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Responding to Patients Who Have Been Sexually Abused

Executive summary

Sexual abuse, including sexual assault or rape, of children and adolescents is a major global public health problem, a violation of human rights, and has many health consequences in the short and long term. The physical, sexual, reproductive health and mental health consequences of such abuse are wide ranging and need to be addressed. Data from several settings show that children and adolescents are disproportionately represented among the cases of sexual abuse that are brought to the attention of health-care providers.

This guideline provides recommendations aimed primarily at front-line health-care providers (e.g. general practitioners, nurses, paediatricians, gynaecologists) providing care to children, including adolescents up to the age of 18 years, who have, or may have, experienced sexual abuse, including sexual assault or rape. It can also be useful for other cadres of specialist health-care providers who are likely to see children or adolescents. The guideline, while global, is particularly concerned with applicability in health-care settings in low- and middle- income countries, taking into account the more limited health-care resources available. Therefore, the feasibility of implementing the recommendations in low-resource settings was taken into account in the drafting.

This guideline aims to provide evidence-based recommendations for quality clinical care for children and adolescents who have, or may have, been subjected to sexual abuse, in order to mitigate the negative health consequences and improve their well-being. The objectives are to support health-care providers to provide quality, immediate and long-term clinical care and to apply ethical, human-rights-based and trauma-informed good practices in the provision of such care. Where relevant for provision of clinical care and where there is supporting evidence, sex-based differences and gender-based inequalities are flagged.

The guideline was developed according to the standards and requirements specified in the WHO handbook for guideline development, 2nd edition.[1] The process involved (i) identification of critical research questions and outcomes; (ii) retrieval of evidence, including commissioning of systematic reviews; (iii) synthesis of the evidence; (iv) quality assessment, including by a Guideline Development Group (GDG); and (v) formulation of recommendations with the GDG and input from an External Review Group (ERG). No relevant conflicts of interests were identified for the GDG and ERG. The document also includes overarching principles that inform clinical practice and that are derived from ethical and international human rights standards. It includes good practice statements that are based on both the guiding principles and the values and preferences of survivors, their caregivers and health-care providers. The recommendations draw on existing WHO recommendations, as well as new content developed as part of this guideline development process. The guiding principles, recommendations and good practice statements are summarized next.

Summary of guiding principles

Based on the United Nations Convention on the Rights of the Child (CRC)[1] and other human rights standards, the following overarching principles need to be observed when providing care to children and adolescents who have, or may have, been sexually abused.

GUIDING PRINCIPLES
• Attention to the best interests of children or adolescents by promoting and protecting safety; providing sensitive care; and protecting and promoting privacy and confidentiality.
• Addressing the evolving capacities of children or adolescents by providing information that is appropriate to age; seeking informed consent as appropriate; respecting their autonomy and wishes; and offering choices in the course of their medical care, as appropriate.
• Observing non-discrimination in the provision of care, irrespective of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status.
• Ensuring the participation of children or adolescents in decisions that have implications for their lives, by soliciting their opinions and taking those into account, and involving them in the design and delivery of care.

Summary of recommendations (R) and good practice statements (GP)

RECOMMENDATIONS AND GOOD PRACTICE STATEMENTS	
A. CHILD- OR ADOLESCENT-CENTRED CARE/FIRST-LINE SUPPORT	
GP1	Health-care providers should provide first-line support that is gender sensitive and child or adolescent centred, in response to disclosure of sexual abuse. This includes: • listening respectfully and empathetically to the information that is provided; • inquiring about the child's or adolescent's worries or concerns and needs, and answering all questions; • offering a non-judgmental and validating response; • taking actions to enhance their safety and minimize harms, including those of disclosure and, where possible, the likelihood of the abuse continuing, this includes ensuring visual and auditory privacy; • providing emotional and practical support by facilitating access to psychosocial services; • providing age-appropriate information about what will be done to provide them with care, including whether their disclosure of abuse will need to be reported to relevant designated authorities; • attending to them in a timely way and in accordance with their needs and wishes; • prioritizing immediate medical needs and first-line support; • making the environment and manner in which care is being provided appropriate to age, as well as sensitive to the needs of those facing discrimination related to, for example, disability or sexual orientation; • minimizing the need for the them to go to multiple points of care within the health facility; • empowering non-offending caregivers with information to understand possible symptoms and behaviours that the child or adolescent may show in the coming days or months and when to seek further help.

B. MEDICAL HISTORY, PHYSICAL EXAMINATION AND DOCUMENTATION OF FINDINGS	
GP2	In line with the principle of "do no harm", when the medical history is being obtained and, if needed, a forensic interview is being conducted, health-care providers should seek to minimize additional trauma and distress for children and adolescents who disclose sexual abuse. This includes: ● minimizing need to repeatedly tell their history; ● interviewing them on their own (i.e. separately from their caregivers), while offering to have another adult present as support; ● building trust and rapport by asking about neutral topics first; ● conducting a comprehensive assessment of their physical and emotional health, in order to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/or referrals; ● asking clear, open-ended questions without repetitions; ● using language and terminology that is appropriate to age and non-stigmatizing; ● allowing the child or adolescent to respond in the manner of their choice, including, for example, by writing, drawing or illustrating with models.
GP3	In conducting physical examinations and, where needed, forensic investigations, health-care providers should seek to minimize additional harms, trauma, fear and distress, and respect the autonomy and wishes of children or adolescents. This includes: ● maximizing efforts to have them undergo only one examination; ● offering information about the implications of positive or negative findings; ● minimizing delays while conducting the examination in accordance with the child's or adolescent's wishes; ● explaining what will be done, prior to each step; ● offering choice in the sex of the examiner, where possible; ● making sure there is another adult present during the examination; ● using age-appropriate visual aids and terms to explain the examination procedures; ● using examination instruments and positions that minimize physical discomfort and psychological distress; ● ensuring collection of forensic evidence is based on the account of the abuse and on what evidence can be collected, stored and analysed; ● not conducting virginity testing (two-finger test or per-vaginal examination), as it increases distress and does not indicate whether or not abuse took place;; ● not routinely using speculums, anoscopes and digital or bimanual examinations of the vagina or rectum of pre-pubertal children, unless medically indicated; if they are used, sedation or general anaesthesia should be considered.
GP4	Health-care providers should accurately and completely document findings of the medical history, physical examination and forensic tests and any other relevant information, for the purposes of appropriate follow-up and supporting survivors in accessing police and legal services, while at the same time protecting confidentiality and minimizing distress for children or adolescents and their caregivers. This includes: ● using a structured format for recording the findings; ● recording verbatim statements for accurate and complete documentation; ● noting down discrepancies between the child´s or adolescent´s and the caregivers´ account, if any, without interpretation; ● recording a detailed and accurate description of the symptoms and injuries; ● where no physical evidence is found, noting that absence of physical evidence does not mean that abuse did not occur; ● documenting the child's or adolescent's emotional state, while noting that no particular state is indicative of sexual abuse; ● seeking informed consent, as appropriate, for taking any photographs and/or videos, after explaining how they will be used; ● handling all collected information confidentially.

