
7 Child sexual abuse

SUMMARY

- The dynamics of child sexual abuse differ from those of adult sexual abuse. In particular, children rarely disclose sexual abuse immediately after the event. Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour.
- The evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination; the examiner may also need to address specific issues related to consent and reporting of child sexual abuse.
- Definitive signs of genital trauma are seldom seen in cases of child sexual abuse, as physical force is rarely involved. The accurate interpretation of genital findings in children requires specialist training and wherever possible, experts in this field should be consulted.
- Decisions about STI testing in children should be made on a case-by-case basis. If testing is warranted, age-appropriate diagnostic tests should be used. Presumptive treatment of children for STIs is not generally recommended.
- A follow-up consultation is strongly recommended. Although a physical examination may not be necessary, a follow-up consultation provides an opportunity to assess any psychological problems that may have since arisen and to ensure that the child and his/her caregiver are receiving adequate social support and counselling.

7.1 Definition of child sexual abuse

These guidelines adopt the definition of child sexual abuse formulated by the 1999 WHO Consultation on Child Abuse Prevention (62) which stated that:

“Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- the inducement or coercion of a child to engage in any unlawful sexual activity;
- the exploitative use of a child in prostitution or other unlawful sexual practices;
- the exploitative use of children in pornographic performance and materials”.

7.2 Dynamics of child sexual abuse

The sexual abuse of children is a unique phenomenon; the dynamics are often very different to that of adult sexual abuse and therefore abuse of this nature cannot be handled in the same way (38, 63–65). Features that characterize child sexual abuse include:

- Physical force/violence is very rarely used; rather the perpetrator tries to manipulate the child's trust and hide the abuse.
- The perpetrator is typically a known and trusted caregiver.
- Child sexual abuse often occurs over many weeks or even years.
- The sexual abuse of children frequently occurs as repeated episodes that become more invasive with time. Perpetrators usually engage the child in a gradual process of sexualizing the relationship over time (i.e. grooming).
- Incest/intrafamilial abuse accounts for about one third of all child sexual abuse cases.

Paedophiles are individuals who prefer sexual contact with children to adults. They are usually skilled at planning and executing strategies to involve themselves with children. There is evidence to suggest that paedophiles may share their information about children (e.g. child pornography). This can occur at an international level, particularly through the use of the Internet.

Adequate training in the dynamics of child sexual abuse is essential for health care professionals to ensure that potential harm to children and their families is avoided by missing a diagnosis or by over-diagnosing.

7.2.1 Risk factors for victimization

A number of factors that make individual children vulnerable to sexual abuse have been identified; although based largely on experience in North American countries, the key determinants are believed to be (63, 66):

- female sex (though in some developing countries male children constitute a large proportion of child victims);
- unaccompanied children;
- children in foster care, adopted children, stepchildren;
- physically or mentally handicapped children;
- history of past abuse;
- poverty;
- war/armed conflict;
- psychological or cognitive vulnerability;
- single parent homes/broken homes;
- social isolation (e.g. lacking an emotional support network);
- parent(s) with mental illness, or alcohol or drug dependency.

7.2.2 Dynamics of disclosure

In the majority of cases, children do not disclose abuse immediately following the event. The reluctance to disclose abuse tends to stem from a fear of the

perpetrator; the perpetrator may have made threats, such as “If you tell anyone I will kill you/ kill your mother” (66–69).

The “child sexual abuse accommodation syndrome”, proposed by Summit (69), has been invoked by a number of researchers to explain why children’s disclosures are often delayed following abuse and why disclosure is sometimes problematic or retracted. According to its author, the typical pattern of events is as follows: the child is forced to keep the sexual abuse a secret and initially feels trapped and helpless. These feelings of helplessness and the child’s fear that no one will believe the disclosure of abuse lead to accommodative behaviour. If the child does disclose, failure of family and professionals to protect and support the child adequately, augment the child’s distress and may lead to retraction of the disclosure (69).

Disclosure of sexual abuse in children can be purposeful or accidental (i.e. either intended or not intended by the child or perpetrator). Disclosure is often initiated after an enquiry about a physical complaint, for example, pain when washing the genital area or a bloodstain in the panties. Child sexual abuse disclosures are usually a process rather than a single event.

When children do disclose it is usually to their mother; however, the mother may also be the victim of abusive behaviour by the same perpetrator. Alternatively, disclosure may be to a close friend, peer or teacher.

7.3 Physical and behavioural indicators of child sexual abuse

Physical and behavioural indicators of child sexual abuse are summarized in Table 14. It is important to note that while the presence of one or more of the findings listed in Table 14 may raise concern, it does not necessarily prove that a child has been sexually abused (38–40).

