Introduction of HIV post-exposure prophylaxis for sexually abused children in Malawi

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Abstract

Background: Child sexual abuse (CSA) is a global problem. The consequences of CSA are physical and psychological damage. In areas with a high prevalence of HIV infection there is the additional risk of acquiring HIV infection. This can potentially be prevented by HIV post-exposure prophylaxis (PEP) with antiretroviral therapy (ART).

Objective: To improve the care of children who are victims of CSA by routinely assessing eligibility for HIV PEP and to investigate the feasibility, safety and efficacy of such treatment started in a paediatric emergency department in Malawi.

Method and setting: Children presenting to the Paediatric Emergency Department, Queen Elizabeth Central Hospital, Blantyre between January 1st 2004 and December 31st 2004 with a history of alleged CSA were all assessed for eligibility for HIV PEP and followed prospectively for 6 months.

Results: The number of children presenting with a history of alleged CSA in the 12-month period was 64. There were 63 girls and one boy. The mean age was 83 months.

Of the 64 children seen, 17 (26.5%) were offered PEP. The remaining 47 children were not offered PEP because of absence of physical signs of abuse in 20 cases (31.3%); delay in presentation beyond 72 hours from assault in 11 (17.2%); repeated sexual abuse in the preceding 6 months in 15 (23.4%); and one child (1.6%) was found to be HIV-infected on initial testing. No family refused an HIV test. No side effects due to ARV therapy were reported. Of the 17 children commenced on PEP, 11 returned for review after 1 month (64.7%), seven returned at 3 months (41.2%) and two of 15 (13.3%) returned at 6 months post assault. None have seroconverted.

Conclusions and recommendations: In a resource-poor setting with a high HIV prevalence HIV PEP following CSA is acceptable, safe and feasible. The opportunity to prevent acquisition of HIV infection should not be missed. HIV PEP should be incorporated in to national guidelines in countries with a high community prevalence of HIV infection.
Introduction

HIV post-exposure prophylaxis (PEP) is a form of secondary HIV prevention that is used to reduce the risk of HIV transmission. It is well established as a treatment for occupational exposure to HIV infection when health care workers are exposed to HIV through their work.[1][2] In such settings it has been shown to reduce risk of transmission rate by 81%.[3]

Increasingly HIV PEP is prescribed in non-occupational settings.[4] These include sexual assault, consensual unprotected sex, injecting drug use, and needle-stick or sharp object injuries in persons other than health care professionals. Recommendations for non-occupational PEP are available in both Europe and the US.[1] [5][6][7]

The transmission rate for HIV infection after a single sexual encounter between two consenting adults is low, estimated to be 0.01-0.2%.[8] However in child sexual abuse because of the increased incidence of violence and trauma, the immature, thin vaginal epithelium and cervical ectopy the risk of transmission is likely to be much higher.[9]

In countries in Africa where the community prevalence of HIV infection is high the risk of transmission of HIV infection through child sexual abuse is likely to be further increased. Although data on the actual risk is difficult to obtain several studies offer information. In Togo, one child of 33 investigated for sexually transmitted infection (STI) following sexual abuse was found to have been infected with HIV.[10] In a study from Nigeria 4.3% of children with AIDS acquired HIV infection through sexual abuse.[11] In Cameroon an alarming 24 of 71 victims (37.5%) of child sexual abuse acquired HIV infection secondary to the abuse.[12]

Because of the increasing numbers of sexually abused children presenting to our department over the preceding three years and concerns regarding the risk of transmission of HIV infection in a high prevalence setting we felt a real and urgent need to improve the care given to these children by introducing HIV PEP.

Here we review our experience and results from a paediatric emergency department in Malawi following a 12-month period of routinely offering HIV PEP to all eligible children following child sexual abuse to potentially prevent acquisition of HIV infection using a locally devised protocol.

