-agency working, joint decision making and information sharing in order to secure improved safeguarding outcomes is stated in a number of reviews, policy documentation and statutory guidance.¹¹

The Children and Social Care Act 2017, provides a framework of multi-agency arrangements for safeguarding children, including how local authorities, police, health and education agencies work together to safeguard and promote the welfare of local children.¹²

Multi-agency safeguarding hubs (MASH) are structures designed to co-locate staff from the local authority children and adult services, health agencies, police and probation services. The ability to share information in a timely and effective manner to facilitate joint decision-making is key to their objectives and can prove effective in preventing abuse, spotting patterns of abuse and repeat offenders through effectively sharing information.

Where safeguarding concerns have been raised in sexual health services, information sharing with primary care is key as they are often able to link together the “safeguarding jigsaw puzzle” from reports from sources such as Accident and Emergency departments and school nursing teams, which may then raise the level of concern. This applies particularly to vulnerable YP or those YP at risk of CSE / CSA who may attend different sexual health services and where safeguarding referrals to CSC would be incomplete from healthcare professionals, unless sexual health service risk information is also shared.

3.3 Information sharing

Information sharing is vital to safeguarding and promoting the welfare of CYP. A key factor identified in many serious case reviews has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action.¹³

When considering sharing information, practitioners should seek consent from CYP where appropriate and where possible, respect and maintain the confidentiality of those who have not consented to share information (such as third parties and the identities of sexual partners contacted for STI partner notification).

A balanced consideration should be given to sharing information without consent, if patient safety is at risk or in the interests of the wider public. Each case should be judged individually, with advice from safeguarding colleagues and the multidisciplinary clinical team. Any decision to share or not share information should be carefully documented with reasons, what was shared and with whom. This includes disclosing information on potential perpetrators in cases of current or historic CSA or CSE. The GMC confidentiality guidance states that disclosures without consent may be made in the public interest to protect individuals or society from serious risk of harm.¹⁴ Before any such decision is taken, the advice of a Caldicott guardian, Trust legal team, regulatory bodies and defence associations should be sought.

GMC guidance states that information about sexual activity involving children under 13 who are considered in law to be unable to consent, should usually be shared.¹⁵ A decision not to disclose should be discussed with a named or designated doctor for child protection along with a record of the reasons and outcome of the decision.

3.4 Safeguarding referrals to children's social care

All providers of NHS funded health services should identify a named safeguarding doctor and or nurse who is able to support MDT safeguarding discussions and decisions for referral to support agencies and provide safeguarding supervision.¹⁶

Any concerns about a child should be discussed with a manager, a named or designated professional or a designated member of staff and if a child is felt to be at risk of harm a referral to CSC or MASH completed. Referral is always appropriate where sexual activity or diagnosis of an STI involving a pre-pubertal child or child aged under 13 years is suspected or known.

Following a referral to CSC, the referrer should confirm receipt with CSC. Social workers should respond within one working day and feedback what action they have decided to take following a referral or information share. Safeguarding supervision and MDT meetings provides an opportunity to monitor feedback and outcomes following referral and information sharing with other health professionals

Social workers may need a further assessment of the child, either through an early help assessment, through a child in need assessment (section 17 of the Children Act 1989) or a child protection enquiry (section 47 of the Children Act 1989). Urgent outcomes following a referral include a strategy discussion meeting or child protection conference. All professionals involved in the child's care are expected to contribute by providing information, or developing and implementing plans.

3.5 Child sexual exploitation

Child sexual exploitation (CSE) is a criminal act that has a devastating impact upon CYP, with longterm consequences on the mental health wellbeing of adults. It is a complex form of CSA which can be difficult to identify in the adolescent period, as warning signs can easily be mistaken for 'normal' teenage behaviour. Over recent years, there have been numerous high-profile CSE investigations, which have led to prosecutions. Sexual health services have a key role in prevention, providing support and encouraging CSE disclosure, to help those affected by exploitation at the earliest possible opportunity.¹⁷

3.5.1 Definitions of CSA and CSE

Working Together to Safeguard Children (2018)¹⁸ defines child sexual abuse as:

... forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

The definition of CSE from Working Together to Safeguard Children (2018) states:

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

The importance of combining professional curiosity with indicators, and the issue of consent, is emphasised by the definition:

Child sexual exploitation is a complex form of abuse and it can be difficult for those working with children to identify and assess. The indicators for child sexual exploitation can sometimes be mistaken for 'normal adolescent behaviours'. It requires knowledge, skills, professional curiosity and an assessment which analyses the risk factors and personal circumstances of individual children to ensure that the signs and symptoms are interpreted correctly and appropriate support is given. Even where a young person is old

enough to legally consent to sexual activity, the law states that consent is only valid where they make a choice and have the freedom and capacity to make that choice. If a child feels they have no other meaningful choice, are under the influence of harmful substances or fearful of what might happen if they don't comply (all of which are common features in cases of child sexual exploitation) consent cannot legally be given whatever the age of the child

3.5.2 Prevalence of CSE

There is a lack of consistency in CSE definitions and in methods for recording cases, which makes comparisons across time and countries difficult. Meta-analyses suggest that, as a minimum, estimates of child sexual abuse (CSA) are 15–20% for girls and 7–8% for boys.¹⁹

The Children's Commissioner for England report (2015), which collated CSA data across agencies has estimated that only 1 in 8 victims of CSA come to the attention of the authorities.²⁰ The Office for National Statistics (2016a) found that 74% of adults reporting penetrative offences in childhood did not tell anyone about this at the time, and in only 7% of cases were the police informed. The most common reason for not telling anyone was embarrassment or humiliation (48%), followed by fearing they would not be believed (38%).²¹

The reporting of CSA and CSE is underestimated as:

- Most CSA remains hidden and is never reported to, or uncovered by, an official agency
- There is a time lag between experiencing CSA and reporting it, with many cases only reported in adulthood (Office of the Children's Commissioner, 2015)
- Recording cases as CSE is relatively recent, with some agencies yet to do it at all, alongside inconsistencies in allocating the correct child abuse category
- Variation in recording reports across agencies, administrative areas and over time; an issue in both police recorded crime and child protection data

Working Together to Safeguard Children (2018) covers the legislative requirements and expectations of services to safeguard and promote the welfare of children.

Like all forms of CSA, CSE can affect any child or young person under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex and can still be abused even if the sexual activity appears consensual.

CSA support services are bespoke and can for example be commissioned jointly at a local level with local authorities, clinical commissioning groups and Police and Crime commissioners to provide appropriate services incorporating sexual and mental health provision and support for victims of care.

On a national level NHS-England commission a network of Sexual Assault Referral Centres (SARCs) and the Ministry of Justice funds specialist rape and sexual abuse support services.

3.5.3 Sexually transmitted Infections as a marker of CSE

STIs have been suggested as markers of CSE.^{22,23} A recent large study from England of 466 children aged 13-15 years old has found that in matched univariate analysis, an STI diagnosis of gonorrhoea, chlamydia or trichomonas was significantly associated with 'highly-likely/confirmed' CSE (OR 3.87, p=0.017) and safeguarding concerns (OR 1.94, p=0.022). Evidence of an association between STI diagnosis and 'highly-likely/confirmed' CSE persisted after adjustment for partner numbers and prior clinic attendance (OR 3.85, p=0.053).²⁴

3.6 Domestic violence

Domestic violence (DV) is defined as 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members. The abuse can encompass psychological, physical, sexual, financial or emotional as well as stalking and harassment. Domestic abuse (DA) also includes honour-based crimes, female genital mutilation and forced marriages.²⁵

There is a strong association between DA and other forms of child maltreatment.²⁶ In 2012, the Home Office definition of DV and DV was widened to include those aged 16-17. This followed a report that YP aged 16 to 19 were more likely to suffer intimate partner abuse than other age ranges²⁷ and 95% of young YP experiencing intimate partner violence were female.²⁸ Intergenerational DA impacts on a child's mental, emotional and psychological health as well as their social and educational development.²⁹ It can also affect their likelihood of experiencing and becoming a perpetrator of DA as an adult, as well as exposing them directly to physical harm.^{30,31}

Increasing sexual health professional's awareness and response to supporting YP experiencing DA is particularly important given the additional vulnerabilities faced by YP transitioning from childhood and adolescent, higher rates of DA in the 16-19 age group compared to older ages,³² YP under 16 years experiencing all forms of DA including intimate partner violence and gaps in specialist DA service provision in responding to the specific needs of YP.

3.7 Local multi-agency safeguarding

Local multi-agency safeguarding arrangements set out the process for referring concerns about the welfare of children to local authority CSC. Some local authorities will have specialised multi-agency panels for CSE known as MASE (Multi Agency Sexual Exploitation). For DV, specialised multi-agency panels may exist, known as the multi agency risk assessment conference [MARAC]. Practitioners should view a referral as the beginning of a process of inquiry to their concerns, not as an accusation.

3.7.1 MASE panels

Panels are responsible for sharing information about victims and potential perpetrators of CSE. They identify the levels of risk; implement effective plans to reduce or prevent harm; identify and develop profiles of perpetrator sexual exploitation; identify and collate information about effective interventions; maintain records of YP believed to be at risk and collate data; identify themes and patterns emerging from analysis of current cases.

3.7.2 MARAC meeting

A multi agency risk assessment conference is a victim focused information and risk assessment meeting to coordinate the response to DA. The minimum age for YP to receive interventions in relation to DA is 16 years. Young people experiencing DA from intimate partners may also be victims of sexual exploitation.

3.8 Safeguarding training

Those working with CYP should access training through multi-agency arrangements to support them in identifying vulnerability, risk and harm. This will help practitioners to know what action to take and to develop a shared understanding about what best practice looks like. The roles and competency levels of healthcare professionals required to safeguard children are set out in a Royal College Nursing Intercollegiate document.³³

Within sexual health services or NHS Trusts, an identified CSE champion/s can act as a central point of contact and co-ordinate staff training for primary care, emergency services and children's department in the identification of CSE.

E-learning resources on CSE, such as "Seen and Heard" (funded by Department of Health and delivered by The Children's Society) is available for free online.³⁴ There is also an e-learning for healthcare module on CSE.³⁵

3.8.1 Staff support and safeguarding supervision

Healthcare professionals working with CYP should actively engage in safeguarding supervision and use it as an opportunity to test out thinking, have practice constructively challenged, and discuss support needs.³⁶ Safeguarding supervision can help to ensure progress and actions of cases are reviewed and maintain focus on the child, as well as address the emotional impact of the work on the practitioner. Both group and individual supervision can be used. More information on safeguarding supervision can be obtained in Appendix 7.

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² Council of Europe. European Convention on Human Rights Available at: http://www.echr.coe.int/Documents/Convention_ENG.pdf (accessed 29th August 2018)

³ GMC: Protecting children and young people. The responsibilities of all doctors. Available at: http://www.gmc-uk.org/Protecting_children_and_young_people___English_1015.pdf_48978248.pdf (accessed 29th August 2018)

⁴ Nursing and Midwifery Council (2015) Standards for competence for registered nurses Available at: <https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-nurses.pdf> (accessed 29th August 2018)

⁵ Department of Education. Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. March 2015. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf (accessed 29th August 2018)

⁶ Scottish Government. National Guidance for Child Protection in Scotland. 2014. Available at: <http://www.cne-siar.gov.uk/ChildProtectionCommittee/documents/Guidelines2014.pdf> (accessed 29th August 2018)

⁷ Welsh Assembly Government. Children and young people: rights to action safeguarding children: working together under the children act 2004. 2006. Available at: <http://gov.wales/pubs/circulars/2007/nafwc1207en.pdf?lang=en> (accessed 29th August 2018)

⁸ Department of Health, Social Services and Public Safety. Co-operating to safeguard children. May 2003. Available at: http://www.dhsspsni.gov.uk/co-operating_to_safeguard_children_may_2003.pdf (accessed 28th August 2018)

⁹ Children Act 2004. Available at: <http://www.legislation.gov.uk/ukpga/2004/31/contents> (accessed 29th August 2018)

¹⁰ Sexual Offences Act 2003. Available at: <http://www.legislation.gov.uk/ukpga/2003/42/contents> (accessed 29th August 2018)

¹¹ Home Office. Multi Agency Working and Information Sharing Project Final report July 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338875/MASH.pdf (accessed 29th August 2018)

¹² Available at <https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted> (accessed 10th March 2021)

¹³ HM Government. Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers March 2015. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf (accessed 29th August 2018)

¹⁴ GMC guidance 2017 Confidentiality: good practice in handling patient information. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality> (accessed 29th August 2018)

¹⁵ GMC: 0–18 years: guidance for all doctors. Updated April 2018. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years> (accessed 10th March 2021)

¹⁶ HM Government. What to do if you are worried a child is being abused: Advice for practitioners March 2015. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf (accessed 29th August 2018)

¹⁷ Public Health England and Association of Directors of Public Health. 2019. Child sexual exploitation How public health can support prevention and intervention. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793351/Child_sexual_exploitation_how_public_health_can_support_prevention_and_intervention.pdf (accessed 10th March 2021)

¹⁸ Working Together to Safeguard Children. Available at: A guide to inter-agency working to safeguard and promote the welfare of children July 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf. (accessed 10th March 2021)

¹⁹ Measuring the scale and changing nature of child sexual abuse and child sexual exploitation: Scoping report 2017. Available at: <https://www.csacentre.org.uk/research-publications/scale-and-nature-of-child-sexual-abuse-and-exploitation/scoping-report/> (accessed 29th August 2018)

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²¹ Office for National Statistics (2016a) *Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016*. Titchfield: ONS.

