West Virginia Foundation for
Rape Information and Services, Inc.

WV Pediatric Protocol for Response
Child Sexual Abuse and the Medical Evaluation

Child Sexual Abuse

In many cases of disclosed child sexual abuse, the abuse is not recent and may have been happening for a long time before it was reported. For these reasons, the timing of the medical evaluation and the need for evidence collection in children is determined on a case-by-case basis by a qualified healthcare provider.

Many children can be sexually abused over a period of years. In some instances, child sexual abuse may be restricted to fondling or genital touching; other instances may begin that way and escalate to penetration or intercourse after an extended period of time. Some children become adolescents before realizing that the sexual contact they have experienced is wrong and does not occur in most households.

For a child of any age, disclosing sexual abuse is especially difficult. Disclosures of abuse, for some children, may be a process that happens over a period of time—a delay in disclosure by a child is common.

System Response to Child Abuse Cases Is Different from Response to Adult/Adolescent Sexual Assault

There are many factors about child sexual abuse that make it uniquely different from the response to adult sexual assault cases; things like an automatic system engagement, delayed disclosure and the likelihood of non-diagnostic findings. In WV there is a system of professionals and processes in place that is activated by a report, unlike what happens in adult cases.

All children, regardless of the time since the abuse, deserve medical evaluation and treatment after a report of sexual abuse from a qualified healthcare provider with specific training. Due to the typical delay in disclosure, many children are brought in for a medical evaluation when forensic evidence is unlikely to be recovered.

Child sexual abuse is rarely diagnosed solely based on a physical examination or laboratory findings. Children's injuries heal quickly, and the majority of children with a history of sexual abuse have normal examinations.

Medical Evaluation of a Child Sexual Abuse Victim

The medical evaluation of a child sexual abuse victim refers to an examination of a child who has disclosed or is suspected of being sexually abused.

This kind of medical evaluation and collaboration with the system of professionals, meant to protect children and hold perpetrators accountable, requires a very specialized training and skill set. Child victims have different developmental, psychological and health needs compared to adults, and require age-appropriate accommodations. This is why it is imperative for a child disclosing sexual abuse or suspected of being sexually abused to be

seen by a qualified health care provider who meets national training standards in the evaluation and treatment of child abuse. This ensures that the child will be provided with holistic, trauma-sensitive, and appropriate care.

The National Protocol for Sexual Abuse Medical Forensic Examinations for Pediatrics provides the following guidelines for medical forensic evaluation of children:

- Provide children with timely access to examinations, trained examiners, and quality care
- Secure the physical and emotional safety of children
- Recognize that each child has unique capacities and strengths to heal
- Offer comfort, encouragement, and support
- Provide information about the exam process and links to resources to further
- address needs
- Involve children in decision making, to the extent possible
- Ensure appropriate confidentiality

The National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatrics, April 2016 can be found at Protocol National Guiding Documents – SAFEta

Role of Child Advocacy Centers in Child Sexual Abuse Medical Evaluation

WVCAN, as the statewide alliance of Child Advocacy Centers (CACs), promotes community awareness and advocacy, provides training and technical assistance to its centers, evaluates and assess their efficacy, and works to ensure that WV CACs are well-equipped to support families and children.

In most WV counties, the Multidisciplinary Team (MDIT) works hand-in-hand with the local Child Advocacy Center (CAC). Both MDITs and CACs are defined in **WV State Code (§49-3-101 and §49-4-402).** Law enforcement, child protective services (CPS), prosecution, mental health providers, qualified healthcare providers, and victim advocacy work together to conduct interviews and make team decisions about the investigation, treatment, management and prosecution of child abuse cases.

In the neutral setting of the CAC, team members can collaborate on strategies that will aid investigators and prosecutors without causing further harm to the child. This innovative, multidisciplinary approach significantly increases the likelihood of a successful outcome in court and long-term healing for the child.

CACs follow the national model established by the National Children's Alliance. The National Children's Alliance sets national accreditation standards for CACs based on research evidence and best practices proven to help children and families heal.