Setting

Malawi is a country in central-southern Africa with a population of 12 million. The prevalence rate of HIV infection in adults (15-49 years) is 14.4%. [13] In the Malawi National Guidelines for Antiretroviral Therapy the use of PEP for sexual assault is mentioned but no specific protocol for management is documented and it has not been implemented.[14]

Blantyre is the major urban centre in the south of the country with a population of 650,000, of which 44% is under 14 years old. Queen Elizabeth Central Hospital (QECH) in Blantyre is the tertiary level referral hospital for the southern region of Malawi. The paediatric emergency department sees 75,000 children per year.

In the QECH the care of victims of child sexual abuse is a consultant led service. During every assessment demographics are collected together with details and timing of the assault. A full
medical history is obtained and a complete examination performed. Since January 2002 findings have been documented on a standard clinical assessment form. (Appendix 1)

Prior to 2004 the only feasible options for children who were victims of CSA, considering the resources available, were antibiotic treatment for prophylaxis against bacterial STI and the offer of an appointment for HIV testing 3 months after the assault. Few of these children returned for testing and no formal data were collected.

Methods

From 1st January 2004 each child presenting with a history of alleged sexual abuse was assessed for eligibility for HIV PEP following a written protocol. (Appendix 2) The child was considered eligible if he or she was seen less than 72 hours after the abuse, had not been previously assaulted in the preceding 6 months, and there was physical evidence of sexual penetration. In addition we asked if the HIV status of the assailant was known or could be ascertained.

If the child was eligible for PEP the guardian (and child if he or she had sufficient understanding and maturity) was counselled and an HIV test was performed (using Determine HIV-1/2 rapid test, Abbot Laboratories, USA). If the child was HIV uninfected PEP was offered and commenced immediately.

If the child was found to be HIV-infected, the guardian was counselled and the child referred to the appropriate paediatric clinic.

The antiretroviral therapy (ART) used for PEP was zidovudine and lamivudine given for a period of 28 days. (Doses in Appendix 2).

A child commenced on HIV PEP was reviewed at 1 month to assess adherence to treatment, any side effects of ART and to identify any other physical, social or emotional problems. The child was seen again at 3 months and 6 months post assault, for repeat HIV testing.

If the child was not eligible for HIV PEP an appointment was arranged for 3 months to repeat the HIV test and review the child.

Under present rules local ethics committee approval was not deemed necessary because this treatment is recognised as standard practice in resource-rich settings following known or high risk HIV exposure.

Results

In 2004 the number of children presenting to our department following alleged CSA was 64. The perpetrator was a family member in 6 cases (9.4%), a known individual (neighbour, household servant, teacher) in 40 cases (62.5%) and an unknown person in 17 (28.1%). One victim was male and 63 female. The median age was 83 months (range 22 –180 months).

Of the 64 children seen 44 (68.8%) had physical signs consistent with penetrative sexual abuse. Eleven children (17.2%) presented more than 72 hours after the abuse. Fifteen children (23.4%) had been assaulted previously in the preceding 6 months. In no case was the HIV status of the assailant known or was there possibility of tracing the person. Therefore 18 (28.2%) children were considered eligible for PEP. None of the families refused HIV testing. One child was
found to be HIV-infected on initial testing. The remaining 17 (26.6%) were offered HIV PEP and all consented to treatment. The children started on PEP presented an average of 25 hours (range 8 to 68 hours) after the assault.

Of the 17 children started on HIV PEP, 11 (64.7%) returned for review after one month of treatment. None of the children had side effects from the ART. None had evidence of STI. Seven of 17 (41.2%) and two of 15 (13.3%) have returned for the 3 and 6 months appointments respectively. None have seroconverted.

Those children not eligible for HIV PEP were offered an appointment at 3 months for review of the child and repeat HIV testing. Of the 46 children, only three presented for review and none of these had seroconverted.