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Section 4: Management of specific groups

4.1 Looked after children

The term 'looked after children' (LAC) is defined in law under the Children Act 1989 as a child or young person 'looked after' by a local authority, if in their care or provided with accommodation for more than 24 hours by the authority. This includes children "subject to care orders (placed into the care of local authorities by order of a court) and children accommodated by voluntary agreement of their parents".¹

In England, the definition of a care leaver is a YP aged 16-25 years old who has been 'looked after' at some point since they were 14 years old, and were in care on or after their 16th birthday. The Children and Social Work Act 2017 requires local authorities to provide personal advisors to complete a pathway plan for care leavers, to ensure that YP receive the same level of care and support as others would receive from a reasonable parent as they transition into adulthood.²

It should be noted that each UK devolved nation has a slightly different definition of a LAC and care leaver, and professionals should follow their own national legislation, policy and guidance.

The local authority holds corporate parental responsibility for children under a care order and the social worker therefore acts as parent on the local authority's behalf. This includes giving consent to medical treatment where a CYP lacks capacity. However, not all LAC are the subject of a care order; the local authority does not hold parental responsibility for CYP who are accommodated voluntarily under section 20 of the Children's Act. Healthcare professionals working with LAC need to be aware of individual CYP's particular legal status in order to ensure consent and information-sharing.

The number of LAC has increased steadily over the last eight years³ and includes unaccompanied asylum-seeking children (UASC).⁴ The majority of YP "looked after" by the local authority is as a consequence of abuse and neglect and they are more likely to have both physical and mental health problems and to have experienced DA and substance misuse.⁴ All these factors mean that LAC and care leavers are particularly vulnerable to CSA and exploitation, exacerbated by their experiences both before and after care. An estimated 20 to 35% of all sexually exploited children in the UK are children in care.⁵

An UASC is a person under 18 years or in the absence of documentary evidence establishing age, appears to be under that age, is applying for asylum on his or her own right and has no relative or guardian in the United Kingdom.⁶ UASC are vulnerable for reasons including experiences of torture and persecution, with significant rates of post traumatic stress disorder, poor health systems in their home countries, and lack of relationship and sex education.

The UASC may lack guidance or support due to separation from their family and may be coping with the consequences of experiencing or witnessing rape and sexual violence.⁷ All these factors have a negative

impact on the sexual health and wellbeing of UASC, making them more vulnerable to sexual exploitation and abuse.

The government's Sexual Health and HIV strategy (Department of Health, 2001), identified the importance of promoting sexual health and access to services among vulnerable groups such as asylum seekers.

Being a LAC or care leaver is an individual risk factor for teenage pregnancy, associated with an increase rate, of approximately 3 times of a young women experiencing pregnancy before 18 years. Other adverse childhood adversities experienced by LAC and care leavers compound these teenage pregnancy rates rates further.

4.1.2 Management of looked after children

There is evidence that where LAC have access to specialist health practitioners, their health outcomes are improved.⁸ Where possible, LAC and care leavers should have their sexual health needs managed by expert team members trained in working with at risk or vulnerable YP. Practical considerations include flexibility for longer clinic appointments, offering additional support and engaging individuals to manage own health needs based on encouraging good decision making.

Discussing confidentiality is particularly important in this group of young people, as knowledge of their legal rights and rights to access to confidential sexual health services may be limited.

Additional time is frequently required for holistic assessment, and provision should be made within sexual health services to accommodate complex cases. LAC health assessment records should be accessible to streamline clinical history enquiries and reduce repeating investigations. Contact details of key workers and professionals involved with the young person should be recorded and YP consent for the practitioner to contact key professionals as needed should be encouraged.

4.1.3 UASC specific considerations

Independent good quality interpretation services are vital to the success of a sexual health consultation when seeing UASC with limited English. Consideration should be given for the YP's preference of face to face versus telephone interpretation and the translator's gender.

UASC may be at higher risk of blood borne viruses, via vertical or horizontal transmission, due to the increased prevalence of infection in their country of origin. STI screening must therefore take endemic risk into consideration.

Routine enquiry into recent and historical sexual violence and DA is recommended with robust referral pathways in place to specialist services and organisations. Discussions around coercion and exploitation resulting in transactional sexual activity should be explored, as many YP resort to selling sex on their journey to asylum.

If an UASC presents to a sexual health service having not previously been known to social services, immediate referral to the local authority's CSC is indicated. Where the YP has been trafficked, they should be referred to the National Society for the Prevention of Cruelty to Children [NSPCC] who have statutory powers to intervene on behalf of children. More information can be found in the FPA resource; Sexual health, asylum seekers and refugees - A handbook for people working with refugees and asylum seekers in England⁷ and BMA Refugee and Asylum Seeker Health Resource⁹ which practitioners may use to help develop services for UASC to support a holistic and person-centred approach.

4.2 Children and young people with learning or physical disabilities

There is a vast spectrum of disabilities that affect children which can be categorised as physical and learning, although there is often considerable overlap between the two. In the UK, 7.3% of children under the age of 18 years are reported to be disabled as defined by the Disability Discrimination Act 1995 and 2005, and experience higher levels of poverty and personal and social disadvantage compared to other children.¹⁰

Children with a disability are over three times more likely to be abused or neglected than children without a disability.^{11,12} Young people with a disability may not understand that they are being abused, might not be able to ask for help or may rely on the abuser to provide their care.¹³ Signs that a child with a disability is being abused or neglected may be misinterpreted as part of a child's impairment.¹³

Children with learning disabilities who are vulnerable to abuse and exploitation, face additional barriers to receiving protection and support and may be specifically targeted by perpetrators due to these vulnerabilities.¹⁴

Sexual health services should have clear pathways with local YP's learning disability teams and ensure that reasonable adjustments are made to facilitate accessibility and communication. Staff should have specific training and use resources such as the GMC's ethical learning disabilities hub.¹⁵

A Brook survey of professionals delivering relationship and sex education (RSE) to young people with a learning disability, reported that sex-positive RSE was commonly lacking as a result of negative societal attitudes and a lack of educational resources.¹⁶

“The reality is that lots of sexual health messages received by young people who have a learning disability are negative and focus primarily on risks and inappropriate behaviours. These are important aspects but there needs to be a balance. If RSE is accessible, positive and inclusive, it can empower young people to become more independent, explore and develop healthy relationships and help to protect against abuse.”

From the 1st September 2020, it is compulsory to deliver Relationships and Sex Education in England for all YP, including those with special educational needs and disability (SEND). Teaching should be tailored to meet the needs of the individual and maybe assessed to form part of an Education Health Care (EHC) plan.

4.3 Female genital mutilation

Female genital mutilation [FGM] comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.¹⁷ FGM is almost universally performed on girls under the age 16 years old and is child abuse.

4.3.1 The law relating to FGM

Female genital mutilation is illegal, prohibited by the Female Genital Mutilation Act 2003 (as amended by the Serious Crime Act 2015) and applies to England, Wales and Northern Ireland. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 (as amended by the Serious Crime Act 2015) applies to Scotland. The Acts extend to FGM performed outside of the United Kingdom and may lead to a fine or imprisonment of up to 14 years by those performing or aiding FGM.¹⁸

In April 2013, the Department of Health introduced FGM Prevalence Dataset Standard Specifications, (superseded by the FGM Enhanced dataset) requiring NHS organisations in England to record and collect information on the prevalence of FGM within their patient population. Sexual health services are excluded from this requirement. In October 2015, under the Serious Crimes Act 2015 it became mandatory for healthcare professionals in England and Wales to report known cases of FGM in CYP under 18 years to the police by calling 101, the non-emergency response number.

At the time of publication, this applies if the young person is currently under 18 and:

- Signs of FGM are visually identified

- FGM is disclosed by the child or young person
- Genital piercings or genital tattoos for non-medical reasons are observed on examination (type 4 FGM)

The mandatory duty to report includes only known or disclosed cases. The professional who initially identifies known or disclosed FGM has a duty to report to the police. It is best practice to report before the end of the next working day and mandatory to report within 48 hours. Healthcare professionals who do not comply with this requirement may be subject to local or professional disciplinary proceedings. It is good practice to also make a referral to CSC at the time of police reporting; however contacting social care alone does not comply with the FGM mandatory duty in England and Wales.

4.3.2 FGM safeguarding

If an adult patient attending sexual health services such as a parent or guardian discloses that a female child under 18 has undergone FGM, advise the adult patient that FGM is illegal in the UK and follow safeguarding procedures by making a referral to CSC for further assessment, preferably with the adult's knowledge. As this is not a direct FGM patient disclosure nor directly observed, reporting to the police is not indicated at this time point. As part of the CSC assessment, medical intervention and counseling will be offered to the child and action taken to protect any young female siblings at risk.

In Scotland and Northern Ireland, FGM reporting to the police is not mandatory under statute, however the usual safeguarding procedures are indicated, including FGM reporting in under 18 year olds to CSC. In Northern Ireland, there is also a duty to report to the police information regarding the commission of a relevant offence, under section 5 of the Criminal Law Act (Northern Ireland) 1967.

FGM is physical abuse and other girls in the family may also be at risk. If there is a concern or suspicion that a child under 18 is at risk of FGM, referral to CSC is indicated. If there is an imminent risk, the police should be alerted immediately by calling 999, the emergency response number.

4.3.3 Clinical assessment of FGM

Healthcare practitioners should listen, acknowledge and offer support to females affected by FGM. Enquiries should include:

- Menstruation
- Urination
- Sexual function
- Psychological sequelae
- Pain and discomfort resulting from FGM

The following is recommended:

- Give Department of Health FGM leaflet¹⁹ and FGM passport²⁰
- Offer referral to local FGM clinic for medical and psychological treatment
- Give information about community organisations for peer support
- If pregnant, inform GP and refer to specialist FGM midwife in the hospital where delivery planned
- Screening for blood borne viruses

Confirmation that FGM has been carried out may be required as part of a safeguarding or criminal investigations. Examination should be carried out by an experienced clinician, in order to maximise the opportunity to confirm the diagnosis of FGM and related injuries and to reduce the need for repeated intimate examinations.

Examination should preferably be with the use of video-colposcope or other appropriate imaging. This allows peer-review and second opinion (eg for forensic purposes) without subjecting the child or YP to repeat their examination. Best practice on the management of intimate images, should be followed.²¹

For younger children who are not deemed able to consent, consent may be gained from parent or guardian with parental responsibility.²²

It is important that the young person is counselled that FGM is illegal, has no health benefits, may cause lifelong health problems and is not a religious requirement.

Up to date information about FGM can be accessed at the Royal College of Paediatric and Child Health (RCPCH), FGM page²³ and free training material dealing with the issues posed by FGM at all stages of a girl or woman's life can be found at <https://www.e-lfh.org.uk/programmes/female-genital-mutilation/>.

4.4 Lesbian, gay, bisexual, transgender (LGBT) young people

Young LGBT people face many barriers to accessing sexual health services, resulting in poorer healthcare experiences, perceived judgmental attitudes and assumptions about sexuality from clinicians. This can result in missed opportunities for STI screening, risk assessment, SRH provision, RSE and sexual health promotion with poorer health including mental health outcomes.