Many health care professionals rely on indicators of this type to assist in the detection of cases of child sexual abuse, especially in children who are non-verbal. However, these indicators must be used with caution, especially in the absence of a disclosure or a diagnostic physical finding.

7.3.1 Sexualized behaviours

Sexualized behaviours include such activities as kissing with one’s tongue thrust into the other person’s mouth, fondling one’s own or another person’s breasts or genitals, masturbation, and rhythmic pelvic thrusting. Distinguishing inappropriate from developmentally appropriate, i.e. normal, sexual behaviours is often very difficult.

There is a growing body of research on sexualized behaviour in children and its relationship to sexual abuse (70–73). Although the majority of sexually abused children do not engage in sexualized behaviour, the presence of inappropriate sexual behaviour may be an indicator of sexual abuse. Generally speaking, sexualized behaviour in children could be defined as problematic when (71):

- it occurs at a greater frequency or at a much earlier stage than would be developmentally appropriate (e.g. a 10 year-old boy versus a 2 year-old

Table 14 **Physical and behavioural indicators of child sexual abuse**

PHYSICAL INDICATORS	BEHAVIOURAL INDICATORS
Unexplained genital injury	Regression in behaviour, school performance or attaining developmental milestones
Recurrent vulvovaginitis	Acute traumatic response such as clingy behaviour and irritability in young children
Vaginal or penile discharge	Sleep disturbances
Bedwetting and fecal soiling beyond the usual age	Eating disorders
Anal complaints (e.g. fissures, pain, bleeding)	Problems at school
Pain on urination	Social problems
Urinary tract infection	Depression
STI ^a	Poor self-esteem
Pregnancy ^b	Inappropriate sexualized behaviours ^c
Presence of sperm ^b	

^a Considered diagnostic if perinatal and iatrogenic transmission can be ruled out.

^b Diagnostic in a child below the age of consent.

^c No one behaviour can be considered as evidence of sexual abuse; however, a pattern of behaviours is of concern. Children can display a broad range of sexual behaviours even in the absence of any reason to believe they have been sexually abused.

- boy playing with his penis in public, or a 6 year-old girl masturbating repeatedly in school);
- it interferes with the child's development (e.g. a child learning to use sexual behaviours as a way of engaging with other people);
- it is accompanied by the use of coercion, intimidation or force (e.g. one 4 year-old forcing another to engage in mutual fondling of the genitals or an imitation of intercourse);
- it is associated with emotional distress (e.g. eating or sleeping disturbances, aggressive or withdrawn behaviours);
- it reoccurs in secrecy after intervention by caregivers.

7.3.2 Genito-anal findings

In practice, clear physical findings of sexual abuse are seldom seen in children because child sexual abuse rarely involves physical harm. Many studies have found that normal and non-specific findings are common in sexually abused prepubertal girls (74–77). A genital examination with normal findings does not, therefore, preclude the possibility of sexual abuse; moreover, in the vast majority of cases the medical examination will neither confirm nor refute an allegation of sexual assault.

Certain sexual actions are unlikely to produce physical injuries (e.g. oro-genital contact) while others (e.g. penetration of the anus, or penetration of the labia but not the hymen) may not necessarily produce injuries. The amount of force used will be the determining factor in such circumstances. Gross trauma

to the genital and/or anal area is easier to diagnose, but healed or subtle signs of trauma are more difficult to interpret.

The position in which the child is examined is critical to the interpretation of the medical observations. If hymenal abnormalities are observed when the child is in the dorsal position (i.e. lying on her back), she should also be examined in the knee-chest position to exclude gravitational effects on these tissues.

Physical genito-anal findings are listed below, grouped according to their strength of evidence for sexual abuse and ranging from normal to definitive:

- *Normal and non-specific vaginal findings* include:
 - hymenal bumps, ridges and tags;
 - v-shaped notches located superior and lateral to the hymen, not extending to base of the hymen;
 - vulvovaginitis;
 - labial agglutination.
- *Normal and non-specific anal changes* include:
 - erythema;
 - fissures;
 - midline skin tags or folds;
 - venous congestion;
 - minor anal dilatation;
 - lichen sclerosis.
- *Anatomical variations or physical conditions that may be misinterpreted or often mistaken for sexual abuse* include:
 - lichen sclerosis;
 - vaginal and/or anal streptococcal infections;
 - failure of midline fusion;
 - non-specific vulva ulcerations;
 - urethral prolapse;
 - female genital mutilation (see Annex 2);
 - unintentional trauma (e.g. straddle injuries)
 - labial fusion (adhesions or agglutination).
- *Findings suggestive of abuse* include:
 - acute abrasions, lacerations or bruising of the labia, perihymenal tissues, penis, scrotum or perineum;
 - hymenal notch/cleft extending through more than 50% of the width of the hymenal rim;
 - scarring or fresh laceration of the posterior fourchette not involving the hymen (but unintentional trauma must be ruled out);
 - condyloma in children over the age of 2 years;
 - significant anal dilatation or scarring.
- *Findings that are definitive evidence of abuse or sexual contact* include:
 - sperm or seminal fluid in, or on, the child's body;
 - positive culture for *N. gonorrhoeae* or serologic confirmation of acquired syphilis (when perinatal and iatrogenic transmission can be ruled out);
 - intentional, blunt penetrating injury to the vaginal or anal orifice.