Discussion

The number of children presenting to our department is likely to represent a small fraction of the total number who have been sexually abused. In addition to the problems of case identification experienced elsewhere, in Malawi families rarely seek medical help first unless there is evidence of severe injury. Most go first to the police and from there are referred to the hospital for a medical report. Hence if the family do not inform the police they are unlikely to present for medical assistance.

We identified a significant number of children who had been repeatedly abused over a period of time. These children were not eligible for PEP because of the possibility of the child having already acquired HIV infection and being in the "window period" prior to seroconversion.

Ideally PEP should be started as soon as possible after HIV exposure and certainly within 72 hours. Unfortunately a large number of children were excluded from PEP due to a delay in presentation. The causes of the delay are multiple. The child may not immediately disclose the assault, the family may not believe the child or decide not to seek treatment urgently, transport may be problematic, and legal notification usually takes precedent over medical assessment.

We acknowledge that by excluding children with no physical signs of abuse we are excluding children who have been abused as it is accepted that sexual penetration can occur without signs on physical examination. However if no trauma is sustained the risk of acquiring HIV infection from one episode of sexual assault is much reduced. In this particular situation we therefore felt that the risks of treatment outweighed the benefits.

In the UK “National guideline for the management of sexually transmitted infections in children and young people” it states that “inadequate information on the risks and benefits of PEP for HIV following abuse or assault in young people makes routine recommendations impossible”.[15] The Children’s HIV Association of the UK and Ireland (CHIVA) classes child sexual abuse as only a “moderate risk” for HIV acquisition and therefore states that the risk of PEP probably out weighs the benefits.[16]

However in a high HIV prevalence setting such as Malawi we feel that the assumption should be made that the assailant is HIV-infected unless known not to be. We feel that all children who have been sexually abused should be assessed for eligibility for HIV PEP and if there are no contraindications this should be offered as routine. This practice is recommended in South Africa, a country which is less resource constrained than Malawi but with a high level of sexual violence and HIV infection.[17]
We found that by discussing the possibility of HIV exposure at the time of presentation, being able to perform an immediate HIV test and initiating HIV PEP for eligible children at the initial consultation proved very efficient. This co-ordinated approach meant there was no need to refer to other departments or members of staff and there was less possibility of the child missing the opportunity to access PEP.

Although our return rate at one month was acceptable the subsequent follow rate was low. This has been found in other studies.[18][19] The reasons are multiple and complex and may be carer or child related. Carer issues may include lack of understanding of the need for follow up or poverty and problems of access to health care. Child related reasons for failing to return may include adverse drug reactions or traumatic associations after the assault.

Tests to monitor for side effects of ART are not routinely available in our hospital. However none of the children receiving ART reported any symptoms of side effects. Other studies have reported a high rate of stopping medication due to side effects.[19][20][21] We followed Malawi national guidelines [14] using a two drug regime without a protease inhibitor and therefore would expect less side effects.

For those children not eligible for HIV PEP the return rate was very poor, as was also found for sexually abused children prior to the introduction of the PEP treatment. The reasons are unclear but may include a fear of seroconversion. Because of the low return rate it is impossible to comment on the risk of seroconversion without HIV PEP.

We aim to make our service to abused children consultant led. We acknowledge that it is a specialised field within paediatrics that needs sensitivity and experience. We initiated HIV PEP as a pragmatic approach to tackle one tragic complication of CSA but this is just one aspect of the management of children who have been sexually abused. Ideally these children should receive medical, social and psychological care. However in Malawi there is no formal procedure for child protection. There is no provision for emergency contraception or psychological support. Police and most first-line medical staff are not trained in the management of victims of CSA.

Since completing this policy of assessing victims of CSA for eligibility for HIV PEP we have made our protocol known nationally in Malawi. We feel that this treatment should be made available to all Malawian children who are sexually abused. However a limiting factor for HIV PEP being offered more widely will be identifying clinicians with experience in dealing with CSA, who are able to handle these children appropriately and recognise the often subtle physical signs of abuse.