C. HIV POST-EXPOSURE PROPHYLAXIS TREATMENT AND ADHERENCE

		QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
R1	HIV post-exposure prophylaxis (PEP) should be offered, as appropriate, to children and adolescents who have been raped involving oral, vaginal or anal penetration with a penis, and who present within 72 hours of the incident.	Indirect evidence	Strong
R2	A 28-day prescription of antiretroviral drugs (ARVs) should be provided for HIV PEP, following initial risk assessment.	Low	Strong
R3	A triple-therapy regimen (i.e. with three drugs) of ARVs is preferred but a two-drug regimen is also effective.	Very low	Conditional
R4	Adherence counselling should be an important element in the provision of HIV PEP to survivors of sexual assault or rape.	Very low	Strong

D. PREGNANCY PREVENTION AND MANAGEMENT AMONG GIRLS WHO HAVE BEEN SEXUALLY ABUSED

		QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
R5	Offer emergency contraception to girls who have been raped involving peno-vaginal penetration and who present within 120 hours (5 days) of the incident.	Moderate	Strong
GP5	If a girl is pregnant as a result of the rape, she should be offered safe abortion to the full extent of the law.		

E. POST-EXPOSURE PROPHYLAXIS FOR CURABLE AND VACCINE-PREVENTABLE SEXUALLY TRANSMITTED INFECTIONS

		QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
R6	Presumptive (or prophylactic) treatment for gonorrhoea, chlamydia and syphilis is suggested for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis, or oral sex, particularly in settings where laboratory testing is not feasible.	Very low, indirect evidence	Conditional
R7	For children and adolescents who have been sexually abused and who present with clinical symptoms, syndromic case management is suggested for vaginal/urethral discharge (gonorrhoea, chlamydia, trichomoniasis), and for genital ulcers (herpes simplex virus, syphilis and chancroid), particularly in settings where laboratory testing is not feasible.	Very low, indirect evidence	Conditional
R8	Hepatitis B vaccination without hepatitis B immunoglobulin should be offered, as per national guidance.	Very low, indirect evidence	Strong
R9	Human papillomavirus vaccination should be offered to girls in the age group 9–14 years, as per national guidance.	Moderate	Strong

F. PSYCHOLOGICAL AND MENTAL HEALTH INTERVENTIONS IN THE SHORT TERM AND LONGER TERM			
GP6	For children and adolescents who have recently been sexually abused, and who experience symptoms of acute traumatic stress (within the first month), health-care providers should offer/continue to offer first-line support that is gender sensitive and child or adolescent centred, as described in **Good practice statement 1**.		
		QUALITY OF EVIDENCE	**STRENGTH OF RECOMMENDATION**
R10	Psychological debriefing should not be used in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.	Very low	Strong
R11	Cognitive behavioural therapy (CBT) with a trauma focus should be considered for children and adolescents who have been sexually abused and are experiencing symptoms of post-traumatic stress disorder (PTSD).	Very low	Conditional
R12	When safe and appropriate to involve at least one non-offending caregiver, CBT with a trauma focus should be considered for both: (i) children and adolescents who have been sexually abused and are experiencing symptoms of PTSD; and (ii) their non-offending caregiver(s).	Low	Conditional
R13	Psychological interventions, such as CBT, may be offered to children and adolescents with behavioural disorders, and caregiver skills training to their non-offending caregivers.	Low	Conditional
R14	Psychological interventions, such as CBT and interpersonal psychotherapy (IPT) may be offered to children and adolescents with emotional disorders, and caregiver skills training to their non-offending caregivers.	Low	Conditional
G. ETHICAL PRINCIPLES AND HUMAN RIGHTS STANDARDS FOR REPORTING CHILD OR ADOLESCENT SEXUAL ABUSE			
GP7	Whether health-care providers have to comply with a legal or policy requirement, or they are guided by an ethical duty to report known or suspected cases of child or adolescent sexual abuse, they should balance the need to take into account the best interests of that child or adolescent with their evolving capacities to make autonomous decisions. This includes: ● assessing the implications of reporting for their health and safety and taking steps to promote their safety; ● protecting their privacy (for example, in dealing with the media); ● promoting their health, by providing immediate medical care and first-line support; ● providing information about the obligation to report and limits of confidentiality; ● documenting the reporting process and maintaining confidentiality of the documented information. Health managers and policy-makers should: ● be aware of any legal requirements to report known or suspected cases of abuse; ● facilitate health-care providers to receive training on when and how to report; ● address health-care providers' beliefs and values that can adversely affect their reporting practices; ● establish systems and policies for record-keeping and information sharing that protect confidentiality; ● work with other agencies or institutions, including child protection and police services, in order to coordinate an appropriate response. Actions that are not in line with the principle of evolving capacities include: ● reporting consensual sexual activity between adolescents, unless that adolescent's safety is at risk; ● informing parents/caregivers where adolescents, depending on their age and maturity, express their preference not to involve their parents/caregivers, unless the adolescent's safety is at risk.		

IMPLEMENTATION CONSIDERATIONS

A. FACILITATING TIMELY UPTAKE OF SERVICES

GP8	Health-care providers, including those working in communities, should facilitate the timely uptake of services by children and adolescents who have been sexually abused. This includes: ● raising public awareness of the signs, symptoms and health consequences of sexual abuse, and the need to seek timely care; ● making available comprehensive and integrated care that reduces the need for visiting multiple points of care; ● publicizing the availability of services, especially to those who are marginalized and have less access; ● reducing stigma related to sexual abuse and improving the acceptability of services; ● advocating with policy-makers and managers to reduce policy-related and practical barriers to accessing care; ● strengthening referrals within and between health services and other sector services (for example, police, child protection and legal services).

B. CREATING A SUPPORTIVE AND ENABLING SERVICE-DELIVERY ENVIRONMENT FOR HEALTH-CARE PROVIDERS

GP9	Health managers and policy-makers should create an enabling service-delivery environment and support health-care providers in carrying out their tasks and responsibilities related to caring for children and adolescents who have been sexually abused. This includes: ● making available and prioritizing the provision of high-quality care in health-care settings for children and adolescents who have been sexually abused; ● facilitating ongoing training, supervision and mentoring; ● addressing needs for adequate staffing, infrastructure, supplies and financial resources; ● supporting health-care providers with court appearances on behalf of survivors; ● supporting health-care providers to prevent and cope with burnout and vicarious trauma; ● strengthening referrals and linkages with other support/allied services, to facilitate a multidisciplinary and multisectoral approach to care; ● making available tools or job aids (e.g. protocols or clinical care pathways) to guide the systematic provision of care; ● conducting monitoring and evaluation of care provision.