Straddle injuries are the most common type of unintentional injury involving the genitalia and arise when soft tissues of the external genitalia are compressed between an object and the pubic bone resulting in a haematoma of the external structures with visible swelling and some pain in the anterior portion of the external genitalia. Sometimes small linear abrasions are seen on the labia majora and minora, as well as at the posterior fourchette. It is extremely unlikely that a straddle injury will cause damage to the hymenal membrane. Straddle injuries are typically asymmetric or unilateral.

Labial fusion is a reasonably common condition and is caused by minor chronic inflammation. It *may* be caused by sexual abuse, but the finding is *not* diagnostic of abuse. In most cases, no treatment is necessary but if the adhesions are extensive, treatment with estrogen cream is usually successful. Surgical treatment for labial fusion is rarely indicated.

Blunt penetrating trauma to the vaginal orifice produces a characteristic pattern of injury; bruising, lacerations and/or abrasions are typically seen between the 4 and 8 o'clock positions of the hymen. Such injuries often extend to the posterior commissure, fossa navicularis and the posterior hymen. Any interruption in the integrity of the hymenal membrane edge that extends to the posterior vaginal wall is likely to be a healed laceration. More subtle interruptions, which are often described as notches or clefts, may be congenital in origin or could represent a less serious injury.

Female adolescent victims of sexual assault are less likely to show signs of acute trauma or evidence of old injuries than pre-pubescent girls. During puberty, the female genital tissues, especially in the hymenal area, become increasingly thick, moist and elastic due to the presence of estrogen (see Annex 2) and therefore stretch during penetration. Furthermore, tears in the hymen may heal as partial clefts or notches that will be very difficult to distinguish in an estrogenized, redundant or fimbriated hymen. Even minor injuries, such as abrasions in the posterior fourchette, will heal almost immediately.

Signs of major trauma, i.e. lacerations, to the anal office are very rarely observed. Minor injuries may sometimes be seen and typically include anal erythema, abrasions or fissures. In the vast majority of cases, there are no visible signs of trauma to the anal area.

The interpretation of genito-anal findings, in terms of making an overall diagnosis of child sexual abuse, is discussed further in section 7.8.1 (Diagnostic conclusions).

7.4 Health consequences

Both the physical and psychological health problems that are associated with sexual abuse in children have been well documented in the scientific literature (38, 66, 78, 79). The physical health consequences include:

- gastrointestinal disorders (e.g. irritable bowel syndrome, non-ulcer dyspepsia, chronic abdominal pain);
- gynaecological disorders (e.g. chronic pelvic pain, dysmenorrhea, menstrual irregularities);
- somatization (attributed to a preoccupation with bodily processes).

The following psychological and behavioural symptoms have been reported in child victims of sexual abuse:

- depressive symptoms;
- anxiety;
- low self-esteem;
- symptoms associated with PTSD such as re-experiencing, avoidance/numbing, hyperarousal;
- increased or inappropriate sexual behaviour;
- loss of social competence;
- cognitive impairment;
- body image concerns;
- substance abuse.

7.5 Assessment and examination of children

7.5.1 General considerations

Whereas adult victims of sexual violence often present as a medical emergency, children are brought to the attention of the health care professional through a variety of routes and circumstances (40):

- A child sexual abuse allegation has been reported and there is a request for an examination by the child protection authorities and/or the police.
- The child is brought by a family member or referred by a health care professional because an allegation has been made but not reported to authorities.
- Behavioural or physical indicators have been identified (e.g. by a caregiver, health care professional, teacher) and a further evaluation has been requested.

The timing and extent of the physical examination depends on the nature of the presenting complaint, the availability of resources in the community, the need for forensic evidence, and the expertise and style of the health professional caring for the child (80). Decisions about the timing of the physical examination should be based on the length of time that has elapsed since the child last had contact with the alleged perpetrator. As a guiding rule:

- If last contact was more than 72 hours previously and the child has no medical symptoms, an examination is needed as soon as possible but not urgently.
- If last contact was within 72 hours and the child is complaining of symptoms (i.e. pain, bleeding, discharge), the child should be seen immediately.