**Conclusions and Recommendations**

Child sexual abuse affects every society and the number of affected children is increasing. HIV PEP is an important part of the care of sexually abused children in a high prevalence setting and has been shown to be safe, acceptable and feasible. We recommend that it is routinely offered to all eligible children as an opportunity to prevent transmission of HIV infection. HIV PEP following sexual abuse should be incorporated into national guidelines in countries such as Malawi with high prevalence of HIV infection.
Acknowledgements
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Competing interests
We declare we have no competing interests.

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What is already known on this topic
- CSA is a world-wide problem with physical, psychological and social consequences.
- In areas of high HIV prevalence there is the additional risk of transmission of HIV infection to the child.
- HIV PEP can prevent transmission of HIV infection
- There is limited data on the use of HIV PEP in sexually abused children in a resource-poor high HIV prevalence setting.

What this study adds
- HIV PEP following child sexual abuse is acceptable, safe and feasible in our setting.
- Integration of HIV PEP in to national guidelines in areas of high HIV prevalence is recommended.
References

2. CDC. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. MMWR 2001;50(No. RR-11):1-42

Appendix 1:

**MEDICAL ASSESSMENT FOR DEFILEMENT**  Hosp No:

Name ............................   Age .........  Date of Birth ............
Address .................................................................

Name of doctor examining patient .......................... Date and time of assessment ............
Others present ..........................................................
Consent given by ....................................................

**HISTORY**

Date and time of most recent alleged incident .......................... Witnesses (if any) ......................
Date(s) and time(s) of other alleged incident(s) ..................

Details of allegations (use additional sheet if needed):

- Condom used  Y / N
- Lubricant used  Y / N  Type of lubricant ....................
- Did ejaculation occur?  Y / N / don’t know
- Bleeding at time of incident  Y / N  Site of bleeding............
- Pain at time of incident  Y / N  Site of pain ..................
- Pain since incident  Y / N  Site and duration of pain ........
- Abdominal pain  Y / N  Site and duration of pain ............
- Constipation  Y / N  How long for .........
- Urinary symptoms  Y / N Details..................How long for ......
- Sexually active before incident  Y / N
- Sexually active since incident  Y / N

*For females:*
- Periods started  Y / N If Y - year ...... usual cycle ........date of last period ........
- Tampons used  Y / N
- Vaginal discharge  Y / N If Y - colour of discharge ............
- Fever  Y / N  How long for ......
- Convulsions  Y / N  How long for ......
- Pallor/Jaundice  Y / N  How long for ......
- Vomiting  Y / N  How long for ......
- Diarrhoea  Y / N  How long for ......
- Cough  Y / N  How long for ......
- Rash  Y / N  How long for ......
- Difficulty breathing  Y / N  How long for ......
- Eating / Sucking  Y / N If N  How long for ......
- Oedema  Y / N  How long for ......
- Other (Please specify) ........................................................

Any previous admissions?  Y / N  (Please give details)  Diagnosis, and Dates .........................

**FAMILY HISTORY**

Any history of TB contact  Y / N, Epilepsy  Y / N, Diabetes  Y / N, Allergy  Y / N

Other  Y /N (detail please) ........................................................................................................

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<td>Y / N</td>
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<td>Previous drugs in last 2 weeks</td>
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EXAMINATION

Weight ............kg  %Weight for Age............
Nutritional status  good / fair / poor

Blantyre Coma Score (BCS)=
Pallor   0   +   ++   +++
Jaundice 0   +   ++   +++
Oedema 0   +   ++   +++
Rash 0   +   ++   +++
Neck stiffness   Y / N  Hepatomegaly   Y / N .....cm
Oral thrush/ sores   Y / N  Spleenomegaly   Y / N ..... cm
Lymphadenopathy   Y / N  Cardiac signs   Y / N
Respiratory signs   Y / N  Ear signs   Y / N
Finger Clubbing   Y / N  Neurological signs Y / N
please draw your findings
Any other masses   Y / N where........