All sexual health staff, including clinical, reception and administrative staff, should have appropriate equality and diversity training which includes accurate and appropriate information about gender diversity, supported by formal equality, diversity and inclusion policies and a transparent complaints procedure.

Sexual health services should be inclusive of LGBT YP with diversity integrated into service design and publicity.

4.5 Young women who have sex with women

Young women who have sex with women (WSW) can be a vulnerable group and tailored sexual health support, advice and signposting to services is required. There are misconceptions that young WSW have a lower risk of STIs and risk behaviours compared to at risk young heterosexual women and men and young MSM.

The term WSW can describe behaviour or a self defined identity, however a large proportion of WSW have had, or are having, sex with men. Data from Natsal-3 reported up to 16 percent of women in the UK aged 16-44 reporting ever having had 'a same sex experience' in their lifetime.²⁴ Much of the research into the sexual health needs of young WSW originates from North America with the following findings:

- Young WSW have higher pregnancy rates than heterosexual girls and are more likely to be tested for and diagnosed with STIs transmitted through male or female partners.²⁵
- Compared with heterosexual peers, young WSW have higher rates of many HIV-related risk factors, including a history of coerced sex, injecting drug use, and multiple lifetime and recent sexual partners.
- WSW are more likely than heterosexual women to report having sex with men who have sex with men or with injecting drug users.

Sensitive discussions with WSW should include:

- Risk assessment of vulnerability factors, CSE and high risk sexual behaviours
- Reproductive health, including contraception and LARC options given that young WSW have higher rates of unplanned teenage pregnancy
- STI risks associated with skin to skin contact, exchange of bodily fluids and exposed sites, the use of barrier methods and support in negotiating safer sex with male and female partners
- Tailored and individualised STI prevention strategies such as vaccination against Hepatitis B and Hepatitis A [in outbreaks] and risk assessment for PEPSE and PrEP

- Need to participate in the national school HPV vaccination programme and national cervical screening programme from the age of 25 years (regardless of sexual history)

4.6 Young men who have sex with men

Young men who have sex with men (MSM) can be a vulnerable group and tailored sexual health support, advice and signposting to services is required. Management should follow guidance related to older MSM and should include STI prevention strategies such as vaccination against Hepatitis B, Human Papillomavirus (HPV) in MSM 45 years and under, and Hepatitis A (in outbreaks), support in negotiating safer sex and risk assessment for PEPSE and PrEP.

Following the Joint Committee on Vaccination and Immunisations recommendations, since September 2019, boys aged 12 to 13 years are now routinely offered the HPV vaccine as part of a universal HPV vaccination programme.²⁶

Appropriate RSE can be lacking for this group in schools, as can supportive peer relationships around negotiating safer sex. Geo-social networking mobile apps can facilitate easier access to sex and a normalisation of certain sexual activities, such as chemsex. This should be explored within the sexual health setting. Likewise, the rise in smartphone and internet use can lead to easier access to pornographic images which has been linked to YP's unrealistic attitudes about sex, a greater acceptance of casual sex and engagement in riskier sexual behaviours such as unprotected anal sex, and the involvement of drugs and alcohol in sex.^{27,28}

It is important to be aware that young males can be at risk of CSE,^{29,30} and they should be assessed for vulnerability, CSE risk and mental capacity and decision making. Child sexual exploitation in young males can lead to high levels of psychological distress, substance misuse and HIV acquisition in adult life.³¹ Further information around CSE can be found in the relevant section of this guideline.

STIs are increased in both YP and MSM. STI screening tests based on risk assessment should include extra genital sampling and serological testing for blood borne viruses.

NHSE commissioned PrEP is now available outside of the NHSE IMPACT trial and licensed by European Medicines Agency from the age of 12 years. Individual assessment should be sought from specialist teams on a case by case basis taking into consideration:

- Competency and capacity to consent to treatment
- Assessment and counselling regarding the potential impact of tenofovir on bone mineral density during the adolescent period
- Medical co-morbidities especially renal impairment

- Vulnerability factors and safeguarding concerns
- Ongoing high risk sexual behaviours which places the YP at high risk of HIV acquisition

4.7 Transgender young people

The term “trans” is an umbrella term to describe people whose gender identity differs from the sex they were assigned at birth. There is a spectrum of trans identities, including but not limited to: trans woman, trans man, transgender, genderqueer, non-binary, agender. Gender dysphoria is described as "a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity" and occurs in both children and adults but can be a time of increased distress during puberty.

Healthcare professional trans awareness is paramount in making transgender YP or those who are gender questioning feel included and welcome in sexual health services to redress any health inequalities previously experienced. Leaflets and literature featuring positive images of transgender people should be available in waiting areas.³² The use of gender neutral terms and discussions around preferred pronouns is recommended. Education and peer support can be lacking and YP should be signposted to specialist NHS and voluntary sector organisations for additional support and advice .

Transgender people have high rates of mental health difficulties,³³ including self-harm and suicidal ideation and this should be explored in the YP’s clinical assessments, alongside their safeguarding risk assessments for DA including intimate partner violence. Management depends on the sexual history and should include sampling from exposed sites in a sensitive and non-invasive manner where appropriate. In some cases, it may be more appropriate to offer urine sampling as an alternative to physical examination and invasive swabs. STI risk, especially HIV can be greater in trans people and a wider range of screening tests may be necessary.³⁴ Physical interventions such as puberty blockers and cross-sex hormones and surgical treatment can lead to a loss in the production of natural lubricants³⁵ so lube, as well as condoms and femidoms or internal condoms should be available if needed.

Transgender YP are eligible for the HPV vaccine. The eligibility of transgender women (i.e. women who were assigned male at birth) should be made on a case-by-case clinical decision based on a risk assessment that includes the woman’s sexual behaviour and the sexual behaviour of her partners. Transgender women are eligible if their risk of acquiring HPV is equivalent to the risk of MSM eligible for the HPV vaccine. Transgender men (i.e. men who were assigned female at birth) are eligible if they have sex with other men, attend specialist sexual health or HIV services and are aged 45 and under.³⁶ If transgender YP have already completed the HPV vaccine programme at the age of 12 or 13 years, no further doses are needed.

Contraception should be explored where there is a risk of pregnancy and advice can be sought from the FSRH guidance around hormonal drug interactions.³⁷

Transgender young men with a cervix should be advised of the need to participate in the national cervical screening programme from the age of 25 years.

Specialist expertise and guidance should be sought through NHS commissioned services such as the Gender Identity Development Service (www.gids.nhs.uk) or voluntary organisations such as Mermaids (www.mermaidsuk.org.uk) and the Gender Trust (www.gendertrust.org.uk), to ensure that trans YP receive excellent advice and guidance, individually tailored to their mental health well being and healthcare needs. Online healthcare professional training can be obtained from <http://genderedintelligence.co.uk/professionals/training>.

The WHO recommends the use of antiretroviral therapy, PEPSE and PrEP for trans people at risk of HIV infection based on an individualised risk assessment.³⁸ There are possible drug-drug interactions with antiretroviral and hormone therapy (<https://www.hiv-druginteractions.org/checker>), however use of antiretroviral medication is not a contraindication with hormone therapy that some trans people may use.

4.6 Young people living with HIV

Adolescents and YP living with HIV may have acquired infection vertically through mother to child transmission (perinatal transmission) or horizontally through sexual transmission. With the routine use of antiretroviral therapy (ART), HIV in childhood has become a chronic condition, and increasing numbers of vertically infected children are entering adolescence and transitioning to adult services.³⁹

Issues specific to YP living with HIV may include dealing with an STI before themselves becoming sexually active, concerns surrounding disclosure of HIV status and complex psychosocial circumstances including management of stigma and secrecy.^{39,40} Specific guidance on the SRH in YP living with HIV and standards of care relating to SRH, are available from the Children's HIV Association (CHIVA) and the HIV in Young People Network (HYPNET).^{40,41}

Pre-pubertal children living with HIV are cared for in a paediatric or family clinic setting, whereas older children, and YP diagnosed with HIV in sexual health settings, may receive care in adult GUM or HIV services with liaison with paediatricians as required, often in dedicated YP's clinics. The transition process from paediatric to adult services should be gradual and centred around the individual and YP attending paediatric HIV services should have a documented transition plan in line with national guidance.^{39,42}

Consultations should include regular discussions surrounding sexual health, beginning in paediatric services, and tailored to the YP's age and development. Vaccination against HPV and hepatitis B infections, and relationship and sex education regarding condom use and safer sex, should start before the YP becomes sexually active.

Although the age of coitarche in UK adolescents with vertically transmitted HIV infection is similar to their uninfected peers,⁴³ high rates of unplanned pregnancy have been described,^{44, 45} and contraceptive advice that takes into consideration antiretroviral drug interactions should be provided.⁴⁶ Adherence to ART is worse during adolescence, and support should include a multidisciplinary team approach including the use of peer support if available.^{47,48,49}

Education surrounding risk factors for HIV transmission should include indications for use of PEPSE and PrEP in sexual partners^{50,51} and discussions that ART reduces risk of HIV transmission to zero in those with an undetectable HIV viral load for at least 6 months,⁵² with an emphasis on the importance of ongoing optimal drug adherence, supported by the public health promotion messages for treatment as prevention (TaSP) and undetectable viral load means HIV is untransmissible [U=U].

Timing of cervical screening in adolescents with HIV infection is not well established. High levels of pre-invasive cervical lesions were seen in a US study of young women with perinatally-acquired HIV.⁵³ In Africa, high risk oncogenic HPV virus was seen in nearly a third of YP living with HIV, and predominant subtypes were not covered by the 9 valent HPV vaccine.⁵⁴ UK data in the post HPV vaccine era is sparse, and risk may depend on several factors including age of coitarche, number of sexual partners and immune function at time of HPV vaccine. Current British guidance recommends that cervical smear testing should start from age 25 years, including adolescents with vertically transmitted HIV, although this is currently under review.⁵⁵ Presently a low threshold for earlier screening should be considered in those with additional risk factors including clinical concerns, early coitarche, absence of HPV vaccination and severe immunosuppression.

4.7 Infants and children of parents living with HIV

Routine antenatal HIV testing and effective use of ART during pregnancy means that mother to child transmission of HIV is now rare in the UK. Guidance on the HIV testing of infants born to mothers living with HIV, and standards of care for testing infants and children at risk of HIV, are available from BHIVA and CHIVA.^{56,57,58}

All children born to individuals living with HIV, including those born prior to the HIV diagnosis, must be assessed for risks of vertical transmission and tested for HIV infection if a risk is identified, regardless of

age of the child. The risk of HIV seroconversion later in pregnancy or during breastfeeding should be considered in mothers with negative antenatal testing but unknown date of HIV acquisition.

Testing of children for serious communicable diseases may be a stressful experience for parents and should be approached sensitively and with appropriate support to parents to enable them to care and protect their children. When a known mother living with HIV or very high-risk mother refuses testing of the neonate/child, the decision must be made in the best interests of the child in accordance with GMC guidance and referral to child protection services or High Courts where necessary.

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Section 5: The significance of STI diagnoses in children in relation to child sexual abuse

This section of the guidance has been adapted with permission from the 2015 RCPCH publication, “The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice.”¹ This edition is an extensive collaboration between the Royal College of Paediatrics and Child Health, American Academy of Pediatrics, Faculty of Forensic and Legal Medicine and the Royal College of London, alongside other stakeholder organisations. The following evidence statements on specific STIs are from the STI evidence-based section, and summarise the significance of STI diagnosis in pre-pubertal children in relation to CSA. The evidence-based literature review underpinning these statements are published in full in the RCPCH guidance.

5.1 Risk factors for child or young person acquiring STIs

The risk of a 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 or contact e.g. penile-vaginal or penile-rectal penetration is more likely to lead to infection than other types of sexual activity or non-penetrative sexual contact
- Injury of the genital tract with trauma increasing the susceptibility to infection
- The sexual maturity of the YP. A YP has an increased biological susceptibility to carcinogens and STIs due to physical and immunological immaturity of the genital tract
- The lack of barrier contraception use
- 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 high risk behaviours such as substance and alcohol misuse

5.2 *Neisseria gonorrhoeae*

Key messages

- Gonorrhoea is uncommon in sexually abused prepubertal 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
- Gonorrhoea is more likely to be proven to be due to sexual abuse in older children, although the results may have been affected by pre-verbal younger children being less likely to disclose

abuse. Limited evidence suggests that most abused children with gonorrhoea have a history of vaginal or anal penetration

Note that the literature review reported on gonorrhoea study data to any site (excluding conjunctiva) and all studies performed cultures.