1. Background

A. The magnitude of child and adolescent sexual abuse

Sexual abuse, including sexual assault or rape, of children and adolescents, is a major global public health problem, a violation of human rights, and has many health consequences in the short and long term. A 2011 systematic review and meta-analysis of the prevalence of child sexual abuse around the world places the prevalence among girls at around 20% and among boys at around 8% *(13)*. Another 2013 meta-analysis of the current prevalence of child (<18 years of age) sexual abuse worldwide suggests that around 9% of girls and 3% of boys experience attempted or completed forced intercourse (oral, vaginal, or anal), and 13% of girls and 6% of boys experience some form of contact sexual abuse *(14)*.

Data from surveys of violence against children in nine low- and middle-income countries (LMICs),[1] in which children and youths aged 13–24 years were interviewed, showed that for respondents aged 18–24 years, the prevalence of any form of sexual violence in childhood (0–17 years) ranged from 4.4% to 37.6% among girls in Cambodia and Swaziland respectively *(15–17)*. This prevalence was over 25% for most of the nine countries. For boys, the prevalence of any form of sexual violence in childhood (0–18 years) ranged from 5.6% in Cambodia to 8.9% in Zimbabwe and 21.2% in Haiti *(15)*. The lifetime prevalence of physically forced or pressured/coerced sexual intercourse among girls (0 to 18 years) ranged from a low of 1.5% in Cambodia to a high of 17.5% in Swaziland. For boys, this figure ranged from 0.2% in Cambodia to 7.6% in Haiti *(15)*. A 2014 study based on three national telephone surveys of youths (aged 15–17 years) from the United States of America (USA) found that 26.6% of girls and 5.1% of boys had experienced sexual abuse and sexual assault by the time they were 17 years old *(18)*.

Adolescents who are part of the lesbian, gay, bisexual, transgender or intersex (LGBTI) population may be disproportionately vulnerable to sexual abuse because of discrimination on the basis of sexual orientation and gender identity. However, this is an emerging area of research, particularly in LMICs. Hence, there is very limited evidence on the magnitude or consequences of sexual abuse in this specific sub-group.

B. Health consequences of child and adolescent sexual abuse

According to a 2009 systematic review, the health outcomes associated with child and adolescent sexual abuse can be physical, including effects on sexual and reproductive health, behaviour and mental health *(19)*. The physical health consequences include injuries and gastrointestinal disorders *(20)*. For girls, the sexual and reproductive health consequences of sexual abuse include the risk of pregnancy, gynaecological disorders such as chronic non-cyclical pelvic pain, menstrual irregularities, dysmenorrhoea, genital infections and sexually transmitted infections (STIs), including HIV *(20–23)*. Several studies have found that boys and girls who have experienced sexual abuse are more likely to engage in risk-taking behaviours, including sexual risk taking and abuse of alcohol and drugs later in life, leading to negative health outcomes in adulthood *(24–27)*.

Child sexual abuse has short- and long-term mental health consequences, including lifetime diagnosis of post-traumatic stress, anxiety, depression, externalizing symptoms, eating disorders, problems with relationships, sleep disorders and suicidal and self-harm ideation and behaviours *(19, 28)*. A study of adult women who were exposed to sexual abuse as children found that those who had been abused on multiple occasions over a longer period of time had higher levels of mental health symptoms as compared to those who were abused at only one point in their life *(29)*. Another study of adult women (18–64 years) in the USA with histories of both physical and sexual abuse in childhood found higher annual health-care use (for mental health, primary care and pharmacy services) and costs (36% higher for history of physical and sexual abuse and 16% higher for only history of sexual abuse in childhood) many years after the abuse *(30)*. The health effects of child sexual abuse may be exacerbated where the perpetrator has a close or influential relationship with the child, and where the abuse is of greater severity, duration and frequency *(31–33)*.

C. Use of health services by children and adolescents who have experienced sexual abuse

Children and adolescents who have been sexually abused may come to the attention of a health-care provider through a variety of ways *(4)*. They may have a routine physical examination or a related or unrelated medical illness or complaint. Alternatively, they may be brought in by a caregiver who suspects sexual abuse, or by someone from an official institution, for a medical evaluation for the purpose of an investigation. However, data show that very few children who experience sexual abuse seek or receive any type of services. For example, the surveys of violence against children mentioned above showed that in most of the nine countries where survey results are available, less than 10% of survivors of sexual abuse received any services, whether it be health, or legal/police services, or counselling support *(15)*. Compared to the other countries surveyed, Swaziland[1] had the largest proportion of child survivors of sexual abuse who had received any service, at 24% *(15)*. In Kenya, 2% of boys and 6.8% of girls (18–24 years) who had experienced sexual abuse sought services prior to reaching the age of 18 years. However, only 0.4% of the boys and 3.4% of the girls actually received care. Moreover, 31% of the girls who had experienced abuse indicated that they would have wanted some or additional health-care services for the sexual violence they had experienced *(34)*. In Haiti, 10% of girls and 6.6% of boys who had experienced sexual abuse received services, most of which were medical services (i.e. 8.8% of girls and 5% of boys) *(35)*.

A study done in the USA in 2008 showed that in 19% of the cases of child sexual abuse perpetrated by a non-specified adult, medical authorities were informed, whereas this figure was 7.4% when the perpetrator was a known adult *(36)*. These data highlight that there is a need to: (i) work with communities to improve timely care seeking by survivors of abuse and their caregivers; (ii) raise awareness of health-care providers about child sexual abuse and its health consequences and how to recognize it; (iii) improve the response by health-care providers towards those children and adolescents who seek services; and (iv) improve coordination and timely referrals between other services or authorities where children and adolescents who are sexually abused are identified or taken to, and health services.

D. Objectives of and rationale for this guideline

This guideline aims to provide evidence-based recommendations for quality clinical care for children and adolescents who have, or may have, been subjected to sexual abuse, in order to mitigate the negative health consequences and improve their well-being. It responds

to an important public health and human rights concern, addresses the gaps in the health response to sexual abuse of children and adolescents, and aims to contribute to improved child health and adolescent sexual and reproductive health and mental health.

Specific objectives

The objectives are to support health-care providers to:

1. provide quality, immediate and long-term clinical care;
2. apply ethical, human-rights-based and trauma-informed good practices[1] in the provision of clinical care.