Female
                  Swelling | Bruising | Abrasion | Laceration
--- | --- | --- | --- | ---
Labia
Clitoris
Peri-urethral area
Hymen
Posterior fourchette
Hymen:  annular / heart shaped / fimbriated size of opening .......

Male
                  Swelling | Bruising | Abrasion | Laceration
--- | --- | --- | --- | ---
Penis
Scrotum
Testes
Anus dilatation   Y / N  fissure   Y / N position ....... tone normal / lax

Other abnormalities:

Summary:

Investigations: Urine diptest ............... Other specimens taken:

Discharge and follow up:
Appendix 2:

**Guidelines for Post-Exposure Prophylaxis after Sexual Abuse**

**Introduction**

The risk of acquiring HIV infection from a single act of sexual intercourse is low but with child sexual abuse there is often associated violence and genital trauma, which will increase the rate of transmission.

Post-exposure prophylaxis (PEP) is not therapy for disease but is a preventative or prophylactic treatment. If started after exposure to HIV it may prevent HIV infection. It should be initiated as soon as possible after the exposure but is effective if started within 72 hours of the assault.

**Procedure**

- Complete existing “Medical assessment for defilement” form, available in A&E and the admissions room.

- During office hours the child should be seen by Dr Ahmad, Dr Ellis or Prof Molyneux.

- At the weekend or after office hours the child should be seen by the consultant on call. If this is not possible the child should be admitted overnight or asked to return the following morning for examination.

- If there are physical signs of trauma and/or penetration, and this is consistent with an event less than 72 hours previously, then PEP should be considered.

- If in the rare event the perpetrator is known and known to be HIV uninfected (written result confirming HIV negative status within the last month) then the child does not need to have an HIV test and PEP is not indicated.

- In all other cases the child and family should be pre-counselled in the usual way and offered an HIV test. If consent to be tested is given, the blood should be taken immediately and a rapid HIV test performed (test kits available from Dr Ahmad in A&E).

- If the initial HIV test is positive the child should not receive PEP. The child and family should be post-counselled and referred to the general paediatric clinic for follow-up.

- If the initial test is negative the family and child should be counselled and offered PEP. It should be emphasized that the treatment should be taken as directed and the course of treatment completed. They should be advised to contact the department if they feel the child is experiencing side effects from the treatment. They should also be aware that PEP is not 100% effective.

- If there are problems obtaining an HIV test, e.g. at night or at weekends, initiation of PEP treatment prior to HIV testing can be considered if the child is otherwise eligible. This is particularly important if the delay incurred waiting for an HIV test would take the time interval between exposure and initiation of treatment over 72 hours. In this situation the child should stay overnight or return on the next available working day for an HIV test. A decision should then be made at consultant level regarding the continuation of PEP therapy.
• PEP treatment is taken for 28 days.

• The child should be seen and reviewed at 1 month, 3 months and 6 months post exposure. This should be in the general paediatric clinic on Wednesday afternoon at 1.30pm. An HIV test will be repeated at 3 and 6 months.

• All children who have been sexually abused should receive prophylactic antibiotics as per protocol.

• Relevant information should be documented in the child’s health passport.

Summary

Children who are eligible for PEP

If there are physical signs consistent with genital trauma or penetration, anal or vaginal.
If the assault occurred less than 72 hour previously
If the child is HIV negative on initial testing.
If the child and guardian understand and agree to PEP treatment.

Children who are not eligible for PEP

If the assault occurred more than 72 hours ago
If the child has been assaulted previously in the preceding 6 months
If there are no physical signs of trauma or penetration
If the child is HIV positive on initial test
If HIV testing is refused.
If the child or family do not consent to PEP treatment

Dosage

The drug used for PEP is duovir: lamivudine 150 mg and zidovudine 300mg.

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Updated information and services can be found at:
http://adc.bmj.com/content/early/2005/09/20/adc.2005.080432.citation

These include:

Supplementary Material
Supplementary material can be found at:
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