Evidence statement

Sexual contact is the most likely mode of transmission in pubertal and pre-pubertal children with gonorrhoea.

Issues for clinical practice

- If a child presents with confirmed gonorrhoea, the possibility of sexual contact should always be considered and it is likely that the child has been sexually abused
- In post-pubertal girls consensual sexual activity should be considered
- The diagnosis of gonorrhoea in a child under 13 years necessitates an urgent referral to child protection services; children over 13 years need to be considered on a case by case basis. A decision not to disclose should be discussed with a named or designated child protection doctor with the final decision and reasons recorded.
- A positive diagnosis of gonorrhoea in the mother should not be assumed as the mode of transmission to the neonate and does not exclude CSA

5.3 *Chlamydia trachomatis*

Key messages

- Chlamydial infection is not common 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
- *C. trachomatis* is more frequent in pubertal than pre-pubertal sexually abused girls, although the result may have been affected by consensual sexual activity in older girls or by pre-verbal and younger children being less likely to disclose abuse

Evidence statement

Sexual contact is the most likely mode of transmission in pubertal and prepubertal children with *C. trachomatis*.

Issues for clinical practice

- If a child presents with a confirmed *C. trachomatis* infection, the possibility of sexual contact should always be considered and it is likely that the child has been sexually abused

- In post-pubertal girls, consensual sexual activity should be considered
- The diagnosis of *C.trachomatis* in a child under 13 years necessitates an urgent referral to child protection services; children over 13 years need to be considered on a case by case basis. A decision not to disclose should be discussed with a named or designated child protection doctor with the final decision and reasons recorded
- A positive diagnosis of chlamydia in the mother should not be assumed as the mode of transmission to the neonate and does not exclude CSA

5.4 Bacterial vaginosis

Key messages

- When studies have screened all rather than just symptomatic girls, the prevalence of bacterial vaginosis [BV] in sexually abused one to 12 year olds is extremely low. Slightly higher rates are found when abused pre-pubertal girls with a discharge are screened
- In pubertal girls, bacterial vaginosis is found in both girls who are both sexually and non-sexually active. However, this is contrary to newer data where no BV was found in young women with no history of vaginal sex, receptive oral sex or receptive digital penetration
- 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. Bacterial vaginosis is seen slightly more often in sexually abused girls who have a discharge. There are insufficient data in children to determine the significance of bacterial vaginosis in relation to CSA.

Issues for clinical practice

- The finding of BV is currently not helpful in indicating whether abuse has occurred
- There is no agreed definition of BV in prepubertal girls

5.5 Genital Mycoplasmas

Key messages

- In the only study of sexually abused children aged 1 to 12 years, genital mycoplasmas have been reported in 2 to 9% depending on the site of the swab
- In sexually abused children aged 1 to 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 *U. urealyticum* and/or *M. hominis* had evidence of penetrative abuse

- *M.genitalium* is increasingly recognised as being sexually transmitted in adults. Research is required using new nucleic acid testing to determine significance in children

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 *M.genitalium* in children
- If *M.genitalium* is found discuss with a genitourinary physician in case further management is required

5.6 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:

Syphilis has been found in limited studies in children who have been sexually abused and sexual contact should be considered.

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 have been excluded
- The diagnosis of syphilis in a child under 13 years necessitates a referral to child protection services depending on the stage of infection and evidence of other transmission modes: children over 13 years need to be considered on a case by case basis. A decision not to disclose should be discussed with a named or designated child protection doctor with the final decision and reasons recorded.
- A positive diagnosis in the mother does not exclude CSA

5.7 Anogenital warts

Key messages

- Five studies have reported anogenital warts in less than 3.2% of sexually abused children
- Seven 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, although the results may have been affected by the pre-verbal younger children being less likely to disclose abuse
- The evidence base does not help to clarify whether human papillomavirus [HPV] typing is of value in the diagnosis of sexual abuse; however, one study has shown HPV detection to be associated with sexual abuse and HPV detection increases with security of sexual abuse certainty

Evidence statement:

A significant proportion of children (31% to 51%) with anogenital warts have been sexually abused. 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.
- The diagnosis of anogenital warts in a child under 13 years of age dictates referral to child protection services; children over 13 years of age need to be considered on a case by case basis. A decision not to disclose should be discussed with a named or designated child protection doctor with the final decision and reasons recorded

5.8 Oral warts

Evidence statement:

There is insufficient evidence to determine the significance of oral warts in relation to CSA at the current time.

5.9 Genital herpes simplex virus

Key messages

- Genital herpes has been reported in less than 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 (one in two and six in eight)

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 one in two and six in eight 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
- The diagnosis of genital herpes in a prepubertal child necessitates an urgent referral to child protection services
- A positive diagnosis of genital herpes in the mother does not exclude CSA

5.10 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 four of six 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 of Hepatitis B in the mother does not exclude CSA

5.11 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

HCV can be sexually transmitted in adults. Therefore, despite the lack of evidence in children, sexual abuse should be considered in children with HCV if vertical, perinatal or blood contamination has been excluded

A positive diagnosis of Hepatitis C in the mother does not exclude CSA

5.12 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 no other risk factors for HIV infection 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 living with HIV in whom the possibility of mother-child transmission or blood contamination has been excluded.

Issues for clinical practice

- In a child living 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

5.13 *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.

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.
- The diagnosis of *T. Vaginalis* in a child over six weeks and under 13 years of age necessitates an urgent referral to child protection services; children over 13 years of age need to be considered on a case by case basis

5.14 Summary of the significance of STI diagnoses in children in relation to child sexual abuse

- There have been relatively few studies where children with a particular STI have been evaluated for the possibility of CSA. This has resulted in a limited base to determine whether a particular STI is a marker of CSA.
- Only two included studies across all STI infections were conducted on UK populations. Most of the studies have been undertaken elsewhere and prevalence rates from these may not be applicable to UK populations
- Sexual contact was demonstrated in at least one third of children infected with *Neisseria gonorrhoea*, *Chlamydia trachomatis* and anogenital warts, suggesting that abuse should be strongly considered in children with these infections. A high prevalence of abuse was also found in studies on *Trichomonas vaginalis*, genital herpes and HIV although population numbers were small.
- The evidence base for syphilis, hepatitis B and C was too limited to offer any information on the association between the presence of infection (which can be sexually transmitted in adults) and abuse. In adults, syphilis is virtually always sexually transmitted

- The evidence reviewed does not provide guidance on the age at which perinatal transmission of a particular STI can be excluded. In general, studies did not rigorously consider and exclude alternative modes of transmission. Attributing infection to perinatal transmission is difficult in very young children who are pre-verbal and cannot disclose abuse, and the possibility of sexual abuse should always be considered
- For *N. gonorrhoea*, *C. trachomatis*, anogenital warts and *T. vaginalis*, the likelihood of a STI in sexually abused children increased with the child's age. However, the interpretation of this finding is complicated by a lack of consideration of consensual sexual activity in adolescents, the difficulties in obtaining an allegation of abuse in young children and incomplete information about how other modes of transmission were excluded.
- Penetrative sexual contact is associated with an increased risk of infection by *N. gonorrhoeae*, *C. trachomatis*, *T. vaginalis* and HIV.
- The possibility of abuse in children with an STI should be considered and thoroughly investigated in all cases, given the wealth of research on the pathogenicity and sexual transmission of STIs in adults. Trained and experienced sexual health clinicians have a key role as expert witnesses in CSA medico-legal cases and in supporting clinical pathways for STI testing and screening in children and adults in child protection cases as part of a multidisciplinary team.

¹ Royal College of Paediatrics and Child Health. The physical signs of child sexual abuse: an updated evidence based review and guidance for best practice. 2015. RCPCH London

Section 6: Screening and testing for STIs in Child Sexual Abuse

This section of the guidance has been taken from and adapted with permission, from the 2015 RCPCH publication, “The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice.”¹

6.1 Recommendations for testing for STIs

STI screening and testing is recommended when:

- sexual history suggests a need to screen
- young person has symptoms/signs which could be caused by an STI including vaginal or penile discharge, genital ulceration and vulvitis, anal lesions/discharge or genital lesions e.g. warts
- for all who have been found to have one STI
- sexual abuse is suspected or proven

Screening and testing for STIs should be considered:

- according to local STI prevalence
- secondary to the circumstances or type of abuse

Screening and testing for STIs may be offered to:

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

6.3 Timing of tests

The scheduling of examinations should depend on the history of voluntary sexual activity, sexual abuse or assault and STI incubation periods. Timing of tests should also be determined on an individual basis taking into account the YP’s (and their parent/carer’s) psychological and social needs. A single examination may be sufficient if the YP 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.

The child or YP should have the option of having another adult present during the examination. This might be a parent or independent chaperone as appropriate. Repeated examinations should be avoided as these may be harmful to the child or YP.²

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

- Tests for STIs should be performed at baseline
- Tests for *Neisseria gonorrhoeae* (NG) and *Chlamydia trachomatis* (CT) should be repeated two weeks after the last penetrative contact if necessary
- 4th generation HIV tests should be done at baseline and repeated at 45 days after last possible exposure. If HIV post-exposure prophylaxis is given following sexual exposure (PEPSE), the final HIV test should be performed 45 days after completing the PEPSE course. If the 28-day PEP course is completed this is 73 days (10.5 weeks) post exposure.
- In needlephobic children, 3rd generation rapid HIV point of care tests [POCT] should be considered at baseline and 3 months following sexual exposure
- Tests for syphilis and Hepatitis C should be done at baseline with a repeat test at three months and consideration of a final test at six months for delayed Hepatitis C antibody seroconversion. Follow up testing for hepatitis B should be guided by hepatitis B vaccination status and baseline immunity

6.3 Testing for STIs in child sexual abuse

This section refers to testing in cases of sexual assault or abuse of CYP under 18 years. For information on STI testing in post-pubertal YP refer to the BASHH STI Testing Guidelines via www.bashh.org.uk.

6.3.1 Indications for testing for STIs

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 and legal proceedings
- In pre-pubertal children, a STI may be of medico-legal significance in supporting a 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

6.3.2 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. For example, gonococcal vaginitis or vulvovaginitis is the most common form of genital gonorrhoea found in pre-pubertal girls. The pre-pubertal anoestrogenic vaginal mucosa creates an alkaline environment that is more readily infected on exposure to *N. gonorrhoeae* than is that of post-pubertal girls. Infection of the endocervix, urethra, and upper genital tract rarely occur.³

Samples from all sites should be taken, as abuse of a particular orifice may not be disclosed even when abuse elsewhere has been established and signs and symptoms of STIs are often not present.

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

NAATs for the detection of *N. gonorrhoeae* or *C. trachomatis* are not licensed for use in extra-genital specimens, and have not been evaluated in genital specimens from children. Evidence for the use of NAATs in children is limited.^{4,5,6} However in adult populations, NAATs are more sensitive than culture and can be used on non-invasive specimens, and therefore on balance, their use is recommended for testing in children.

The prevalence of these infections in the paediatric population is low, and therefore the positive predictive value of a reactive test is low. In order to reduce the risk of false positive results, it is essential that all reactive NAATs for *N. gonorrhoeae* or *C. trachomatis* are confirmed by using another NAAT which detects a different molecular target from the initial test.^{7,8}

6.3.3.1 Gonorrhoea

NAATs for *N. gonorrhoeae* and culture for *N. gonorrhoeae* if clinically suspected or confirmed gonorrhoea infection should be performed. Ideally, samples for culture for *N. gonorrhoeae* should be directly plated onto culture medium, but Amies swabs (or equivalent) are clinically acceptable when this is not possible, providing there is prompt transport of samples to the laboratory. Microscopy for gonorrhoea in CSA is

inconclusive, as it cannot differentiate between *N. gonorrhoeae* and *N. meningitidis* or other *Neisseria* spp.

6.3.3.2 Chlamydia

NAATs for *C. trachomatis* are the test of choice for all specimens. Culture for *C. trachomatis* is no longer available in either primary diagnostic laboratories or at Public Health England reference laboratories.