There are two distinct aspects to the gathering of information from the child (or caregivers) in cases of alleged child sexual abuse: (a) the medical history and (b) the interview. The function of the **medical or health history** is to find out why the child is being brought for health care at the present time and to obtain information about the child's physical or emotional symptoms. It also provides the basis for developing a medical diagnostic impression before a physical examination is conducted. The medical history may involve information about the alleged abuse, but only in so far as it relates to health problems or symptoms that have resulted there from, such as bleeding at the time of the

assault, or constipation or insomnia since that time. The medical history should be taken by a health professional.

The **interview** stage of the assessment goes beyond the medical history in that it seeks to obtain forensic information directly related to the alleged sexual abuse, for example, details of the assault, including the time and place, frequency, description of clothing worn and so on. Forensic interviewing of children is a specialized skill and, if possible, should be conducted by a trained professional (e.g. a child protection worker, a police officer with interviewing skills). In some communities, however, the health worker attending the child will be the most experienced interviewer available. Section 7.5.3 below provides guidance on forensic interviewing for health workers called upon to provide this service.

Regardless of who is responsible for the medical history and the forensic interview, the two aspects of the child's evaluation should be conducted in a coordinated manner so that the child is not further traumatized by unnecessary repetition of questioning and information is not lost or distorted.

7.5.2 Consent and confidentiality issues

In most communities, consent must be obtained from the child and/or caregiver to conduct a physical examination and to collect specimens for forensic evidence. In some cases, however, consent can be problematic, especially when the best interests of the child conflict with the child and/or caregiver's immediate concerns about giving consent. In cases where a caregiver refuses to give consent for the medical evaluation of a child, even after the need for the examination has been explained, the child protection authorities may need to be called in to waive the caregiver's custodial rights over the child for the purpose of facilitating the medical evaluation. In settings where consent is obtained upon arrival at the facility (e.g. the Emergency Department of a hospital), the examining health worker should ensure that the process of consent and all the procedures of the medical evaluation have been fully explained to the child and caregiver (see also section 4.2.3 Obtaining consent).

Codes of practice require all professionals to consider carefully their legal and ethical duties as they apply to patient confidentiality. The child and his/her parents/guardian need to understand that health care professionals may have a legal obligation to report the case and to disclose information received during the course of the consultation to the authorities even in the absence of consent (see section 7.8.2 Reporting abuse).

7.5.3 Interviewing the child

Community protocols usually dictate how, and by whom, the interview of the child is conducted. Some jurisdictions require the interview to be conducted by a trained professional, especially if there are legal implications, to ensure that information relevant to the case is obtained according to the proper procedures, and to this end have dedicated forensic interviewing teams who

can be called upon to conduct the interview of the child. In other settings, the health care worker attending the child will be responsible for conducting the interview as well as taking the medical history. In such circumstances, in addition to obtaining an account of the allegations, the interview stage of the assessment affords an opportunity for the health practitioner to develop rapport and trust with the child.

Interviewing a child for forensic purposes is an important component of the assessment of alleged cases of child sexual abuse; information so obtained will become part of the medico-legal process.

The forensic interviewing of children demands knowledge of a range of topics such as the process of disclosure and child-centred developmentally sensitive interviewing methods, including language and concept formation, memory and suggestibility (81). Health practitioners involved in the management of this process must also have knowledge of the dynamics and the consequences of child sexual abuse, an ability to establish rapport with children and adolescents, and a capacity to maintain objectivity in the assessment process (82).

Approaches and strategies that may be useful for interviewing children are outlined in Box 8. For further guidance on forensic interviewing of children, please consult Poole and Lamb (1998) details of which are listed in the bibliography.

BOX 8

Interviewing child victims of sexual abuse

Health workers responsible for investigative interviewing of children in cases of alleged sexual abuse may find it useful to bear in mind the following:

- All children should be approached with extreme sensitivity and their vulnerability recognized and understood.
- Try to establish a neutral environment and rapport with the child before beginning the interview.
- Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time, and that they may use terminology differently to adults making interpretation of questions and answers a sensitive matter.
- Always identify yourself as a helping person.
- Ask the child if he/she knows why they have come to see you.
- Establish ground rules for the interview, including permission for the child to say he/she doesn't know, permission to correct the interviewer, and the difference between truth and lies.
- Ask the child to describe what happened, or is happening, to them in their own words.
- Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity.
- When planning investigative strategies, consider other children (boys as well as girls) that may have had contact with the alleged perpetrator. For example, there may be an indication to examine the child's siblings. Also consider interviewing the caretaker of the child, without the child present.

7.5.4 Taking a history

The purpose of history-taking is to obtain routine, background information relating to the medical history of the child, as well as information about any medical symptoms that have arisen, or may result from, the abuse. As explained earlier, history-taking is distinct from interviewing the child about allegations of sexual abuse.