Local CACs provide an array of child-focused services, including specialized forensic interviewing, medical evaluation and treatment, trauma-focused evidence-based mental health assessment and treatment, multidisciplinary case reviews, and comprehensive advocacy services.

Per CACs' national accreditation standards, programs must be able to provide children with child abuse medical evaluations as a regular part of the team's community response to child abuse. Exams must be conducted using these standards:

- The qualified healthcare provider must have a baseline level of training specific to the evaluation/treatment of child sexual abuse, such as that provided by the WV Online Pediatric Sexual Assault Nurse Examiner (SANE) training.

- The medical provider must obtain a minimum of 8 continuing education credit hours specific to the field of child abuse per every 2 year CEU cycle for that individual's level of practice.

- The CAC should facilitate the medical provider's access to expert medical review of child sexual abuse evaluations.

- The CAC must make these evaluations available on-site or through community linkages to all child victims, regardless of their ability to pay.

- The CAC and the MDIT(s) must have written protocols for how children are to be given access to appropriate medical evaluation and treatment and circumstances under which this care is recommended by the team.

- Medical findings must be recorded through writing and photo-documentation, with CAC and MDIT members having HIPAA-compliant access to findings to be discussed when making decisions about investigation and treatment.

- CAC staff and non-medical MDIT members should receive training regarding the purpose and nature of the medical forensic exam in reported child sexual abuse cases.

Research has shown that healthcare providers without specialized training may be less capable of accurately identifying genital structures of children, correctly identifying abnormal findings, and may not know the evaluation techniques that ensure correct diagnoses and findings.

Specifically, the child abuse medical evaluation is a head-to-toe exam to:

- Help ensure the health, safety, and well-being of the child
- Evaluate, document, diagnose, and address medical conditions resulting from abuse
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Document, diagnose, and address medical conditions unrelated to abuse
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary
- Reassure and educate the child and family
- Refer for therapy to address the trauma related to the abuse/assault, if not provided by another member of the MDIT/CAC

Components of the Medical Evaluation

All children/adolescents who are suspected victims of child sexual abuse are entitled to a medical evaluation. The medical evaluation for most children will include a medical history, a physical examination. and an external inspection of the genitalia and the anus.

All qualified healthcare providers need to understand the procedures to follow when presented with a child suspected of having been sexually abused. These procedures must be performed and documented by the medical provider who has appropriate knowledge and clinical experience. If your county is served by a Child Advocacy Center (CAC), that organization will have a memorandum of understanding with a qualified healthcare provider who meets national child abuse medical training standards.

The West Virginia Child Advocacy Network, in collaboration with WVFRIS and other stakeholders, has developed protocols for medical providers responding to child abuse that aid in screening and referrals to care. These have been endorsed by the WV Chapter of the American Academy of Pediatrics and the WV Chapter of the American College of Emergency Physicians and can be found in the appendices.

Qualified healthcare providers need information from parents and children to determine safety concerns and the importance of a prompt examination. A medical forensic examination should be conducted, physical findings identified and documented, forensic materials preserved, and testing done for sexually transmitted infections (STIs), when appropriate.

The medical forensic examination includes:

- Assessing for any health consequences and providing treatment as needed
- Assessing the patient and parents' emotional status
- Reassuring the child and family that the child is "OK" and that any injuries present will heal
- Helping ensure the health, safety, and well-being of the child
- Making referrals for counseling, if need is indicated, and
- Providing expert witness testimony, when necessary

Timely evidence collection is critical to ensure the safety of the child, for medical intervention, for treatment of infections, for documentation and for treatment of injuries, and the recovery of any forensic evidence.

An **acute examination** is conducted when any of the following are present:

- Symptoms or history of recent traumatic sexual contact such as bleeding from the genital or anal area
- Complaints of anogenital pain
- Possible sexually transmitted infections (STIs)
- Need for emergency contraception or
- Time frame since the incident is within 96 hours of the sexual abuse
- Disclosure of previous abuse by the child and was in the care of that individual within the last 96 hours

The child should be seen, as soon as possible, to minimize the loss or deterioration of any evidence on the child's clothing or body.