Section 6.3.4 Testing for STIs in child sexual abuse: good practice points

- Examination of a pre-pubertal child should be undertaken by an experienced paediatrician either as a single or a joint examination with a complementary suitably qualified forensic clinician or genitourinary medicine physician with the appropriate expertise, skills and knowledge as the case demands.⁹
- Consideration should be given to the clinical environment and setting for the examination to minimise distress and put the child or YP at ease.
- 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, should be understood. It is recommended that interpretation of positive bacterial and protozoal STI NAAT results should be done in collaboration with genitourinary medicine and microbiology specialists
- Where there has been an allegation of any abuse, then triple site sampling 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, vulvo-vestibular swabs inside the labia minora but avoiding the hymen should be used. Trans-hymenal sampling should only be taken in exceptional circumstances with the smallest ENT swab by a senior experienced clinician, if it is possible to pass a swab without causing distress ie there is a wide hymenal opening diameter or the child is being examined under anaesthesia. Urine NAATs can be used as screening tests in young females if swabs are not feasible, but have lower sensitivity compared with vulvo-vaginal swabs in adults.
- First-pass urine for NAAT testing should be undertaken in young males
- Self-sampling can be considered where age appropriate and the child or young person has a preference. However in the case of a positive STI test result, sampling may need to be repeated by a clinician in order that the result's validity is not challenged in medicolegal proceedings.

6.4 Forensic and legal aspects in CSA

The management of CSA should have equivalence with the management of physical abuse in terms of the robustness and quality of the healthcare response, noting that emotional abuse and neglect often co-exist.

It is essential to have competent doctors in terms of knowledge, experience, skills and attitudes to undertake the role of examining and caring for children who have or may have experienced sexual abuse.

The forensic approach of a child, in the context of actual or suspected acute or historical CSA includes:¹⁰

- Assessment of the pre-and post-pubertal child for emergency contraception and HIV and Hep B post exposure prophylaxis
- Acute and non-acute examinations with documentation of any injuries, fresh healing or healed and detailed assessment of the external genitalia
- Appropriate investigations
 - taking samples for DNA or toxicological analysis
 - testing for STI
- Follow up care, including:
 - Addressing safeguarding concerns from all forms of maltreatment
 - Assessment of physical, mental health and psychological well being that may or may not be related to the alleged CSA and referral to longer term therapeutic services
 - Referral to appropriate health services and agencies for treatment

The quality standards for doctors undertaking Paediatric Sexual Offence Medicine outlines the training requirements, workplace based supervision, CPD and service standards required to enable CYP up to the age of 18 years to be seen by clinicians for single and joint paediatric forensic assessments depending on the availability, skills and competences of individual examiners.¹

The latest up to date good practice guidance is available on the Faculty of Forensic and Legal Medicine (FFLM) <https://fflm.ac.uk> and RCPCH websites.

6.4.1 Chain of evidence

National guidance on chain of evidence and specimen storage is available from the Royal College of Pathologists.¹¹

If the presence of an 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.

Testing and treatment of any consensual and non-consensual sexual contacts including family members (if consent is given) should be addressed if an STI is detected. Parents should be tested where there is a possibility of vertical or sexual transmission.

Typing of *N. gonorrhoeae* isolates to link alleged perpetrators to victims of CSA is not currently available. *N. gonorrhoeae* multi-antigen sequence typing (NG MAST) does not provide sufficient discrimination, and whole-genome sequencing has not yet been validated for this purpose.

6.4.2 Forensic and legal aspects in CSA: good practice points

- Services undertaking Paediatric Sexual Offence Medicine should comply with the service standards required for training, workplace based supervision, CPD, to enable CYP up to the age of 18 years to be seen by clinicians for single and joint paediatric forensic assessments depending on the availability, skills and competences of individual examiners.
- A child protection examination should only be carried out if it is necessary and appropriate in the circumstances and it is clear whether the outcome is likely to affect the proposed course of action. Consideration should be given to the child or YP having the option of having another adult present during the examination (this might be a parent, or an independent chaperone, as appropriate). Repeated examinations should be avoided as these may be harmful to the child or YP.¹²
- If the presence of an STI is to be used in medico-legal proceedings then services should ensure that pathways are in place for COE samples to be taken. Ideally, a COE should be in place in all CSA cases and positive samples stored. However, if an infection is found but there was no COE performed, the test should be repeated with a COE in place.

6.5 Recommended STI tests (summarised in the flowcharts in Appendix 5)

6.5.1 Blood samples

Consider testing for HIV, syphilis, Hepatitis B and Hepatitis C in all cases depending on the risk factors. Fourth generation HIV Ag / Ab serology should be performed 45 days post assault and at 45 days post HIV PEPSE completion if given.

Consideration can be given to the use of 4th generation dried blood spots for HIV testing if venepuncture is declined. Rapid HIV POCT blood and saliva sampling (not validated in children) can be performed at 12 weeks after assault if blood testing is declined or not appropriate. Those with positive samples need re-testing using venous blood sample.

6.5.2 STI testing in pre-pubertal females

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

(1) Vulvo-vestibular swabs

Essential:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

Optional if discharge present:

- Microscopy for *Trichomonas vaginalis* (TV)/candida/bacterial vaginosis (BV) and/or culture for TV/candida/anaerobes/aerobes
- Point of care test: OSOM Trichomonas Rapid Test Kit, if available
- TV NAAT if available is the gold standard test for *Trichomonas vaginalis*

(2) Urine sample

Only if child/carer declines examination and self-taken vulvo-vaginal swab not possible

- NAAT for *N. gonorrhoeae* and *C. trachomatis*

(3) Rectal swab

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

(4) Pharyngeal swab

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

6.5.3 STI testing in post-pubertal females

As for pre-pubertal females, but use vulvo-vaginal or endocervical swab for NAAT testing in preference to trans-hymenal swabs. An endocervical swab is required for *N. gonorrhoeae* culture if symptomatic or speculum tolerated.

Urine sample if vulvo-vaginal or endocervical swab declined:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*

Rectal swab indicated if anal penetration:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

Pharyngeal swab indicated if oral penetration:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

6.5.4 STI testing in young males

(1) Urethral discharge (if present):

If urethral discharge then meatal swab (pre-pubertal) or urethral swab (post-pubertal)

- Microscopy for pus cells
- *N. gonorrhoeae* culture

(2) First void urine sample:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*

(3) Rectal swab:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

(4) Pharyngeal swab:

- NAAT for *N. gonorrhoeae* and *C. trachomatis*
- *N. gonorrhoeae* culture

6.5.5 Presence of genital blisters or ulcers

- Swab for herpes simplex virus PCR
- Swab for bacterial culture (consider)
- Dark ground microscopy for *Treponema pallidum* should be considered. Swab for *T. pallidum* PCR if available. Syphilis serology should also be performed, and repeated in six weeks

6.5.6 Presence of ano-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.

¹ RCPCH. The physical signs of child sexual abuse: an updated evidence based review and guidance for best practice. 2015. RCPCH London

² General Medical Council guidance, *Protecting children and young people: The responsibilities of all doctors* May 2018. Available at:

<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people> (accessed 10th March 2021)

³ Woods CR. Gonococcal Infections in Neonates and Young Children. *Semin Pediatr Infect Dis* 2005 16:258-270.

⁴ Kresnicka LS, Rubin DM, Downes KJ, Lavelle JM, Hodinka RL, McGowan KL, Grundmeier R, Christian CW. Practice variation in screening for sexually transmitted infections with nucleic acid amplification tests during prepubertal sexual abuse evaluations. *J Pediatr Adolesc Gynecol*. 2009 Oct;22(5):292-9.

⁵ Black CM, Driebe EM, Howard LA, Fajman NN, Sawyer MK, Girardet RG, Sautter RL, Greenwald E, Beck-Sague CM, Unger ER, Igietsme JU, Hammerschlag MR. Multicenter study of nucleic acid amplification tests for detection of Chlamydia trachomatis and Neisseria gonorrhoeae in children being evaluated for sexual abuse. *Pediatr Infect Dis J*. 2009 Jul;28(7):608-13

⁶ Hammerschlag MR, Gaydos CA. Guidelines for the use of molecular biological methods to detect sexually transmitted pathogens in cases of suspected sexual abuse in children. *Methods Mol Biol*. 2012;903:307-17.

⁷ Public Health England. Guidance for the Detection of Gonorrhoea in England: Including Guidance on the use of Dual Nucleic Acid Amplification Tests for Chlamydia and Gonorrhoea. August 2014.

⁸ Public Health England. UK Standards for Microbiology Investigations: Chlamydia trachomatis infection – testing by Nucleic Acid Amplification Tests (NAAT) *Virology* | V 37 | Issue no: 4 | Issue date: 09.01.17

⁹ Faculty of Forensic & Legal Medicine. Quality Standards for doctors undertaking Paediatric Sexual Offence Medicine (PSOM) Apr 2017.

Available at: <https://fflm.ac.uk/wp-content/uploads/2017/06/Quality-Standards-for-doctors-undertaking-PSOM-Dr-Cath-White-and-Prof-Ian-Wall-April-2017.pdf> (accessed 29th August 2018)

¹⁰ Faculty of Forensic & Legal Medicine. Child sexual abuse (CSA) forensic medical examinations: Interim Guidance Regarding Numbers of Examinations and the Maintenance of Competence. Jan 2017. Available at: <https://fflm.ac.uk/wp-content/uploads/2017/06/CSA-Examinations-Interim-Guidance-Dr-Bernadette-Butler-Jan-2017.pdf> (accessed 29th August 2018)

¹¹ NEW GUIDANCE FOR HANDLING MEDICOLEGAL SAMPLES AND PRESERVING THE CHAIN OF EVIDENCE. Royal College of Pathologists, 2017. Available at: <https://www.rcpath.org/discover-pathology/news/new-guidance.html> (accessed 29th August 2018)

¹² General Medical Council. *Protecting children and young people: The responsibilities of all doctors* GMC 2012. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people> (accessed 10th March 2021)

Section 7: Management of specific STIs and STI prophylaxis

This section of the guidance has been taken and adapted with permission, from the 2015 RCPCH publication, “The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice.”¹

This is a rapidly changing field. For the most up-to-date information on the treatment on individual sexually transmitted infections, refer to the most recent online version at <http://www.bashh.org>, the latest version of the BNF for children (BNFc) <https://bnfc.nice.org.uk/> and Immunisation against Infectious diseases: The Green Book <https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18> . 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 (see Appendix:5 STI treatment protocols).

Prescribing unlicensed medicines or medicines outside the recommendations of their marketing authorisation alters and increases the prescriber’s professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines.

7.1 Antibiotic prophylaxis for STIs in children and young people following sexual abuse

Overall, the risk of acquiring a STI is low. Risk varies according to the type of abuse and will depend on:

- 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 COE cannot be rectified. As more sensitive NAAT tests are being used for *N. gonorrhoea*, *C. trachomatis* and *T. vaginalis*, the issues of specificity become more problematic and the opportunity to repeat tests for confirmation becomes more important.

If prophylaxis is to be given, COE must be used as without COE any positive results may not be accepted in court and depending on timing of repeat sampling, positives test results may become negative if antibiotic prophylaxis had been given.

7.1.2 Gonorrhoea and Chlamydia

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

- testing for *N. gonorrhoea* and *C. trachomatis* is not performed/is declined
- child is unlikely to return for treatment if a STI is detected
- risk of infection is high, e.g. alleged perpetrator has an infection or there were multiple assailants

7.1.3 Syphilis

Prophylaxis should be considered if an alleged perpetrator is known to have infectious syphilis. A balance is needed between gathering forensic evidence with the need to prevent syphilis infection and reduce the likelihood of syphilis antibody seroconversion and the long-term stigmata of positive syphilis serology in the child.

7.1.4 Hepatitis B

Hepatitis B vaccination should be considered if the child has not been previously vaccinated and presents within six weeks of the last alleged assault, as there is evidence in adults that vaccination 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. The decision on the schedule should take into consideration the age of the child (super accelerated extensively used in adolescents in sexual health services) and the risk of exposure [see Appendix: 5 STI treatment protocol].
- Hepatitis B immunoglobulin post exposure should be considered if the alleged perpetrator is known to have acute or newly diagnosed chronic Hepatitis B eAg and the child presents within 48-72 hours, but can be used up to seven days²
- Vaccine is the most important intervention and this should be carried out as soon as possible and not delayed whilst awaiting HBIG or test results

7.1.5 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 with direct acting antivirals may be effective. Vaccination is not currently available.