Ideally, a history should be obtained from a caregiver, or someone who is acquainted with the child, rather than from the child directly; however, this may not always be possible. Nonetheless, it is important to gather as much medical information as possible. Older children, especially adolescents are frequently shy or embarrassed when asked to talk about matters of a sexual nature. It is a good idea to make a point of asking whether they want an adult or parent present or not; adolescents tend to talk more freely when alone.

History-taking from children, particularly the very young, requires specific skills. As in the case of the interview, questions need to be adjusted to the age or comprehension of the child. Ideally, health workers performing this role should have specialized training and proven expertise in this field.

When gathering history directly from the child it may be worth starting with a number of general, non-threatening questions, for example, “What grade are you in at school?” and “How many brothers and sisters do you have?”, before moving on to cover the potentially more distressing issues. Be non-leading and non-suggestive and document all information as close to verbatim as possible; include observations of the interactions between, and emotional states of, the child and his/her family.

The following pieces of information are essential to the medical history; suggested phrasing of the corresponding questions, if directed to children, is given alongside in italicized typeface:

- Last occurrence of alleged abuse (younger children may be unable to answer this precisely). *When do you say this happened?*
- First time the alleged abuse occurred. *When is the first time you remember this happening?*
- Threats that were made.
- Nature of the assault, i.e. anal, vaginal and/or oral penetration. *What area of your body did you say was touched or hurt?* (The child may not know the site of penetration but may be able to indicate by pointing. This is an indication to examine both genital and anal regions in all cases.)
- Whether or not the child noticed any injuries or complained of pain.
- Vaginal or anal pain, bleeding and/or discharge following the event. *Do you have any pain in your bottom or genital area? Is there any blood in your panties or in the toilet?* (Use whatever term is culturally acceptable or commonly used for these parts of the anatomy.)
- Any difficulty or pain with voiding or defecating. *Does it hurt when you go to the bathroom?*
- Any urinary or faecal incontinence.

- First menstrual period and date of last menstrual period (girls only).
- Details of prior sexual activity (explain why you need to ask about this).
Have you had sex with someone because you wanted to?
- History of washing/bathing since (a recent) assault.

7.5.5 The physical examination

The examination of prepubescent children should be performed, or the findings interpreted, by practitioners who have specialist knowledge and skills in the field of child sexual abuse (40, 75, 80, 83, 84).

Before proceeding, ensure that consent has been obtained from the child and the caregiver, or the necessary authorities as prescribed by local consent guidelines. If the child refuses the examination, it would be appropriate to explore the reasons for the refusal. It may be possible to address some of the child's fears and anxieties (e.g. a fear of needles) or potential sources of unease (e.g. the sex of the examining health worker). Consider examining very small children while on their mother's (or carer's) lap or lying with her on a couch.

If the child still refuses, the examination may need to be deferred or even abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal and this coercion may represent yet another assault to the child. Consider sedation or a general anaesthetic *only* if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected. If it is known that the abuse was drug-assisted, the child needs to be told that he/she will be given a sedative or be put to sleep, that this may feel similar to what he/she has experienced in the past. Reassure the child about what will take place during the time under sedation and that he/she will be informed of the findings.

Health workers should find the examination of children greatly eased by following a few simple general rules of conduct, namely:

- Always ensure patient privacy. Be sensitive to the child's feelings of vulnerability and embarrassment and stop the examination if the child indicates discomfort or withdraws permission to continue.
- Always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety. Encourage the child to ask questions about the examination.
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination. Some older children may choose a trusted adult to be present.

The physical examination of children, which should consist of a head-to-toe review plus a detailed inspection of the genito-anal area, can be conducted according to the procedures outlined for adults in section 4.4 (The physical examination). When performing the head-to-toe examination of children, however, the following points are particularly noteworthy:

- Record the height and weight of the child (neglect may co-exist with sexual abuse).

- Note any bruises, burns, scars or rashes on the skin. Carefully describe the size, location, pattern and colour of any such injuries.
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Check for any signs that force and/or restraints were used, particularly around the neck and in the extremities.
- Record the child's sexual development (Tanner) stage (see Annex 2) and check the breasts for signs of injury.

In order to conduct the genital examination in girls, it is helpful to ask the child to lie supine in the frog-leg position, and/or, if comfortable, in the knee-chest position. A good light source is essential; an auroscope provides both a light source and magnification. A colposcope may also be used; however, although it is useful for documenting some types of injury and/or anatomical abnormalities, it is very expensive and generally does not reveal any additional medical findings.

In girls, the external genital structures to be examined are the:

- mons pubis;
- labia majora and labia minora;
- clitoris;
- urethra;
- vaginal vestibule;
- hymen;
- fossa navicularis;
- posterior fourchette.