Why this guideline was developed

Sexual abuse of children and adolescents is a significant public health problem and a violation of fundamental human rights including the right to life, right to protection from all forms of violence and the right to enjoy the highest attainable standard of health. The physical, including sexual and reproductive health, and mental health consequences of such abuse are wide ranging and need to be addressed. Data from several settings show that children and adolescents are disproportionately represented among the cases of sexual assault that are brought to the attention of health-care providers *(37, 38)*. As the data above highlight, survivors of sexual abuse often do not receive health services. Health-care providers need to be prepared to respond appropriately to sexual abuse among children and adolescents, in order to mitigate its health and other impacts and enhance these individuals' health and well-being.

For similar reasons, in 2013, the World Health Organization (WHO) published the first clinical and policy guidelines for the health sector to respond to intimate partner violence and sexual violence against women that provide recommendations on identification and clinical care of adult women suffering from partner violence and sexual violence, as well as on training providers and delivering and managing services *(39)*. These have been widely disseminated in countries and, in the process of doing so, WHO was requested to also provide specific guidance for addressing sexual abuse among children and adolescents.

E. Target audience

This guideline provides recommendations aimed primarily at front-line health-care providers (e.g. general practitioners, nurses, midwives, gynaecologists, paediatricians) to provide high-quality, evidence-based clinical care for children and adolescents who have, or may have, experienced sexual abuse, including sexual assault or rape. These include those working within sexual and reproductive health, HIV and mental health programmes and services. However, the guideline can also be useful for other service providers (e.g. social workers, providers of psychosocial support), including specialists who are likely to see children or adolescents. The guideline also includes good practice considerations to address ethical and human rights issues, as well as implementation considerations aimed at policy-makers and managers, to enable and support provision of clinical care to children and adolescents who have, or may have, been sexually abused. The guideline, while global, is particularly concerned with applicability in health-care settings in LMICs, taking into account the more limited resources available. Therefore, the feasibility of implementing the recommendations in low-resource settings was taken into account.

F. Scope of the guideline

The scope of this guideline includes the following:

- **Population:** all children, including adolescents, between the ages of 0 and 18 years who have, or may have, been sexually abused. The guideline takes into account disproportionate vulnerability of children and adolescents who may face discrimination.
- **Interventions:** all relevant interventions for the provision of quality clinical care, including mental health care and immediate/short-term and long-term care. It also covers good practices to minimize harms and trauma in the process of medical history taking, physical examination and documentation, and ethical and safety considerations for reporting to the appropriate authorities. It flags implementation considerations related to the uptake of services, training of health-care providers and creating a supportive or enabling environment to facilitate provision of care. All of these are framed by ethical and human-rights-based guiding principles.
- **Interventions addressed in other guidelines:** recommendations related to identification of sexual abuse of children or adolescents will be part of a complementary guideline on clinical response to other forms of child maltreatment that will be published by WHO in 2018.[1]
- **Outcomes:** primary outcomes are related to improved child and adolescent health and well-being, including prevention of long-term disability and improved functioning. Secondary outcomes are related to the uptake of services by survivors and to the well-being of the non-offending caregivers.

The scope of this guideline excludes the following:

- **Populations:** children and adolescents who have been subjected to other forms of child maltreatment such as physical or emotional abuse or neglect, in the absence of sexual abuse; female genital mutilation; human trafficking; and reproductive coercion (e.g. tampering with contraception) in absence of sexual abuse.
- **Interventions:** non-clinical interventions – for example, pertaining to provision of allied care and services for children and adolescents subjected to sexual abuse outside of health services (e.g. child protection, legal or social services). This guideline does not include policy recommendations related to service-delivery models or training approaches. Perpetrator interventions will be addressed in the complementary guideline on other forms of child maltreatment that will be published in 2018 (see footnote 1), and are therefore not addressed here.

2. Methods

This guideline was developed according to requirements specified in the WHO handbook for guideline development, second edition *(40)*. The process involved: (i) identification of critical research questions and outcomes; (ii) retrieval of evidence, including commissioning of systematic reviews; (iii) synthesis of the evidence; (iv) quality assessment including by a Guideline Development Group (GDG); and (v) formulation of recommendations with the GDG and input from peer-reviewers.

A. Guideline contributors

The guideline development process was guided by three main groups (see **Annex 1** for names and designation):

a. a Steering Group comprising a core group of WHO staff members from relevant departments. A methodologist advised the Steering Group in reviewing the protocols and the grading of recommendations, assessment, development and evaluation (GRADE) tables *(41)* produced by the systematic reviews teams;

b. the Guideline Development Group (GDG), comprising 15 external (non-WHO) international stakeholders, including content experts, clinical experts and researchers in the field of sexual violence against children, who advised on the scope of the guideline and assisted in formulating the recommendations; agencies and United Nations partners that are likely to implement the guideline were invited as observers;

c. an External Review Group (ERG) of relevant international stakeholders who peer-reviewed the final document for clarity and accuracy, and advised on contextual issues and implications for implementation.

B. Declaration of interests by external contributors

All GDG members and other external contributors were required to complete a standard WHO declaration-of-interest form before engaging in the guideline development process, including participating in the guideline meetings. The WHO steering group reviewed all the declaration-of-interest forms and assessed any conflict of interest, before inviting experts to participate in the development of the guideline in accordance with the WHO guidelines for declaration of interest *(42)* and the requirements of the WHO Office of Compliance, Risk Management and Ethics (CRE). In addition, in accordance with the regulations for transparency, short biographies of all the GDG members were posted on the WHO website for 2 weeks before inviting them to participate. None of the meeting participants declared a conflict of interest that was considered sufficiently significant, to pose any risk to the guideline development process or to reduce its credibility *(40)*. Observers participated in the second GDG meeting when evidence was presented and recommendations were developed. They provided inputs upon request, but were not involved in developing the recommendations. A summary of the declaration-of-interest statements and how conflicts of interest were managed is included in Web Annex 1. No significant conflicts of interest were identified by the WHO steering group that required additional review by the WHO CRE.

C. Identification of priority research questions and outcomes – scoping exercise

The scope of the guideline was developed by the WHO Steering Group, based on the review of the available literature, including relevant WHO and other guidelines. The first GDG meeting was held in February 2016, to present and review the scope of the guideline and agree on the priority research questions, using the population, intervention, comparator, outcome (PICO) format. These questions respond to (i) pharmacological interventions for provision of immediate clinical care; and (ii) psychological interventions in the short and long term (the list of priority questions agreed by the GDG is available upon request).