A **non-acute examination** is conducted when the time frame is more than 96 hours after the incident. In many cases, the reporting delay can be several days, weeks or months since the sexual abuse occurred. In non-acute cases, information can be obtained from the documentation of healed injuries or the presence of STIs.

Most medical evaluations of sexually abused children are non-acute. These medical evaluations may be scheduled at a local Child Advocacy Center (CAC) or other location that specializes in the medical evaluation and treatment of the child who has been sexually abused. The date of the most recent contact should be taken into account when deciding when and where to schedule a medical evaluation. Each case will need to be evaluated based on the medical history and potential for the collection and preservation of evidence.

Request for Medical Evaluation for Child Sexual Abuse

Because of the inability of most children to secure medical treatment on their own, the majority of sexually abused children do not receive immediate medical attention. When medical attention is received, it is usually at the request of a third party.

This request is frequently made by a parent who notices genital soreness and/or discharge or urinary problems, by a teacher who sees a sudden change in the child's behavior, by a relative who suspects physical abuse or by a physician who discovers an STI from a vaginal, urethra or throat culture. Sometimes, a request for a medical evaluation is made by a child protective service (CPS) worker or law enforcement officer as part of an ongoing investigation.

Collaboration is needed among organizations providing services to child sexual abuse victims, utilizing the expertise of professionals who are trained in the medical response and psychodynamics of child sexual abuse.

Work of a Multidisciplinary Team

CACs work collaboratively with multidisciplinary teams to develop county-based protocols that address investigation and treatment in child abuse cases. These protocols include a component related to the medical evaluation and treatment of the child.

Ideally, each community should develop a multidisciplinary team of trained professionals to provide consistent, comprehensive care to children who have been sexually abused. The team may include a pediatrician, physician assistant, pediatric nurse practitioner, Pediatric Sexual Assault Nurse Examiner (PA-SANE or SANE-P) for the physical examination; a victim advocate from the rape crisis center, and/or a social worker to provide patient support; law enforcement, a Child Protective Service (CPS) worker, staff from the Child Advocacy Center (CAC) and/or a mental health provider to coordinate the investigation, treatment and advocacy services for children and their families; and the prosecutor for the criminal justice process.

West Virginia's Protocol for Child Sexual Abuse Medical Evaluation

A. Consent for the Medical Evaluation

Permission to provide a medical forensic exam must always be obtained. Qualified healthcare providers must identify the parent/guardian who will be responsible for providing permission for the child's care. Policies and procedures to follow must be in place should the parent/guardian be suspected of abuse, if a parent/guardian refuses to consent to an exam, or if a parent/guardian is not available to provide consent.

A qualified healthcare provider would **NOT** proceed with an examination without the assent/cooperation of the child, even if the child's parent/guardian have given consent. Consent may be withdrawn at any time during the exam process. Children and parents/guardians should be informed of their options and their right to decline any of the exam procedures.

B. Child Physical Abuse

The qualified healthcare provider would never restrain or otherwise force a child to comply with any part of the exam. An exception would be in cases of serious medical injury, pain, or trauma. If a child is not tolerating the examination, consider bringing the child back the next day for re-examination.

The circuit court, in the county in which they live, may direct the appointment of a special guardian for the purposes of consenting to and providing authorization to provide medical treatment. The circuit court would not consider any petition without support documentation from a licensed physician.

C. Presence of Parent(s) or Guardian

As few people as possible should be present during the medical history interview and medical evaluation. However, children should have the person of their choice available for support. Ideally, the parent or guardian should be supportive of the child/adolescent and help decrease anxiety. Those involved in the investigation, such as law enforcement or CPS, should not be in attendance during these procedures.

In the event that a child presents to an Emergency Department without a parent or guardian, the qualified healthcare provider should consult the hospital's policies and procedures regarding conducting a medical forensic examination without a parent being available to provide consent.

The pediatrician, physician assistant, pediatric nurse practitioner or Pediatric/Adolescent SANE (PA-SANE) will determine if the presence of the parent(s) or guardian may be detrimental to the examination.