In most cases, the hymen and surrounding structures will be easily identified. If not, the following technique may be useful for assisting in the visualizing of the hymen and surrounding structures to check for signs of injury:

- separate the labia with gentle lateral movement or with anterior traction (i.e. by pulling labia slightly towards examiner);
- after forewarning the child, gently drop a small amount of warm water on the structures; this may cause the structures to “unstick” and become more visible;
- ask the child to push or bear down.

Describe the location of any injuries using the face of a superimposed clock, paying close attention to the area between 4 and 8 o'clock, the most probable location of a penetrating injury.

Most examinations in pre-pubertal children are non-invasive and should not be painful. Speculums or anosopes and digital or bimanual examinations do not need to be used in child sexual abuse examinations unless medically indicated. If a speculum examination is needed, sedation or anaesthesia should be strongly considered.

In boys, the genital examination should include the following structures and tissues, checking for signs of injury (i.e. bruising, laceration, bleeding, discharge):

- the glans and frenulum;
- shaft;
- scrotum;
- testicles and epididymis;
- inguinal region;
- perineum.

In order to examine the anal area (in boys and girls), place the child in the lateral position and apply gentle traction to part the buttock cheeks. During the course of an anal examination the following tissues and structures should be inspected, again looking specifically for signs of injury (e.g. bruising, fissures, lacerations, bleeding, discharge):

- anal verge tissues;
- ano-rectal canal;
- perianal region;
- gluteal cleft.

Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

7.6 Collecting medical and forensic specimens

The comments made about the collection of medical and forensic specimens in adults apply equally to children and reference should be made to the appropriate section of these guidelines for information on these matters (see sections 4.6 Diagnostic tests, specimen collection and forensic issues and 5.2 Forensic specimen collection techniques).

7.7 Treatment

7.7.1 Children and STIs

The epidemiology, diagnosis and transmission modes of STIs in children differ from those in adults; age-appropriate diagnostic tests are thus required and treatment prescribed accordingly (80, 83, 85–87).

There are a number of ways in which children and adolescents can become infected by sexually transmitted organisms, including:

- in utero (vertical) transmission (e.g. HIV, syphilis);
- perinatal acquisition via cervical secretions (e.g. gonorrhoea, chlamydia, human papilloma virus (HPV), herpes simplex virus (HSV));
- direct contact with infected secretions as a result of sexual abuse, consensual sexual contact (adolescents), non-sexual contact or fomite transmission (extremely rare).

STI testing

Decisions about whether or not to screen a child who has been sexually abused for STIs are best made on a case-by-case basis. Testing for STIs is strongly indicated in the following situations (59, 86):

- the child presents with STI signs or symptoms (e.g. vaginal discharge, genital ulcers);
- the alleged offender is known to have a STI or is at high risk of contracting STIs;
- high prevalence of STIs in community;
- siblings or other household members have STIs, or signs or symptoms of STIs;
- the patient or parent requests testing.

Additional information relating to the screening for selected STIs is provided in Table 15.

When evaluating a child and the need for STI screening, it is important to bear in mind that if the sexual abuse occurred recently, STI cultures are likely to be negative, unless the child had a pre-existing STI. A follow-up visit 1 week after the last sexual exposure may be necessary in order to repeat the physical examination and to collect appropriate specimens for STI testing.

If STI testing is deemed appropriate, the following should be performed as part of the initial and follow-up examinations (59):

- Cultures for *N. gonorrhoeae* and *C. trachomatis*, using only standard culture systems.
- Wet-mount microscopic examination of vaginal swab specimen for *T. vaginalis*.
- Dark-field microscopy or direct fluorescent antibody testing of specimen(s) collected from vesicles or ulcers for *T. pallidum*; where available, tissue culture for HSV.
- Collection of a serum sample for analysis in the event of positive follow-up tests, or, if the last incident of sexual abuse occurred more than 12 weeks before the initial examination, immediate analysis for antibody to sexually transmitted agents.

In pre-pubertal children, swabs for STIs are only indicated where symptoms (e.g. vaginal discharge, pain) are present. Genital swabs in pre-pubescent children should be taken from the vaginal orifice or canal; cervical specimens are only required in adolescents (i.e. those at Tanner stage II of puberty or later), as adolescents may have asymptomatic infections.

Treatment of STIs

Presumptive treatment of children who have been sexually abused is not generally recommended for the following reasons (59):

- a) the estimated risk of contracting STIs through sexual abuse is low;
- b) pre-pubertal girls appear to be at lower risk of ascending infection than adolescent and adult women.

Children and adolescents who test positive for a sexually transmitted infection should be treated according to Table 16. Pregnant adolescents should be treated according to Table 12 (see section 6.3 Sexually transmitted infections).