Following the first GDG meeting, PICO questions for the critical and important outcomes for the psychological interventions[1] were ranked by the GDG through an online survey. The GDG was asked to rate the importance of the outcomes for psychological interventions on a scale of 1 to 9. Those outcomes that had an average rating of between 7 and 9 were ranked as "critical" and those with a score between 4 and 6 were considered "important", but not "critical".[2] The GDG agreed that for the following topics, existing WHO guidelines and recommendations were applicable to the population for this guideline. This includes (i) pregnancy prevention and management; (ii) vaccines to prevent STIs; (iii) HIV prevention – offer of post-exposure prophylaxis (PEP), dosage and regimen; and (iv) some mental health interventions. The decision to use existing WHO recommendations for these topics was based on the fact that these recommendations were based on recent systematic reviews and/or are not likely to be different for the population of interest for this guideline. A total of four new priority (i.e. PICO) questions were agreed for developing recommendations.

D. Values and preferences to inform good practices and guiding principles

Additionally, two literature reviews of both qualitative and quantitative studies were conducted to identify (i) the values and preferences of survivors, their caregivers and health-care providers; and (ii) practices and preferences related to reporting of sexual abuse to relevant designated authorities. These literature reviews, together with international standards related to human rights, ethics and gender equality, informed the development of: (i) guiding principles; (ii) good practice statements for delivery of clinical care, reporting abuse and implementation considerations; and (iii) remarks formulated for implementing the recommendations. The topics identified for informing good practices and guiding principles included: (i) first-line support to disclosure of sexual abuse; (ii) medical history, physical examination and documentation practices to minimize harms and trauma; (iii) ethical and human rights standards for reporting abuse; (iv) facilitating timely uptake of services; and (v) creating supportive and enabling service-delivery environment for health-care providers to fulfil their responsibilities in provision of care. These topics were considered for good practice statements, based on the premise that actions deriving from ethical and human rights standards cannot be subjected to experimental methods. Additionally, where actions were based on sound practical judgement, including public health and medical practice, and/or carried little to no risk of harm to health or safety, these were also incorporated into the good practice statements.

E. Evidence retrieval

A systematic and comprehensive retrieval of evidence was conducted to identify published studies concerning the PICO questions prioritized through the scoping exercise. Systematic reviews were identified for three out of the four priority questions agreed by the GDG for which new recommendations had to be developed. However, these were older than 2 years prior to the development of this guideline. Hence, an update of previous systematic reviews was undertaken. The systematic reviews were commissioned to external groups (see **Annex 1** for names). Protocols were prepared for each systematic review, including the updates of previous ones. The protocols included the PICO question and the criteria for identification of studies, including search strategies (with support from the WHO librarian), methods for assessing the risk of bias and a plan for data analysis. The Steering Group and the guideline methodologist reviewed and endorsed the protocols.

To identify relevant studies, systematic searches of several electronic databases were conducted, including Pubmed, Ovid, Medline, CINAHL (EBSCOhost), Web of Science, SCOPUS, African Index Medicus, LILACS, PsycINFO (EBSCOhost), POPLINE, WHOLIS via LILACS, ERIC (EBSCOhost), NYAM Library, ClinicalTrials.gov and African Journals Online. The search strategies employed to identify the studies, and the specific criteria for inclusion and exclusion of studies, were reported using the preferred reporting items for systematic reviews and meta-analyses (PRISMA) guidelines and flow diagram *(43)*. These are described in the full reports of the individual systematic reviews. Searches were also conducted in French, Spanish, Portuguese and Mandarin. For the questions related to the guiding principles and good practices, additional literature reviews were conducted using similar databases to those mentioned above. The full reports of the systematic reviews and the literature reviews for the good practices, including their search strategies, are available as Web Annexes 2–7.

F. Quality assessment, synthesis and grading of the evidence

The systematic reviewers performed quality assessments of the body of evidence using, where appropriate, the GRADE methodology *(41)*. Following this approach, the quality of evidence for each outcome was rated as "high", "moderate", "low" or "very low", based on the following set of pre-established criteria: (i) risk of bias, based on the limitations in the study design and execution; (ii) inconsistency of the results; (iii) indirectness; (iv) imprecision; and (v) publication bias *(40)*. In some cases, the strength of evidence is labelled as "indirect evidence", when no direct evidence was identified for the population of interest or outcome, or there are no studies directly comparing the intervention and comparator. However, these studies, which were mainly observational studies were also subject to quality assessments based on risk of bias assessment. Therefore, the decision for making the recommendation is derived from indirect comparisons of the intervention and comparator, or the data are extrapolated from other appropriate populations or based on intermediate outcomes. GRADE evidence profile tables (or "summary of findings") were developed for each priority PICO question for which evidence was available. The GRADE tables include quality assessments based on the above-mentioned criteria for rating each outcome as high, moderate, low or very low. GRADE tables are available as Web Annexes 3b, 5b and 6b.[1]

G. Formulation of recommendations

Prior to the second GDG meeting (December 2016), the Steering Group formulated an initial draft statement for each priority question, which served as a basis for discussion. During the meeting, the evidence summaries, GRADE tables and draft statements were presented to the

GDG. The GDG systematically reviewed and discussed (i) the evidence (contained in GRADE tables – Web Annexes 3b, 5b and 6b); and (ii) each draft statement, using an established set of criteria (see Box 1) elaborated in evidence-to-decision tables (see Web Annexes 3a–6a).

BOX 1. FACTORS CONSIDERED IN FORMULATING THE RECOMMENDATIONS

- Priority of the addressed health problem
- Values and preferences of children and adolescents who have been abused, and of health-care providers
- Balance between benefits and harms
- Quality of the available evidence
- Resource implications
- Cost-effectiveness
- Equity and human rights issues
- Acceptability of the proposed intervention
- Feasibility of the proposed intervention

Each recommendation contained in this guideline encompasses a direction (in favour or against) and a rating of the degree of strength (see **Annex 2** for the implications of the rating). The following categories were used to establish the rating of the strength of a recommendation *(40)*:

- *strong recommendation* means there is confidence that the desirable effects of adherence to a recommendation outweigh the undesirable effects;
- *conditional recommendation* means that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but there is not full confidence of that conclusion.

At the second meeting of the GDG in December 2016, the final recommendations for or against an intervention and its strength were decided by consensus. For each recommendation, based on iterative discussions, consensus was reached when there was unanimous agreement or no disagreement voiced. No major disagreements occurred that had to be resolved or put to vote.

H. Document preparation and peer-review

Following, the second GDG meeting (December 2016), a report was prepared. The WHO Steering Group drafted the guideline containing all the recommendations (new and existing), good practice statements and guiding principles. The full draft of the guideline was sent electronically to all the GDG members for further inputs, and thereafter to the ERG for peer-review. Seven peer-reviewers from different WHO regions with expertise in paediatric research or clinical practice, or representing organizations providing services to children and adolescents affected by sexual abuse, were selected after reviewing their declarations of interest (see **Annex 1** for names). The inputs from the ERG were limited to correcting factual errors, improving language clarity and providing contextual information. No major disagreements arose during the process of review and no modifications were made to the direction, strength or content of the recommendations.