If the following situations occur, the parent(s) or guardian should **not** be present:

- When the parent is distraught or disbelieving and this behavior may have a negative effect on the child/adolescent
- When a parent is acting to censor information the child/adolescent may provide
- When a history of sexual abuse in the parent may trigger emotions in the parent that may affect the child/adolescent's behavior, or
- When the parent or guardian is the suspect

The interview or examination must **NEVER** be done in the presence of a parent/guardian who is suspected of being the abuser.

C. Medical History Interview

An appropriate medical history should be obtained in all cases before conducting a medical forensic examination. The qualified healthcare provider (the pediatrician, physician assistant, pediatric nurse practitioner or PA-SANE) obtaining the medical history from the child must be sure to use non-leading questions and techniques specific for the child's cultural background and age-appropriate language development.

Attempting to determine exactly what happened to the child and by whom is the responsibility of the forensic interviewer. An exception to this protocol is if the child makes spontaneous statements about the reported event.

If it is necessary to obtain information directly from the child, remember the following:

- Avoid leading questions
    - Many times children will respond "yes" to everything based on what they think you want them to answer
- Provide time for children to process questions and generate their answers
- Avoid the use of medical terminology and use words that are easily understood by children
- Document what the child says and put it in quotes using the child's exact words

With children, to a much greater extent than with adults, the qualified healthcare provider must be aware of the long-term ramifications of the questions that are asked. While the immediate goal is to elicit the clearest possible information from the child, medical personnel should try not to communicate any attitudes or personal feelings that might create or increase the child's trauma. This is especially important in cases of sexual abuse by a family member where, in the child's mind, the action may have been thought to be one of affection.

Physical injuries provide documentation to show the use of physical force and to determine treatment options. The findings, from the history and time frame provided, will help determine

consistency with the signs and symptoms of sexual abuse. Throughout the medical evaluation and interviewing process, the qualified healthcare provider should explain each step of the procedures along with the rationale for doing them.

An assessment of the child's emotional state is a vital part of the medical history interview. This is an age-dependent interpretation. It is also important to note the child's verbal skill level and for the examiner to use terms that are understandable to the child. This assessment may often be accomplished by asking typical questions about family, school, television, and every day events.

Sitting at eye-level with the child can help decrease fear and intimidation and says to the child that you, the medical provider, are genuinely interested.

Talking with children about abuse of any kind, physical or sexual, requires special skills. It can be difficult to get the child to talk or to understand what the child says. When children are asked about their sexual activities with adults or other children, many times their inability or reluctance to answer is due to embarrassment, shyness, a fear of being thought of as a "tattle-tale," disloyal or simply due to a lack of understanding of the question itself.

D. Medical Forensic Examination

The medical evaluation should include the following:

- Medical history interview
- General physical examination
- Anogenital examination
- Use of photography
- Specialized exam techniques, when needed
- Collection of forensic evidence
- Documentation of findings
- Assessment of findings, treatment and referrals

Familiarity with the normal genital anatomy of infants and preadolescent children is a crucial skill needed to evaluate and document findings.

A normal examination is a common finding in cases of child sexual abuse. A substantial number of children are not physically injured because of the following:

- The abusive act often involves touching, fondling, or genital contact without vaginal or anal penetration
- The vaginal opening is very elastic, even in prepubertal girls
- The anal opening may dilate, therefore reducing the chance of injury, and
- The healing of the genital areas can be very rapid.

A normal genital examination can neither confirm nor negate sexual abuse incidents. In cases with obvious physical findings, medical personnel should document that the examination is consistent with the history of child sexual abuse.

The presence or absence of physical evidence does not prove whether a person has been sexually abused. Rather, the examination may provide supportive evidence that can be used to help in prosecution of the case. The ultimate diagnosis of child sexual abuse is made by an analysis of the child's medical history interview and subsequent investigation of the reported child abuse.