Table 15 **Children and sexually transmitted infections: diagnostic information**

STI	NOTES AND COMMENTS
Chlamydia	<p>Chlamydia can be acquired perinatally, but if diagnosed in the second year of life, it is most likely to be sexually acquired.</p> <p>Nucleic acid amplification (NAA) examination by two separate test methods targeting different parts of the genome should be employed and repeated as necessary according to jurisdictional requirements. If this is not possible, enzyme immuno-assays tests should be used.</p>
Gonorrhoea	<p>Gonorrhoea infections outside the immediate neonatal period can be attributed to sexual abuse.</p> <p>Cultures for gonorrhoea are rarely positive in pre-pubertal children without signs or symptoms of vaginitis.</p> <p>Culture via direct inoculation, under optimal conditions, is the gold standard for diagnosis.</p>
Hepatitis B	<p>Testing should be done if perpetrator has multiple sex partners, is known to be an IV drug user, or is a man known to engage in sex with men.</p> <p>Serologic testing should be completed if the child has not received the HBV vaccine.</p>
HIV	<p>There are some documented cases of HIV and AIDS transmission via sexual abuse in children.</p> <p>HIV screening for all sexual abuse victims should be offered in high prevalence areas.</p> <p>Screening should be done at 3, 6 and 12 months following the abuse.</p>
HPV	<p>Perinatal exposure is common.</p> <p>Many cases of genital warts have been shown to be sexually acquired.</p> <p>Non-sexual transmission has been postulated.</p> <p>Many unanswered questions regarding HPV epidemiology in children remain and therefore, although sexual abuse should be considered as possible etiology, caution is advised during investigation.</p> <p>Detection is by cellular morphology or direct detection of HPV DNA.</p>
HSV, type I and II	<p>Type I is a common universal infection transmitted by close bodily contact such as kissing. It causes sores on the mouth and lips. Type I rarely causes genital infections.</p> <p>Type II is transmitted predominantly through sexual contact with an infected individual shedding the virus. Vertical transmission occurs if delivery takes place concurrently with the presence of sores in the mother's genital tract. Standard laboratory diagnosis is by inoculation of cells in tissue culture with infected secretions. Clinical diagnosis alone is not sufficient.</p>
Syphilis	<p>Considered to be proof of sexual abuse unless shown to be acquired congenitally.</p> <p>Diagnosis is by dark-field microscopy from a primary chancre or secondary lesion, or by serological tests on serum.</p>
Trichomoniasis	<p>Found rarely in pre-pubertal girls.</p> <p>In adults and adolescents it is almost always sexually transmitted.</p> <p>Diagnosed by microscopy and culture.</p>

HIV = human immunodeficiency virus; HPV = human papilloma virus; HSV = herpes simplex virus.

Table 16 WHO recommended STI treatment regimens for children and adolescents^a

STI	MEDICATION	ADMINISTRATION ROUTE AND DOSAGE
Gonorrhoea	Ceftriaxone	125 mg IM in a single dose
	or Cefixime	400 mg orally in a single dose or for children under 12 years, 8 mg/kg body weight orally in a single dose
Chlamydia	Doxycycline ^b	100 mg orally twice a day for 7 days if body weight ≥ 45 kg, or 2.2 mg/kg body weight orally twice a day for 7 days if body weight < 45 kg
	or Azithromycin	1 g orally in a single dose
Trichomoniasis and bacterial vaginosis	Metronidazole	2 g orally in a single dose or 1 g orally every 12 hours for 1 day
Syphilis	Benzathine penicillin G ^c	2.4 million IU IM in a single dose
	or Tetracycline ^{b,d}	500 mg orally twice a day for 14 days

IM = intramuscularly; IU = International Units.

^a The following regimens are intended to be guidelines only and are not inclusive of all available treatment regimens for STIs. Appropriate and accepted local regimens and protocols should be followed.

^b Contraindicated during pregnancy (Pregnant adolescents should be treated according to the regimens set out in Table 10.)

^c If not allergic to penicillin.

^d If allergic to penicillin.

Source: adapted from reference (88).

7.7.2 HIV and post-exposure prophylaxis

As is the case with adults, data on the efficacy and safety of post-exposure prophylaxis for HIV in children are inconclusive. However, as a guiding rule, if the child presents within 72 hours of an assault and a) the perpetrator(s) are at high risk for HIV infection, and b) compliance with treatment regimens is likely to be high, HIV prophylaxis should be considered. If available, a professional specializing in HIV infection in children should be consulted prior to prescribing PEP.

7.7.3 Pregnancy testing and management

In terms of pregnancy prevention and management, the recommendations provided for adults apply equally to adolescent females (see section 6.2 Pregnancy prevention and management).