3. Guiding principles derived from ethical principles and human rights standards

Clinical care for children and adolescents who have been sexually abused should be guided by obligations to protect, prevent and respond to all forms of violence against children and adolescents. These obligations are specified in international human rights standards (for a listing of the relevant instruments, see **Annex 3**). Several human rights instruments that many governments have signed up to, including the Convention on the Rights of the Child (CRC) *(2)*, and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) *(44)* recognize the rights of children and adolescents, as well as the responsibilities of the duty bearers in protecting and promoting these rights. These human rights standards specify the responsibilities of duty bearers (i.e. health-care providers and health-care institutions) to take all appropriate measures to protect the child or adolescent from all forms of violence and abuse. They confer rights to protection,[1] privacy,[2] participation[3] and health,[4] including access to care and information for children and adolescents. Health-care providers need to be aware of these standards and how they translate in relevant national laws, and apply them as guiding principles in providing care to children and adolescents who have been sexually abused. The overarching guiding principles derived from the key international human rights standards are listed next.

A. The principle of best interests of the child or adolescent

In practice, this requires that duty bearers take the actions listed next.

- **Protect and promote safety:** promoting and protecting the physical and emotional safety of the child or adolescent must be the primary consideration throughout the course of care. This means that, with the participation from the child and adolescent and their non-offending caregivers, as appropriate, health-care providers need to consider all potential harms and take or choose actions that will minimize the negative consequences on the child or adolescent, including the likelihood of the abuse continuing.
- **Provide sensitive care:** children and adolescents who disclose sexual abuse need to be listened to attentively, without interpreting or judging their account, even when it might differ from that of the accompanying caregivers. Children and adolescents should be offered an empathetic and non-judgemental response that reassures them that they are not to blame for the abuse and that they have acted appropriately in disclosing it.
- **Protect and promote privacy and confidentiality:** protecting privacy during care and confidential handling of all collected information is of particular importance to promote the safety of the child or adolescent. This means that during consultation and examination, only those who need to be present in the room (including to ensure the safety of the child or adolescent) should be allowed. For safety reasons, children and adolescents should be interviewed on their own, separately from the caregiver (see **Good practice statement 2**). Information collected from interviews and examination should

be shared on a need-to-know basis and only after obtaining informed consent from the child or adolescent and/or caregivers, as appropriate. In cases where there are limits to confidentiality, including any obligations to report incidents, these should be explained to children/adolescents and their caregivers at the beginning of care provision. Collected information should be stored securely (e.g. protected by key or password).

B. The principle of evolving capacities of the child or adolescent

The capacity[1] of children and adolescents to understand information about the nature of the clinical care they will receive and its benefits and consequences, and to make voluntary and informed choices or decisions, evolves with their age and developmental stage. The evolving capacities of the child or adolescent will have a bearing on their independent decision-making on health issues. Health-care institutions need to have policies that support the ability of children and adolescents to make decisions on their medical care in accordance with this principle.[2] In practice, health-care providers and health-care institutions should consider the actions listed next.

- **Provide information that is appropriate to age** as well as to other considerations (e.g. sex, race, ethnicity, religion, sexual orientation, gender identity, disability and socioeconomic status). This requires tailoring the information that is offered and how it is delivered (e.g. in choice of words or language, use of visual aids) to the child's or adolescent's age and developmental stage, including their cognitive, behavioural and emotional maturity to understand the information.
- **Seek informed consent as appropriate** to the child's or adolescent's age and evolving capacity and the legal age of consent for obtaining clinical care for all decisions and actions to be taken. Where the child or adolescent is below the legal age of consent, it may still be in their best interests to seek informed consent. For example, in some situations, adolescents may be deterred from seeking care where consent is required from their parents or legal guardians. Recognizing this, in some settings, older adolescents are able to provide informed consent in lieu of, or in addition to, their parents or legal guardians. Moreover, the CRC recognizes that, in accordance with evolving capacities, children have the right to access confidential counselling or advice and information without the consent of their parents or legal guardians.[3] In situations where it is assessed to be in the best interests of the adolescents who are in need of care, and based on their preferences, health-care providers may consider whether to involve the parents or legal guardians.
- **Respect the autonomy** and wishes of children or adolescents (e.g. not forcing them to give information or be examined) while balancing this with the need to protect their best interests (e.g. protect and promote their safety). In cases where a child's or adolescent´s wishes cannot be prioritized, the reasons should be explained to the child or adolescent before further steps are taken.
- **Offer choices** in the course of the medical care, as appropriate.

C. The principle of non-discrimination

This principle requires that all children and adolescents should be offered quality care, irrespective of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status. Health-care providers need to recognize and take into account gender and other social inequalities that can disproportionately increase vulnerabilities to sexual abuse and pose barriers in access to services for some groups over others. Therefore, attention should be paid to the specific needs of groups in special or vulnerable situations – for example, adolescent girls from poor communities, children or adolescents with disabilities, LGBTI adolescents, or adolescents that are part of ethnic minorities and indigenous groups.

D. The principle of participation

Children and adolescents have a right to participate[1] in decisions that have implications for their lives, in accordance with their evolving capacities. In practice this means they should be asked what they think and have their opinions respected and taken into account when decisions are being made in relation to clinical care being offered to them. Moreover, young people generally want to be consulted and engaged and to meaningfully participate in the design and delivery of health services that affect them *(45)*.

4. Recommendations and good practice statements

This section presents recommendations and good practice statements drawing on both the new content developed as part of this guidelines development process, as well as existing WHO recommendations and good practice statements that are applicable for the provision of clinical care to children and adolescents who have been sexually abused. Evidence summaries and evidence-to-recommendation justifications are presented only for those recommendations and good practice statements that are new or updated and were developed for consideration by the GDG for this guideline. For existing WHO recommendations or statements, the reader is directed to the source or original WHO guideline for those details. The original rating for quality of evidence and strength of recommendation from the source WHO guideline are maintained for existing recommendations. Accompanying remarks for existing recommendations are also based on the original source WHO guideline. However, where relevant, specific remarks pertaining to the population of interest have been added. This section has been structured in the order of the flow in which clinical care needs to be offered to children or adolescents who have been sexually abused. The guiding principles related to human rights, equity and gender equality are integrated either into the wording of the recommendation or good practice statement and/or reflected in the accompanying remarks.