An immediate assessment of the child must be made to determine the presence of any significant vaginal, anal, penile or other sites of trauma or bleeding. If present, the control and stabilization of any trauma must be the priority.
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The likelihood of finding visible physical evidence of child sexual abuse depends on the following factors:

- Whether force was used
- The size and age differences of the suspect and the child
- Whether a foreign object was placed/forced into the mouth, vulva, or anus
- How the child was positioned and the use of lubricants during the abuse
- Type of abuse and its frequency and chronicity
- Whether the child resisted

When interpreting medical findings in cases of suspected child sexual abuse, examiners must consider that not all findings are due to trauma or sexual contact. As per N.D. Kellog et al., findings that are highly suggestive of abuse, even if no disclosure from the child has occurred, unless there is a plausible and timely report of accidental anogenital injury or previous surgical procedure that is confirmed with medical record review include:

- Acute trauma to genital/anal tissue
    - Acute laceration(s) or bruising of labia, penis, scrotum, or perineum
    - Acute laceration of the posterior fourchette or vestibule, not involving the hymen
    - Bruising, petechia, or abrasions on the hymen
    - Acute laceration of the hymen, of any depth; partial or complete
    - Vaginal laceration
    - Perianal bruising or perianal laceration with exposure of tissues below the dermis

- Residual (healing) injuries to genital/anal tissues
    - Perianal scar (a very rare finding that is difficult to diagnose unless previously documented acute injury at the same site)
    - Scar of the posterior fourchette (a very rare finding that is difficult to diagnose unless previously documented acute injury at the same site)
    - Healed hymenal transection/complete hymen cleft below the 3 to 9 o'clock position that extends to or through the base of the hymen, with no hymenal tissue discernible at that location
    - Signs of female genital mutation (FGM) or cutting, such as loss of the prepuce, clitoris, labia minora, or vertical linear scar adjacent to the clitoris

- Acute trauma to oral tissues
    - Acute oral trauma, such as unexplained injury or petechia of the lips or palate, particularly near the junction of the hard and soft palate

- Infections caused by sexual contact, if confirmed by appropriate testing, and perinatal transmission has been ruled out
    - Genital, rectal or pharyngeal Neisseria gonorrhea infection
    - Syphilis
    - Genital, rectal or pharyngeal Chlamydia trachomatis infection
    - Trichomonas vaginalis infection isolated from vaginal secretions or urine
    - HIV, if transmission by blood or contaminated needles has been ruled out

In addition, some infections can be spread by both sexual and non-sexual transmission. Interpretation of the significance of these infections requires additional information, including mother's gynecologic history (HPV) or child's history of oral lesions (HSV), or presence of skin

lesions elsewhere on the body (Molluscum), which might clarify the likelihood of sexual transmission.

- Molluscum contagiosum in the genital or anal area. In young children, transmission is most likely non-sexual. Transmission from intimate skin-to-skin contact in the adolescent population has been described
- Condyloma acuminatum (HPV) in the genital or anal area
- Herpes Simplex Type 1 or 2 infections in the oral, genital or anal area diagnosed by culture or nucleic acid amplification test
- Urogenital Gardnerella vaginalis (associated with sexual contact but also found in pubertal and adolescent vaginal flora)
- Urogenital Mycoplasma genitalium or ureaplasma urealyticum; while sexually transmitted in adolescents, prevalence and transmission of these infections in children is not well understood.

There are only two definite findings that are diagnostic of sexual contact:

- Pregnancy
- Semen identified in forensic specimens taken directly from a child's body

An initial head-to-toe assessment, carefully looking for signs of injuries on the child's body, should be completed first. After the full examination, an alternate light source should be passed over the child to determine if seminal fluid is present on the body. If present, these areas should be swabbed.

A thorough physical examination should be carried out, with findings documented on the body diagrams. Photographic documentation should be requested if necessary.
The presence of any bruises, abrasions, lacerations, burns or other injuries should be documented, along with descriptions of the injuries, noting hematomas and the degree of healing of any abrasions. Fractures, loose or absent teeth, grab marks, suction or bite marks should also be documented.

Painful procedures, such as blood drawing, should be done nearer the end of the exam; and the genital/anal examination as the last part of the complete examination.

Each step in the examination process should be explained to the child prior to being performed. In some situations, if the child is not able to cooperate, the exam should be rescheduled for another time.