7.8 Follow-up care

7.8.1 Diagnostic conclusions

It is possible to draw some conclusions regarding the likelihood of sexual abuse from observations made during the course of a patient evaluation; key areas of interest in this regard are (89, 90):

- history;
- behavioural or physical indicators (if present);

- symptoms;
- acute injuries;
- STIs;
- forensic evidence.

This process is greatly assisted by the use of a classification system for the range of physical, laboratory and historical information that is obtained in cases of alleged child sexual abuse. Table 17 illustrates the use of one such a system, developed by Adams (90), in which both physical examination findings and other data (i.e. statements from the child, observed behavioural changes and laboratory findings) are used collectively in order to make an overall assessment of the likelihood or otherwise of sexual abuse.

In some cases, physical findings alone will confirm abuse; for example, penetrating trauma to the hymen without an explanation. In others, forensic findings, such as sperm on a child's body will be sufficient to make the diagnosis. Alternatively, in the absence of physical findings (i.e. negative or non-specific findings) the diagnosis of abuse can be made on the basis of the child's statement or that of an eye-witness to the abuse.

Table 17 **Classification of physical findings and other data; a diagnostic tool in child sexual abuse cases**

DIAGNOSTIC CONCLUSION	EVIDENCE
Definite abuse or sexual contact	Finding sperm or seminal fluid in, or on, a child's body. Pregnancy. Positive cultures for <i>N. gonorrhoeae</i> . Evidence of syphilis or HIV infection (outside perinatal transmission and or transmission via blood products or contaminated needles). Clear evidence of blunt force or penetrating trauma to the hymenal area (without history). Clear videotape or photograph of abuse or eye-witness of abuse.
Probable abuse	Positive culture for <i>C. trachomatis</i> . Positive culture for HSV Type II. Trichomoniasis infection (absence of perinatal transmission). Child has given spontaneous, clear, consistent and detailed description of abuse, with or without abnormal or physical findings.
Possible abuse	Normal or non-specific physical findings in combination with significant behavioural changes, especially sexualized behaviours. HSV Type I. Condyloma accuminata with otherwise normal examination. Child made a statement but statement is not sufficiently detailed.
No indication of abuse	No history, no behavioural changes, no witnessed abuse. Normal examination. Non-specific findings with the same as above. Physical findings of injury consistent with history of unintentional injury that is clear and believable.

Source: Reference (90)

7.8.2 Reporting abuse

Every community has its own set of laws governing how, and to whom, a report regarding suspicion of child sexual abuse should be made. Most communities also have a mandatory reporting structure for professionals working with children and in many jurisdictions a failure to report child sexual abuse would constitute a crime. Typically the reporting law leaves the final determination as to whether or not abuse occurred to the investigators, not the reporters (91).

It is important that health workers are aware of the laws governing the reporting of child sexual abuse as it applies in their own area. Not every community will have such legislation, and under these circumstances, the health professional will need to decide what will be the most effective course of action to take in order to try to protect the child from further abuse.

7.8.3 Follow-up treatment

Because physical findings are rare in cases of child sexual abuse, a follow-up examination may not be necessary especially if there were no findings in the initial evaluation. If, however, findings were present at the time of the initial examination, a follow-up examination should be scheduled. The timing of follow-up examinations is dependent on the nature of the injuries and the conditions being treated and health care workers are advised to use their own judgement when determining how soon after the initial visit a follow-up examination should be done, allowing for the fact that injuries in the genital area heal very quickly in children.

The following conditions warrant special mention:

- If the initial exposure to sexual abuse was recent at the time of the first examination, a follow-up visit at 1 week may be required to conduct STI testing.
- Blood tests for HIV, hepatitis B and syphilis, whether done at the initial visit or not, may require repeating at 12 weeks, and again at 6 months.

In some cases, a follow-up examination can be viewed more as a psychosocial follow-up measure to ensure that the appropriate counselling referrals have been made and that there is adequate support for the child and family. Some centres use follow-up appointments as an opportunity to provide prevention and safety teaching to children and families.

7.8.4 Counselling and social support

While the initial medical assessment may not reveal any immediate psychological problems, it is important that a further assessment be conducted to ensure that any issues that may arise are addressed and dealt with appropriately.

Counselling services should be provided in a coordinated fashion, and considered in conjunction with similar services provided by schools and other community groups. Thought must also be given to providing support and/or counselling to those caring for the child. This may be required even if the child itself is not assessed as needing therapy. In general:

- Abuse-specific cognitive behavioural treatment is generally the most effective form of therapy for post-traumatic stress reactions.
- Group therapy for children is not necessarily more effective than individual therapy.
- Many sexually abused children may have co-morbid conditions that require specific treatment.
- Younger children may not understand the implication of abuse and therefore may appear to be less distressed than older children.
- A believing and supportive mother or non-offending caretaker can be a strong determinant for a good prognosis.