A. Child- or adolescent-centred care/first-line support

Children or adolescents who have experienced, or are experiencing, sexual abuse may be traumatized and suffer a range of negative consequences on their physical and mental health that require immediate and long-term care and support. They may experience barriers in seeking and accessing care that include, for example, fear of disclosing their experience of abuse to an adult caregiver (especially if the perpetrator is a family member or known to the family), owing to the stigma and feelings of shame. Caregivers may not know about the signs, symptoms or consequences of abuse or where services are available. In addition, policies may require caregivers to report to the police before obtaining health care. There are a minimum set of actions, including provision of first-line support, that should guide the health-care response to children or adolescents who have, or may have, experienced sexual abuse.

GP1: GOOD PRACTICE STATEMENT 1

Health-care providers should provide first-line support that is gender sensitive and child or adolescent centred, in response to disclosure of sexual abuse. Offering first-line support includes the following:

- listening respectfully and empathetically to the information that is provided by the child or adolescent and his or her caregivers;
- inquiring about the child's or adolescent's worries or concerns and needs, and answering all questions; if abuse is disclosed, providing reassurance of efforts to minimize any harms;

- offering a non-judgemental and validating response – reassuring the child or adolescent that they are not to blame for the abuse and that they have acted appropriately in disclosing it;
- taking actions to enhance the child's or adolescent's safety and minimize harms, including those of disclosure and the likelihood of the abuse continuing, where possible; this includes ensuring visual and auditory privacy;
- providing emotional and practical support by facilitating access to psychosocial support for the child or adolescent and their non-offending caregivers; such support can include referrals to counselling, social services, including child protection services, police and legal services;
- providing age-appropriate information and explanation to children and adolescents and their non-offending caregivers, about what investigations will be conducted, what treatments will be offered to them, and whether the abuse will need to be reported to relevant designated authorities;
- attending to them in a timely way and in accordance with the child´s or adolescent´s needs and wishes (e.g. triaging where necessary to avoid long waiting times, but without rushing them);
- prioritizing immediate medical needs and first-line support;
- making the environment and manner in which care is being provided appropriate to age, as well as sensitive to the needs of those facing discrimination;
- minimizing the need for the child or adolescent to go to multiple points of care for treatment within the health facility, and ensuring that they are accompanied by the caregiver or an adult within the health facility;
- empowering non-offending caregivers with information to understand possible symptoms and/or behaviours that the child or adolescent may show in the coming days and months and when to seek further help.

Evidence summary

The actions for provision of first-line support are derived from (i) the WHO guidance on psychological first aid *(10, 39)*; (ii) the guiding principles articulated in section 3; and (iii) the literature review of the values and preferences of children, adolescents and their caregivers. The literature review aimed at answering the question: "*what are the guiding principles for provision of child- or adolescent-centred and gender-sensitive first-line support?*". It focused on studies that provided insights into the values and preferences of children or adolescents, their caregivers and health-care providers, to receiving an initial response to a confirmed or suspected case of sexual abuse.

A total of 22 studies were included, with a majority ($n = 16$) from high-income countries and six from LMICs *(46–67)*. The common themes identified across the studies as being of importance to survivors, caregivers and/or health-care providers included: providing information, explanation and timely care; respecting confidentiality and privacy; respecting the autonomy and wishes of the child or adolescent; receiving a non-judgemental and validating response that communicated belief in the survivor's account; acting in the best interests of the child or adolescent; careful and respectful listening of survivors' and caregivers' accounts; prioritizing

assessment of medical and psychological needs and care; and a child- or adolescent-friendly environment. In addition to these themes, the GDG highlighted the need to also engage the parents/caregivers in the provision of treatment/care to the child, but with the caveat that this should only include "non-offending" caregivers (see Web Annex 2 for the full report).

B. Medical history, physical examination and documentation of findings

GP2: GOOD PRACTICE STATEMENT 2

In line with the principle of "do no harm", when the medical history is being obtained and, if needed, a forensic interview is being conducted, health-care providers should seek to minimize additional trauma and distress for children and adolescents who disclose sexual abuse *(4, 68)*. These actions include the following:

- minimizing the need for the child or adolescent to repeatedly tell their history of sexual abuse, as it can be re-traumatizing;
- for reasons of confidentiality and safety, interviewing the child or adolescent on their own (i.e. separately from their caregivers), while offering to have another adult present as support;
- building trust and rapport by asking about neutral topics before delving into direct questions about the abuse;
- conducting a comprehensive assessment of their physical and emotional health; this is critical, as the child or adolescent's account of what happened to them provides important information to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/or referrals;
- asking clear, open-ended questions without repetitions; in some settings, while there may be requirements to document some information for reporting the abuse, it is important not to insist that the child or adolescent answers or discloses information that may cause them trauma or compromise their safety;
- using language and terminology that is appropriate to age and non-stigmatizing,[1] and training interpreters where needed;
- allowing the child or adolescent to answer questions and describe what happened to them in a manner of their choice, including, for example, by writing, drawing or illustrating with models.

Evidence summary

A systematic review of the literature was conducted that sought to answer the question "*what are child- or adolescent-centred, gender-sensitive and trauma-informed practices to obtain medical history and conduct forensic interviewing?*". This review resulted in the inclusion of 19 studies *(46, 47, 50, 59, 69–83)*. The common themes that emerged from these studies for the respondents were: building rapport; using a supportive and non-judgemental approach; asking clear and open-ended questions while avoiding repetition; using appropriate terms and language; training interpreters if they are used; giving children or adolescents a choice in how to answer the questions during the interview; and providing a child- and adolescent-friendly environment. In addition to these themes, the GDG also added specific suggestions

related to communicating with subgroups of children, such as those with disabilities (see Web Annex 2 for the full report).

GP3: GOOD PRACTICE STATEMENT 3

In conducting physical examinations and, where needed, forensic investigations, health-care providers should seek to minimize additional harms, trauma, fear and distress, and respect the autonomy and wishes of children or adolescents. These actions include the following:

- maximizing efforts to have the child or adolescent undergo only one examination, in order to minimize the trauma;
- offering information about the implications of positive or negative findings of the physical examination and forensic investigations;
- minimizing delays while conducting the examination in accordance with the child's or adolescent's wishes (for example, not rushing them);
- during the examination, explaining what will be done prior to each step;
- offering choice in the sex of the examiner, where possible;
- as is standard practice, making sure that there is another adult present during the examination;
- using age-appropriate visual aids and terms to explain the examination procedures;
- using examination instruments and positions that minimize physical discomfort and/or psychological distress;
- collecting forensic evidence in a way that is based on the account of the sexual abuse and on what evidence can be collected, stored and analysed; it should be done with informed consent from the child or adolescent and non-offending caregivers, as appropriate *(4, 68)*.