Keys to minimizing trauma in an examination include:

- Adequate preparation of the child
- Qualified healthcare providers who are familiar with various examination positions
- Approaching the child with confidence and sensitivity
- Communicating with the child in a developmentally appropriate way

E. Evidence Collection

Selective completion of the SAECK with a child patient may be most appropriate. The kit should be used to collect evidence in cases of child sexual abuse occurring within 96 hours (4 days) or when circumstances warrant evidence collection past the 96 hour time frame. Detailed instructions for the collection of evidence for children can be found in the instructions in the WV SAECK.

F. Child Genitalia Examination – (Females)

A qualified healthcare provider must decide on a case-by-case basis the extent to which vaginal examinations should be performed. For the young female child, a complete gynecological exam is **not recommended** unless there is evidence or reasonable suspicion of genital trauma. However, a careful visual inspection should still be made.

Females are examined in a frog-leg position or supine on the examining table so that genitalia can be fully viewed in a manner that is not painful or invasive.

The presence of erythema, hematomas, excoriations, abrasions, old scars and bleeding, as well as the overall appearance of the introitus and the interlabial spread after traction, should be documented. The urethral meatus should be examined for any signs of trauma or abnormal dilation. Inspection of the vaginal area should also be directed to any discharge, odors, evidence of foreign bodies, tears, skin tags and tenderness.

Intentional trauma usually results in injury to structures such as the hymen, posterior fourchette, fossa navicularis and the anus.

All females have a hymen. The hymen is a membranous collar that surrounds the vaginal opening, rarely completely. There are anatomical variations in both the size and types of openings of the hymen. There are 3 basic kinds of hymen: fimbriated hymen, annular hymen and crescentic hymen.

The size of the hymenal opening is based on relaxation, position, technique used, and anatomic structure. The hymen is rarely affected in non-intentional trauma like straddle injury or falls. When a female lacks estrogen, the hymen is sensitive to touch, appears thin, smooth and atrophic. When a female has high levels of estrogen, the hymen appears to be pale pink or white and thick, quite redundant, and is not sensitive to touch.

Internal speculum exams on children are administered in **ONLY** extreme cases, such as a life-threatening situation or when the removal of a foreign object would cause undue pain and trauma to the child. These exams would be done in the Operating Room with a recommendation that general anesthesia be used.

G. Child Genital Examination – (Males)
Both the glans and the scrotal area are targets of trauma in acute sexual assault. Evidence of erythema, bruises, suction marks, excoriations, burns or lacerations of the glans and frenulum should be documented. The presence of testicular or prostatic tenderness or discharge from the urethra may reflect trauma or infection and may be a sign of abuse.

H. Child Anal and Perianal Examination (Males and Females)
A qualified healthcare provider must decide on a case-by-case basis the extent to which anal examinations should be performed for children, both male and female, during the initial examination.

Recent anal trauma may manifest itself by perianal erythema, edema or contusions, skin tags and spasms of the anal sphincter. An examination of the sphincter tone for spasm or laxity is important. Any findings should be noted. Use of photography has been of value in detecting small scars and striations not previously visible to the eye.

If anal tears or bleeding are present, anoscopy should be performed only by medical personnel trained to do the exam.

Children and STDs
It is important to recognize that the diagnosis of an STD in a prepubescent child may be evidence that the child has experienced sexual abuse. The CDC (2015e) noted the identification of sexually transmissible agents in children beyond the neonatal period strongly suggests sexual abuse (Jenny, Crawford-Jakubiak, & Committee on Child Abuse and Neglect, 2013).

Medical evaluation for children should include:
 Determining if an STI is present, then treatment would be essential
 Acquiring evidence for use in a criminal investigation, should that be necessary

In any case that a prepubescent child presents with an STI, an investigation should be conducted on an individual case-by-case basis, taking into account the risk factors and contacts, information obtained from the medical and social history and the medical evaluation conducted for sexual abuse. (*Black et al., 2009; CDC 2015e; Jenny, Crawford-Jakubiak, & Committee on child Abuse and Neglect, 2013; Girardet et al., 2011).*

STI presumptive treatment is NOT recommended until after initial tests are conducted and positive results are confirmed with a follow-up test (CDC, 2015e).