7.1.6 Herpes simplex virus (HSV)

No vaccine or prophylactic medication is currently available.

7.1.7 Anogenital warts / Human Papilloma Virus (HPV)

The HPV vaccine is licensed for use in males and females aged 9 to 45 years. If given prior to infection with a particular HPV type, it is effective in preventing cervical and anal cancers and genital warts. Its role in the management of CYP who have experienced sexual abuse has not been determined.

7.1.8 Human Immunodeficiency Virus (HIV)

Overall risk is very low. Post exposure prophylaxis after sexual exposure (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. A decision should be made according to criteria in the national BHIVA guidelines for adults, and CHIVA guidelines. The decision to treat, must balance the risk of acquiring infection with the risks of antiretroviral therapy and the likelihood of compliance.

Factors to consider are:

- type of sexual activity
- violence assault and whether anogenital injuries with bleeding were present
- HIV status of assailant (if known) or according to prevalence rate in assailant's 'community'

PEPSE must be initiated as soon as possible within 72 hours, with close monitoring for toxicity and compliance while on therapy, with input from paediatric HIV and/or adult specialists depending on the age of the child. Highly active 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. HIV serology using a 4th generation HIV ab/Ag testing should be repeated at a minimum of 45 days post treatment as HIV seroconversion may be delayed after PEPSE has been given.

Ref1

¹ RCPCH. The physical signs of child sexual abuse: an updated evidence based review and guidance for best practice. 2015. RCPCH London

² Human hepatitis B immunoglobulin specific for hepatitis B post-exposure July 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/815106/Human_hepatitis_B_immunoglobulin_specific-post_exposure.pdf8571 (accessed 10th March 2021)

Section 8: Auditable outcome measures for young people's sexual health services

The suggested auditable outcomes are based on evidence from good practice, national standards and guidance.

- Percentage of clinical staff with level 3 children and young peoples safeguarding training (target 100%)
- Percentage and number of all under 25s accessing the service for first time
 - Confidentiality statement discussed (target 97%)
 - CSE risk assessment using Spotting the signs or similar risk assessment tool if under 18 years (target 97%)
 - Pregnancy risk assessment and emergency contraception for young women involved in heterosexual sex (target 97%)
 - Signposting to contraceptive services or offer of contraceptive methods including LARC for young women involved in heterosexual sex (target 97%)
- Percentage and number of all new sexually active under 25s accessing the service for the first time offered and tested for chlamydia, threshold locally determined according to demographics of the local population and Chlamydia Testing Activity Dataset (CTAD).
- Re-infection rates in young people: of those identified with a previous acute STI and re-attending the same service, the uptake of STI testing 3 months after diagnosis of an acute STI, threshold locally determined according to demographics of the local population and Chlamydia Testing Activity Dataset (CTAD).
- Audit of complexity of care in vulnerable groups maybe useful for commissioning purposes. The number of referrals to other services should include:
 - Number of YP screened for and subsequently identified with drug and alcohol misuse.
 - Number of YP screened and identified as being at risk of or experiencing CSE domestic abuse, FGM and sexual assault using the recommended BASHH Information Group vulnerability codes.
 - Safeguarding alerts raised, and referrals made to Local Authority and multiagency safeguarding hubs.

Section 9: Editorial statements

9.1 Statement of Editorial Independence

This guideline was commissioned, edited and endorsed by BASHH CEG without external funding being sought or obtained.

9.2 Conflicts of Interest

No author on the writing group declared a conflict of interest

9.3 BASHH CEG Composition

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Appendix 1: Working group and methodology

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Appendix 2: Electronic data collection form

Writing group member(s):	Date:
Work stream 1: <input type="checkbox"/> Children and YP Service standards <input type="checkbox"/> Safeguarding / CSE <input type="checkbox"/> Management of special groups	Work stream 2: <input type="checkbox"/> STI epidemiology <input type="checkbox"/> STI diagnostics <input type="checkbox"/> Forensic / legal aspects in CSA <input type="checkbox"/> Management of specific STIs and STI prophylaxis

Record of search strategies	
Record of abstracts and papers reviewed	
Key search terms	
Main text – includes pragmatic and organisational issues relevant to guideline	
Summary tables	
Summary key points	
Key recommendations using GRADE system – see resources BMJ papers and online modules	
References used	
Additional resources	
Useful appendices	
Potential cost implications of implementation of the guidelines – resources	
Other notes:	

Appendix 3: Young people's participation workshop

Brook session plan and report: accessible on BASHH website at <https://www.bashh.org/bashh-groups/special-interest-groups/adolescent-sexual-health/>

Contributors:

- Brook - Sue Burchill, Head of Nursing and Laura West, Participation and Volunteering Manager
- BASHH Adolescent Specialised Interest Group – Jane Ashby and Dawn Wilkinson
- Effi Stergiopoulou, Deputy Safeguarding and Health Adviser Lead Mortimer Market and Archway Centres, CNWL and Camish Network Coordinator
- Craig Tipple BASHH PPI

The workshop was funded by the BASHH PPI. The findings from the workshop will be used to inform future BASHH engagement strategies with YP and plan information resources.

Additional young people's participation resources:

- BASHH/Brook Spotting the signs https://www.brook.org.uk/attachments/Spotting-the-signs-CSE-_a_national_proforma_April_2014_online.pdf
- You're welcome quality standards
http://www.youngpeopleshealth.org.uk/yourewelcome/wp-content/uploads/2017/02/YoureWelcome_RefreshedsStandards.pdf

Appendix 4: Competency and consent to medical treatment

Fraser guidelines relate specifically to contraception advice and treatment, treatment for sexually transmitted infection and abortion provision. They are used to decide if a young person under the age of 16 can consent to advice and treatment without their parent's knowledge or the consent of person with parental responsibility:

1. He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
2. He/she cannot be persuaded to tell his/her parents or to allow the doctor to tell them
3. He/she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment
4. His/her physical or mental health is likely to suffer unless he/she received the advice or treatment
5. The advice or treatment is in the young person's best interests.

Gillick competence is used to determine if a young person under the age of 16 has the capacity to consent to a medical treatment or invention. The understanding required for different interventions will vary and capacity can fluctuate eg in mental health conditions.

Mental Capacity Act [MCA] 2005

The MCA provides a framework in England and Wales for caring or treating people aged 16 years and over who lack the ability to make decisions for themselves. Young people aged 16 or 17, are presumed in law, like adults to have the capacity to consent to medical treatment. However unlike adults, refusal of treatment can in some instances be overridden by a parent, someone with parental responsibility or a court, given the duty to act in the best interests of a child. This includes circumstances where refusal of treatment is likely to result in death, severe permanent injury or irreversible mental or physical harm. There should be clear records documenting how any decision about a young person was reached, reasons for the decision, who was consulted and what factors were considered.

The MCA framework requires an assessment of capacity before treatment by a decision-maker acting on behalf of the person's best interests using 5 key principles:

1. Assume a person has capacity unless proved otherwise.
2. Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them.
3. A person should not be treated as incapable of making a decision because their decision may seem unwise.
4. Always do things or take decisions for people without capacity in their best interests.

5. Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

References:

Wheeler R (2006) Gillick or Fraser? A plea for consistency over competence in children. *BMJ* 332(7545): 807

Gillick v West Norfolk & Wisbech AHA & DHSS [1983] 3 WLR (QBD)

Axon, R (on the application of) v Secretary of State for Health [2006] EWHC 37 (Admin)

Mental Capacity Act 2005

Appendix 5: STI treatment protocols

This STI treatment protocol is for guidance only and the BASHH CEG advises that specialist Genitourinary Medicine, Paediatric and Pharmacy advice should be obtained before prescribing for children aged 15 years and under, in conjunction with STI specific BASHH guidance at <http://www.bashh.org>.

For CYP aged 12 years and over with weight <45kg, discuss with paediatric pharmacist for appropriate paediatric dosing. Note that children under the age of 12 years would rarely be seen within a Sexual Health Clinic, without Paediatric input.

Condition / Infection	Suggested treatment
Gonorrhoea	<p>The updated BASHH guidance 2019 has moved to ceftriaxone monotherapy as first line treatment.</p> <p>No data exists regarding the use of dual antibiotic therapy for treating children with gonococcal infection.</p> <p>Prior to treating gonococcal infection, ensure GC culture(s) are obtained from all potentially exposed sites to obtain antibiotic sensitivities.</p> <p>Gonococcal ophthalmia [neonate] This is an ophthalmic emergency and ophthalmology input and hourly eye irrigation is essential to prevent visual loss from corneal ulceration and scarring.</p> <p>Ceftriaxone 50mg/kg IV or IM single dose (maximum dose 125mg*) or Cefotaxime 100mg/kg IM single dose (maximum dose 1g)</p> <p>*Ceftriaxone is contraindicated in premature neonates up to a corrected gestational age of 41 weeks. Ceftriaxone should be administered cautiously to hyperbilirubinemic infants. IV infusion to be administered over 60minutes. Expert Paediatric advice is required regarding dosage.</p> <p>Non-ophthalmic gonorrhoea <i>Child <2 years</i> Ceftriaxone 125mg IM single dose</p> <p><i>Child <12 years and weight <45kg</i> Ceftriaxone 125mg IV or IM single dose</p> <p><i>Child 9–11 years weight >45 kg</i> Ceftriaxone 250 mg IV or IM single dose</p>

	<p>Alternative regimes for child < 12 years and weight <45kg if cephalosporin / penicillin / other β-lactam antibiotic allergic, given the limited availability of spectinomycin and lack of data for dual antibiotic treatment in children:</p> <p>Spectinomycin 40 mg/kg IM single dose (maximum dose 2g) [unreliable in pharyngeal infection and unlicensed product with limited availability] AND azithromycin 20mg/kg PO single dose [no data for dual treatment in children]</p> <p>Gentamicin 2.5mg/kg IM single dose [equivalent to IM adult single dose] and azithromycin 20mg/kg PO single dose [no data for dual treatment in children]</p> <p><i>Child >12 years</i> Refer to adult BASHH guidance for latest guidance https://www.bashhguidelines.org/media/1208/gc-2019.pdf</p> <p>Ceftriaxone 1g IM single dose</p> <p>If declines IM injection Cefixime 400mg PO single dose plus azithromycin 2g PO stat</p> <p>When antimicrobial susceptibility is known prior to treatment at all suspected sites of infection #Ciprofloxacin 500mg PO single dose # MHRA/CHM advice: Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019)</p> <p>Cephalosporin / penicillin / other β-lactam antibiotic allergic: Gentamicin 240mg IM single dose [body weight >45kg] AND azithromycin 2g PO stat OR Spectinomycin 2g IM single dose [unreliable in pharyngeal infection and unlicensed product with limited availability] AND azithromycin 2g PO stat</p>
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Chlamydia	<p>Neonate Azithromycin 20 mg/kg/day PO od for 3 days* Or Erythromycin 12.5 mg/kg PO qds for 14 days*</p> <p>*Erythromycin and azithromycin in neonates under 2 weeks increases risk of hypertrophic pyloric stenosis</p> <p><i>Child weight <45 kg</i> Erythromycin 50 mg/kg/day PO divided into 4 doses daily for 14 days</p>
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	<p><i>Child aged ≥2-12 years</i> Erythromycin 250mg PO qds for 7 days or bd for 14 days</p> <p>Alternatives: <i>Child aged <8 years and weight ≥45 kg:</i></p> <p>Azithromycin 1g PO single dose</p> <p>Data are limited on the effectiveness and optimal dose of azithromycin for the treatment of chlamydial infection in infants and children who weigh <45 kg, however pragmatically azithromycin od is the preferred option and erythromycin qds the alternative.</p> <p><i>Child aged 8-11 years</i> Doxycycline [use where no alternative and with expert advice as causes deposition in growing bone and teeth, binding to calcium causing staining and occasional dental hypoplasia] 8-11 years, >45kg – 200mg on day 1, 100mg daily ongoing 8-11 years, <45kg – 4.4mg/kg/day (in 1 or 2 divided doses) for 1 day then 2.2mg/kg/day (in 1 or 2 divided doses)</p> <p><i>Child >12 years</i> Refer to adult BASHH guidance https://www.bashhguidelines.org/media/1191/update-on-the-treatment-of-chlamydia-trachomatis-infection-final-16-9-18.pdf</p> <p>First line treatment for uncomplicated urogenital, pharyngeal and rectal chlamydia infections: Doxycycline 100mg PO bd for 7 days</p> <p>Alternatives treatment regimes: Urethral, cervical or pharyngeal Azithromycin 2g PO (in divided doses ie 1g single dose plus 500mg od for 2 days) Erythromycin 500mg PO bd for 14 days</p> <p>#Ofloxacin 200mg bd or 400mg PO od for 7 days</p> <p># MHRA/CHM advice: Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019)</p>
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Pelvic inflammatory disease	There are no randomised controlled trials for antimicrobial therapy for PID in children and the following recommendations are based on evidence from adults trials modified for paediatric use.
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	<p><i>Child 2 –12 years weight <45kg</i> Ceftriaxone 125mg IM single dose And erythromycin 250mg PO bd for 14 days And metronidazole PO bd or tds (refer to cBNF for dosing based on weight) both for 14 days</p> <p><i>Child >12 years and weight >45kg</i> [adult BASHH guidance https://www.bashhguidelines.org/media/1217/pid-update-2019.pdf]</p> <p>1st Line: Ceftriaxone 1g IM single dose And doxycycline 100mg PO bd for 14 days And metronidazole 400mg PO bd for 14 days</p> <p>2nd Line: Ofloxacin 400mg PO bd for 14 days And metronidazole 400mg PO bd for 14 days</p> <p>If MG positive: #Moxifloxacin 400mg PO od for 14 days # MHRA/CHM advice: Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019)</p> <p>If pregnant / or breastfeeding: Ceftriaxone 1g IM single dose And erythromycin 500mg PO bd for 14 days And metronidazole 400mg PO bd for 7 days</p> <p>Gonococcal pelvic inflammatory disease</p> <p>If GC suspected / confirmed or GC contact, add ceftriaxone 1g IM if not using 1st line PID treatment (or cefixime 400mg PO if IM injection refused) plus azithromycin 2g stat Substitute with appropriate alternative (eg spectinomycin) if cephalosporin allergic or severe penicillin allergy.</p>
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Trichomonas and bacterial vaginosis	<p><i>Child 1-3 years</i> Metronidazole 50 mg PO tds for 7 days <i>Child aged 3yrs to <7 years</i> Metronidazole 100 mg PO bd for 7 days <i>Child aged 7 years to <10 years</i> Metronidazole 100 mg PO tds for 7 days <i>Child >10 years</i> Metronidazole 400 mg PO bd for 7 days OR</p>
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	<p>Metronidazole 2g PO single dose</p> <p>NB: Metronidazole gel 0.5% and clindamycin cream 2%, are not licensed for use in children.</p> <p>Intravaginal treatment is not recommended for younger girls and oral treatment may be more appropriate.</p>
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Anogenital candidiasis	<p><i>Child <16 years</i></p> <p>Clotrimazole cream 1% topical application bd or tds</p> <p>Oral triazoles are not licensed in this age group for genital candidiasis, however intravaginal treatment is not recommended for younger girls and oral fluconazole 150mg stat may be more appropriate if post pubertal</p>
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Anogenital warts	<p>Observation period for minimum of three months unless symptoms of pain, bleeding or irritation.</p> <p>First line treatment cryotherapy +/- local topical anaesthetic</p> <p>Podophyllotoxin and Imiquimod are not licensed for use in children. Can be used 2-18 year olds with specialist advice off-licence. These preparations can cause considerable irritation of the treated area and therefore are only suitable for YP who are able to cooperate with treatment. Refer to adult BASHH guidelines for preferred topical regimes and treatment regimes. Excision/electro surgery under general anaesthesia – consider if all other treatment modalities failed</p> <p>https://www.bashhguidelines.org/media/1075/uk-national-guideline-on-warts-2015-final.pdf.</p>
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Mycoplasma genitalium	<p>Evidence base for the treatment and management of mycoplasma genitalium is limited in children</p> <p><i>Child >12 years</i></p> <p>Refer to adult BASHH guidance and specialist GUM input</p> <p>https://www.bashhguidelines.org/media/1198/mg-2018.pdf</p> <p>Treatment regimens for uncomplicated infection:</p> <p>Doxycycline 100mg PO bd for 7 days followed by azithromycin 1g orally as a single dose then 500mg PO od for 2 days</p> <p>#Moxifloxacin 400mg PO od for 10 days</p> <p>Treatment of complicated urogenital infection (PID, epididymo-orchitis):</p>
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	<p>#Moxifloxacin 400mg PO od for 14 days</p> <p># MHRA/CHM advice: Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects (March 2019)</p>
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Genital herpes	<p>Neonatal herpes High risk of vertical transmission, suspected or unwell neonate IV aciclovir (20 mg/kg 8 hourly) for 10 days</p> <p>https://www.bashhguidelines.org/current-guidelines/genital-ulceration/herpes-in-pregnancy-2014/</p> <p>Acute HSV episode Treat if within 5 days of start of episode or while new lesions are still developing. <i>Child 1 month–2 years</i> Aciclovir 100 mg PO five times a day for 5 days</p> <p><i>Child >2 years</i> Aciclovir 200 mg PO five times a day for 5 days</p> <p><i>Child weighing >40kg</i> Aciclovir 400mg PO tds for 5 days</p> <p><i>Child >12 years</i> Aciclovir poorly absorbed, consider valaciclovir 500mg bd dosing if adherence issues [refer to BNFC for dosing]</p> <p>If suppressive therapy is required see adult guidelines for indications and BNFC for dosing. https://www.bashhguidelines.org/media/1019/hsv_2014-ijstda.pdf</p> <p>NB: Famciclovir are not licensed for use in children.</p>
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Congenital syphilis	<p>Refer to BASHH Guidelines https://www.bashhguidelines.org/current-guidelines/genital-ulceration/syphilis-2015/</p> <p>https://www.bashhguidelines.org/media/1196/syphillis-bp_print_2016_p3.pdf</p>
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	<p>Benzyl penicillin sodium 60–90 mg/kg daily IV (in divided doses given as 30 mg/kg 12 hourly) in the first seven days of life and 8 hourly thereafter for a further 3 days for a total of 10 days</p> <p>Alternative regimens</p> <p>Procaine benzylpenicillin 50,000 IU/kg daily IM 10 days.</p> <p>Benzathine benzylpenicillin 50,000 IU/kg IM [up to the maximum adult single dose of 2.4million units] up to 3 weekly doses depending on stage of infection.</p> <p>In children, IV therapy is preferable due to the pain associated with IM injections</p> <p>Interruptions in treatment for late and congenital syphilis.</p> <p>If drug administration is interrupted for more than one day at any point during the treatment course, it is recommended that the entire course is restarted</p>
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Acquired syphilis	<p><i>Child <12 years</i> [https://www.cdc.gov/std/tg2015/congenital.htm]</p> <p>IV Benzyl penicillin sodium 200,000-300,000 IU/kg/ day IV administered as 50,000 IU/kg every 4-6 hours x 10 days.</p> <p>Or</p> <p>Benzathine benzylpenicillin 50,000 IU/kg IM [up to the maximum adult single dose of 2.4 million units] up to 3 weekly doses depending on stage of infection.</p> <p><i>Child >12 years</i></p> <p>Treatment should take into account the stage of infection ie epidemiological treatment, early (primary/secondary/early latent) or late syphilis. Expert advice should be sought, and reference made to BASHH syphilis guidelines https://www.bashhguidelines.org/current-guidelines/genital-ulceration/syphilis-2015/ and the BNFC.</p> <p>IV Benzyl penicillin sodium 50,000 IU/kg every 4-6 hours x 10 days.</p> <p>or</p> <p>IM Procaine benzylpenicillin G 50,000 IU/kg daily in a single dose for 10 days up to a maximum daily dose of 750,000 IU</p>
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	<p>or Benzathine benzylpenicillin 2.4 million units single dose (early); or weekly x 3 weeks i.e. 3 doses (late)</p> <p>Penicillin Allergy Consider Penicillin desensitisation</p> <p>or Doxycycline 100mg PO bd x 14 days (early); x 28 days (late) or other treatments as recommended in BASHH guidelines and BNFC</p>
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Scabies	<p>Permethrin 5% dermal cream Apply once weekly for 2 doses. Apply cream over whole body [including face, neck, scalp and ears in children aged >2 years]; wash off after 8-12 hours. If hands are washed with soap within 8 hours of application, they should be re-treated. Medical supervision of treatment required in children aged two months to two years</p> <p>or</p> <p>Malathion liquid 0.5% in aqueous base. Apply once weekly for 2 doses. Apply over whole body [including face, neck, scalp and ears in children aged >2 years]; wash off after 24 hours. If hands are washed with soap within 24 hours, they should be retreated. Medical supervision of treatment required in children aged less than six months.</p>
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Pubic lice	<p>Malathion liquid 0.5% in aqueous base Apply once weekly for 2 doses over whole body, allow to dry naturally, wash off after 12 hours or overnight. Repeat after 1 week.</p>
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<p>Hepatitis B vaccine</p>	<p>There are many different immunisation schedules for hepatitis B vaccine which depend on the vaccine product used, supply issues and how quickly protection is needed for pre or post exposure. For the most up to date schedules refer to the latest editions of BNFC and Green book. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628602/Greenbook_chapter_18.pdf June 2017 [accessed 30th April 2019] and BASHH guidance https://www.bashhguidelines.org/media/1161/viral-hepatitides-2017-update-18-12-17.pdf</p> <p>Note from late 2017, the routine childhood programme consists of three doses of a hepatitis B-containing product with an interval of one month between each dose, before the age of one year. If the primary course is interrupted it should be resumed but not repeated, allowing an interval of four weeks between the remaining doses.</p> <p>Engerix B®</p> <p><i>Neonate</i> 3 doses of Engerix B® 10 micrograms at 0, 1 and 6 months If born to HbsAg +ve mother: 4 doses of Engerix B® 10 micrograms at 0 (along with Hep B immunoglobulin at a separate site) and then at 1, 2 and >10 months</p> <p><i>Child 1 month-15 years</i> 3 doses of Engerix B® 10 micrograms at 0,1 and 6 months</p> <p><i>Child 16-17 years and adults</i> 3 doses of Engerix B® 20 micrograms at 0,1 and 6 months</p> <p>Note:</p> <ul style="list-style-type: none"> • Accelerated schedules at 0, 1, 2 and >10 months may be given in all age groups • Ultra rapid schedule in children over 16 years old: Engerix B® 20 micrograms at 0, 7 days, 21 days and 12 months • Alternative 2 dose schedule for children aged 11-15 yrs: 2 doses of Engerix B®20 micrograms at 0 and 6 months (not suitable if high risk of infection between doses or if compliance with 2nd dose uncertain) <p>Fendrix® Patients with renal insufficiency aged 15yrs and over 4 doses of 20 microgram at 0,1,2 and 6 months</p> <p>HBvaxPRO®</p> <p><i>Neonate</i> 3 doses of 5 micrograms at 0, 1 and 6 months</p>
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	<p>If born to HbsAg +ve mother: 4 doses of HBvaxPRO® 5 micrograms at 0 (along with Hep B immunoglobulin at a separate site) and then at 1, 2 and 12 months.</p> <p><i>Child 1 month-15 years</i> 3 doses of HBvaxPRO® 5 micrograms at 0, 1 and 6 months</p> <p><i>Child 16-17 years and adults</i> 3 doses of HBvaxPRO® 10 micrograms at 0, 1 and 6 months</p> <p>Note:</p> <ul style="list-style-type: none"> Accelerated schedules at 0, 1, 2 and >10 months may be given in all age groups
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References:

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Acknowledgements:

West Scotland clinical network guideline group: <https://www.wossexualhealthmcn.org.uk/west-of-scotland-managed-clinical-network/resources/guidelines.htm>; Dr Janice Allan janice.allan@nhs.net

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Appendix 6: CSE risk assessment

BASHH / Brook Spotting the Signs proforma allows sexual health professionals to use a standardised approach to pick up on the warning signs of CSE in all its forms. It is designed to be integrated into existing sexual and social history taking frameworks. Spotting the Signs has been piloted in focus groups with YP and provides a framework to support conversations with CYP around CSE linked to latest research and evidence bases.

https://www.brook.org.uk/attachments/Spotting-the-signs-CSE-_a_national_proforma_April_2014_online.pdf

https://www.bashh.org/documents/Spotting-the-signs-CSE-proforma%20A4_Update.pdf

[https://www.brook.org.uk/data/Spotting the Sign foldout final August 2015.pdf](https://www.brook.org.uk/data/Spotting_the_Sign_foldout_final_August_2015.pdf)

Appendix 7: Safeguarding supervision

It is recommended that all those involved with safeguarding CYP should have access to protected safeguarding supervision to:

- enable a safe environment to explore concerns and actions needed
- ensure local safeguarding procedures are followed
- provide psychological support to the staff member

Supervision is currently provided in sexual health services in a variety of ways depending on the setting and availability of staff:

- one to one clinical supervision either planned or unplanned
- peer group supervision to teams to promote a structured consistent and cohesive approach
- psychological supervision to debrief and explore the emotional aspects of stressful case management

It is recognised that the professional responsible for leading safeguarding, may themselves struggle to get adequate supervision. It is important that they access supervision either through their own clinical setting or through local safeguarding services. Professionals leading safeguarding supervision should have received recognised training in safeguarding supervision such as NSPCC Safeguarding Supervisors Courses (<https://learning.nspcc.org.uk/training/child-protection-supervision-skills>).