Factors that indicate the need for STI testing for prepubescent children, regardless of whether the case is acute or non-acute include a child who:

- Experienced penetration or there is evidence of recently healed penetrative injury to genitals, anus or oropharynx
- Has been abused by a stranger
- Has been abused by a perpetrator known to be infected with a STIs or at high risk for STI (e.g., intravenous drug users, men who have sex with men, people with multiple sex partners, and those with histories of STIs)
- Has a sibling or other relative or person in the household with an STI
- Lives in an area with a high rate of STIs in the community
- Has signs or symptoms of STIs (e.g., vaginal discharge or pain, genital itching or odor, urinary symptoms, and genital lesions or ulcers)
- Has been diagnosed with one STI
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- Patient or family request for testing

If no infections were identified during the medical forensic evaluation and the exposure was recent, a repeat examination and testing should be done approximately 2 weeks after initial testing.

Qualified healthcare providers should offer information about the risks of STIs for this population, symptoms, the necessity for testing, treatment options upon diagnosis and follow—up testing and care (adapted from the *National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric*).

POST-EXAMINATION INFORMATION

A. Referrals and Follow-Up

Document all information needed for any follow-up care. It is extremely important that children return for follow-up visits. A follow-up visit approximately 2 weeks after the most recent sexual exposure can include a repeat physical examination and collection of additional specimens.

CDC recommends repeat serologic testing for syphilis, Hepatitis B, and HIV at six (6) weeks and three (3) months after the assault.

A single examination might be sufficient if the child was abused for an extended period and if a substantial amount of time elapsed between the last suspected episode of abuse and the medical evaluation.

Refer the child for any follow-up tests or services. The provision of psychological and/or counseling services for children and their parent(s) or guardian(s) is important. This referral should be made to the rape crisis center, Child Advocacy Center (CAC), or other appropriate agency in the community.

B. Human Immunodeficiency Virus (HIV)

The risk of the child acquiring HIV as a result of sexual abuse must be considered during the medical evaluation. If there is a risk in an individual case, provision of HIV non-occupational post-exposure prophylaxis (nPEP) must be an option. The sooner nPEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission, if HIV exposure did occur (Day & Pierce-Weeks, 2013). There is a short timeline to start nPep—no later than 72 hours post–exposure.

Understand that the decision to recommend HIV serologic testing, as well as HIV nPEP, depends on local epidemiology, a case-by-case assessment of risk factors of the perpetrator, and details of the contact. The risk for an individual patient is difficult to calculate, since details of the perpetrator's risk factors and HIV status are usually unknown.

When children are at a high risk for exposure to HIV, it is recommended to consult with a provider who specializes in evaluation and treatment of children with HIV infection.

C. Discharge Information

Qualified medical providers should check all forms for completeness of information and signatures. Procedures for handling any discharge paperwork should follow each hospital's policies and protocols.

Discharge planning should involve the child, parent or guardian, and all responders to the case. This allows for a community response that ensures the child's discharge needs are adequately met. Child sexual abuse can have lifelong health impacts that include mental health consequences and chronic STIs, so the importance of counseling and supportive services in addition to medical follow-up must be stressed.

Written discharge information should be adapted to the unique needs of the child. These documents should be a summary of the care provided to the patient, including any testing that was completed, medication provided or prescribed, follow-up appointments, and signs and symptoms to watch for. Information about services for follow-up care, such as the services offered at the Children's Advocacy Center, should be included.

Before discharge, the child's physical comfort needs should be addressed. This includes offering food and drink, allowing them to wash or brush their teeth, and providing clothing if theirs was collected for evidence.

Safety is critical to consider when discharging a child. The qualified healthcare provider should assess for any safety risks in the home, such as the potential for repeated exposure to the assailant. If a safety concern arises before discharge, it must be addressed with the multi-disciplinary team to ensure the child is not discharged to an unsafe environment.