One model of supervision as an example used in a Sheffield Sexual Health service, uses the normative, formative and restorative model. This enables the supervisee to explore safeguarding issues using three stages.

Formative:

The supervisee's learning and development is the focus. The case is discussed to explore how the supervisee managed the situation. What lessons can be learnt for further development?

Normative:

Ensure patient welfare and to ensure that the supervisee complies with the safeguarding standards of the organisation. Was standard/local practice followed and was the patient safeguarded appropriately?

Restorative:

Help staff to understand and process the emotional impact of the difficult scenarios presented to them and give the supervisee an opportunity to explore their emotional response to managing the scenario. How did the situation make them feel?

Appendix 8: Flow diagrams for STI screening in children and young people

These flow charts should be used in conjunction with the text in section 6.5

The flow charts are intended for use by paediatricians and forensic clinicians



STI Screen for Pre-pubertal and Pubertal Females

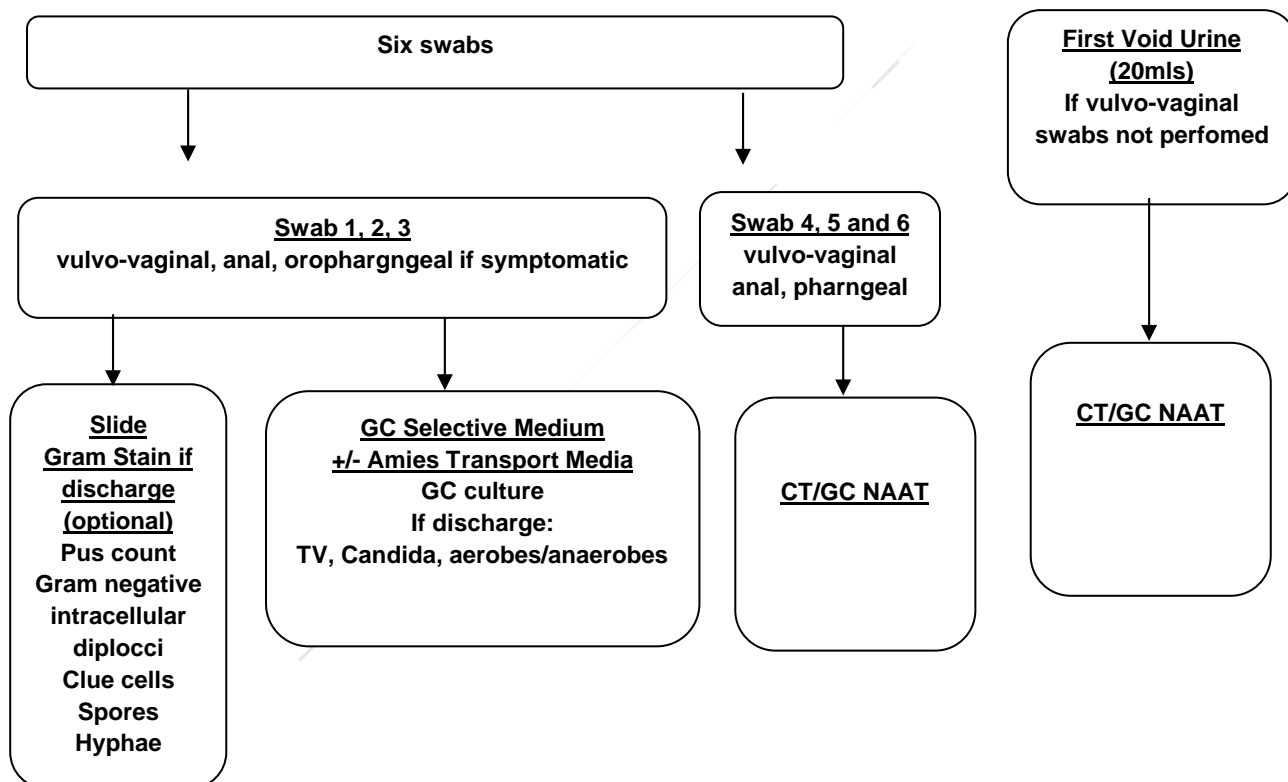
Criteria for screening

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

Screening schedule

- Immediate: Serology (4th generation Ab/Ag HIV serology, STS, Hep B and C) and samples as below
- 2 weeks*: Samples as below
- 45 days: 4th generation Ab/Ag HIV serology
- 3 months: Serology (HIV serology if PEP given, STS, Hep B and C)

* If initial sample within two weeks of last assault



Other tests if indicated:

Open sore:

One swab HSV+/- TP NAAT. Dark ground microscopy for TP. Swab for bacterial culture.

TV NAAT if available: vulvo-vaginal swab

Pregnancy test

STI Screen for Symptomatic Pubertal Females

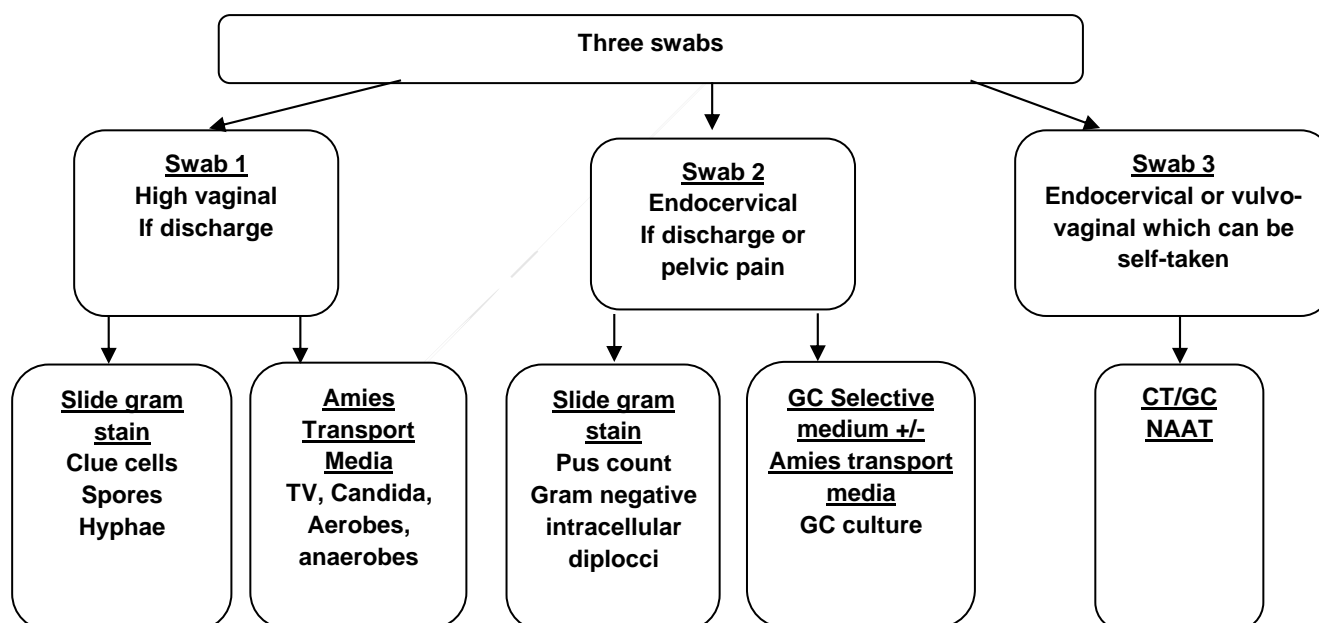
Criteria for screening

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

Screening schedule

- Immediate: Serology (4th generation Ab/Ag HIV serology, STS, Hep B and C) and samples as below
- 2 weeks*: Samples as below
- 45 days: 4th generation Ab/Ag HIV serology
- 3 months: Serology (HIV serology if PEP given, STS, Hep B and C)

* If initial sample within two weeks of last assault



Other tests if indicated:

- Oral penetration:** Two oropharyngeal swabs, one selective medium +/- Amies transport media for GC culture & one CT/GC NAAT.
- Anal penetration:** Two anal swabs, one selective medium +/- Amies transport media for GC & one CT/GC NAAT.
- Open sore:** One swab HSV +/- TP NAAT. Dark ground microscopy for TP. Swab for bacterial culture.
- Decline Endocervical or vulvo-vaginal swab:** Urine CT/GC NAAT
- Pregnancy test(s)**
TV NAAT if available (vulvo-vaginal swab)

STI Screen for Pre-pubertal and Pubertal Males

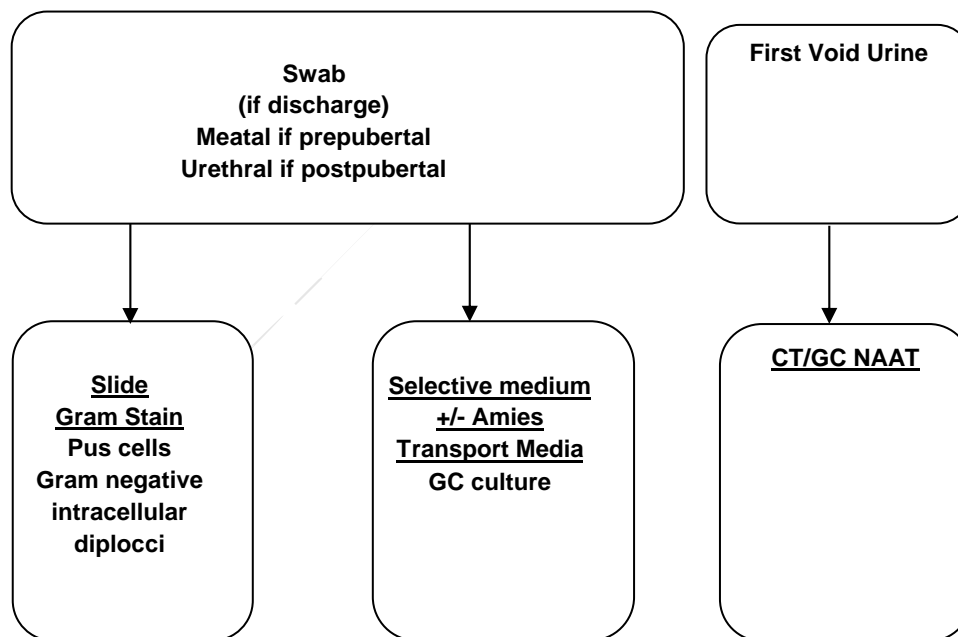
Criteria for screening

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

Screening schedule

- Immediate: Serology (4th generation Ab/Ag HIV serology, STS, Hep B and C) and samples as below
- 2 weeks*: Samples as below
- 45 days: 4th generation Ab/Ag HIV serology
- 3 months: Serology (HIV serology if PEP given, STS, Hep B and C)

* If initial sample within two weeks of last assault



Other tests as indicated:

- Oral penetration:** Two oropharyngeal swabs, one selective medium +/- Amies transport media for GC & one NAAT for CT +/- GC.
- Anal penetration:** Two anal swabs, one selective medium +/- Amies transport media for GC & CT + GC NAAT.
- Open sore:** One swab HSV +/- TP NAAT. Dark ground microscopy for TP. Swab for bacterial culture.