Actions that are medically unnecessary or are likely to increase harms or distress for the child or adolescent and, hence, are not to be undertaken, are as follows:

- carrying out the so called "virginity test" (also known as the "two-finger test" or per-vaginal exam). It has no scientific validity (i.e. does not provide evidence of whether or not a sexual assault took place), increases distress and harms to those examined and is a violation of their human rights *(84)*;
- speculums or anoscopes and digital or bimanual examinations of the vagina or rectum of a pre-pubertal child are not routinely required, unless medically indicated; if a speculum examination is needed, sedation or general anaesthesia should be considered *(68)*.

Evidence summary

A systematic review of the literature identified 26 studies, mostly from high-income countries (n = 23), that addressed the values and preferences of survivors of sexual abuse, caregivers and health-care providers *(46, 47, 50, 52, 53, 57, 67, 85–103)*. These studies sought to answer the question: "*What are good clinical practices for conducting a physical examination and forensic investigation, in order to minimize harms/trauma to the child or adolescent who has, or may have, been exposed to sexual abuse?*". The review identified additional papers highlighting

recommendations of clinical experts for good clinical practice for this population. The common themes that emerged were: the need to conduct a comprehensive assessment of the child or adolescent's physical and emotional well-being and health-care needs; conducting timely examinations; minimizing patients' and caregivers' fear and distress; respecting patient autonomy; and using examination instruments and positions that minimize discomfort. Very limited evidence was found in the studies on comfort level of adolescents with respect to the use of a speculum for the examination. However, clinical experts do not generally recommend the use of speculums for pre-pubertal children (see Web Annex 2 for the full report). In addition, the GDG highlighted the importance of balancing the need for timely examinations with not rushing children and adolescents who are not prepared to undergo the examination right away. They also suggested that this guideline flag practices, such as the "two-finger test" or the so-called "virginity test", that are medically unnecessary and traumatic for children and adolescents. A WHO-supported systematic review has documented the lack of medical utility of virginity testing and the potential physical, psychological and social harms of this practice *(84)*.

GP4: GOOD PRACTICES STATEMENT 4

Health-care providers should accurately and completely document the findings of the medical history, physical examination and forensic tests, and any other relevant information, for the purposes of appropriate follow-up and supporting survivors in accessing police and legal services, while at the same time protecting confidentiality and minimizing distress for children or adolescents and their caregivers. These actions include the following:

- using a structured format for recording the findings;
- recording verbatim statements of the child or adolescent and the non-offending caregivers, when applicable, for accurate and complete documentation of disclosures of abuse;
- noting down discrepancies between the child´s or adolescent´s and the caregivers´ account, if any, without interpretation;
- recording a detailed and accurate description of the child's or adolescent's symptoms and injuries;
- where no physical evidence is found, noting that absence of physical evidence does not mean that abuse did not occur;
- documenting the child's or adolescent's emotional state, while noting that no particular state is indicative of sexual abuse;
- seeking informed consent, as appropriate, for taking any photographs and/or videos, after explaining how they will be used;
- handling all collected information confidentially (for example, sharing information only after obtaining permission from the child or adolescent and caregiver and only on a need-to-know basis, in order to provide care; storing the information securely in a locked cupboard or a password-protected file; anonymizing identifying information; and not disclosing any identifying information about a specific case to those who do not need to know, and especially not to the media).

Evidence summary

The systematic review of the literature identified 12 studies that responded to the question "*what are the good practices for documentation of the medical history and findings of physical and forensic examination?*" *(47, 51, 52, 59, 61, 92, 104–109)*. Only two studies came from LMICs. The respondents varied across studies, from health-care providers to survivors. A couple of studies included a review of patient charts to identify documentation practices. The key themes that emerged as being of relevance to the respondents included: the need to use a structured format for recording findings; requesting permission from survivors before taking pictures to document forensic evidence, and explaining how these will be used; recording the child's or adolescent's statements verbatim; and including detailed descriptions of the child's or adolescent's symptoms and likely mechanisms of injuries, if any. Additionally, the GDG emphasized the importance of noting the findings, to make it clear that the absence of physical evidence does not mean that abuse did not occur. This is because in courts there is an emphasis on physical evidence, whereas in many cases of child and adolescent sexual abuse, depending on the nature of the abuse and when the child or adolescent is brought to the health-care provider, there may not be any physical evidence *(84)*. The GDG also highlighted the importance of noting the child's or adolescent's emotional state and noting any discrepancies between the account of the child or adolescent and that of the caregiver, without any interpretation on the part of the health-care provider (see Web Annex 2 for the full report).

C. HIV post-exposure prophylaxis treatment and adherence

Penetrative sexual assault (i.e. rape) of a child or adolescent involving oral, vaginal or anal receptive intercourse carries with it the risk of HIV transmission. The risk of sexual transmission of HIV from a single act of consensual sex is generally low. The risk of HIV transmission associated with child or adolescent sexual abuse is unknown. However, there are several characteristics associated with penetrative sexual abuse, particularly of children and adolescents, that can affect the risk of HIV transmission. For example, adolescent girls are known to be biologically at higher risk of HIV transmission because thinner vaginal walls, immature cervices and low estrogen levels make them physiologically more vulnerable to HIV transmission than adult women *(110)*. Other factors that increase the likelihood of HIV transmission are the presence of tears and genital injuries from forced sexual intercourse and the involvement of multiple perpetrators (i.e. gang-rape) *(111, 112)*.

A limited number of studies have tried to determine rates of HIV infection among children who have been sexually abused and who sought medical services. Sample sizes in these studies were small and the mode of transmission could not always be confirmed *(22, 23)*. In a study from Cameroon, the rate of HIV infection was found to be 37.5% among children who were sexually abused with penetration *(113)*. Another review of literature on child sexual abuse in sub-Saharan Africa estimated that 1% of all children in South Africa will have experienced penetrative sexual abuse by a person living with HIV by the time they are aged 18 years *(114)*. In settings of high HIV prevalence, there may be strong ethical arguments for provision of HIV PEP to children and adolescents who have, or may have, experienced penetrative oral, vaginal or anal sexual abuse and who seek services within 72 hours of the incident.

R1: Recommendation 1 (existing) *(115)*

The GDG accepted that the existing recommendations for HIV PEP treatment (including regimen and frequency) for the general population of children and adolescents facing non-occupational exposure to HIV, and for sexually assaulted women, is applicable to children and

adolescents who have, or may have, been exposed to sexual abuse involving oral, vaginal or anal penetration *(39, 115, 116)*.

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
HIV PEP should be offered, as appropriate, to children and adolescents who have been raped involving oral, vaginal or anal penetration with a penis, and who present within 72 hours of the incident (see remarks for additional considerations for PEP eligibility).	Indirect evidence	Strong

R2: Recommendation 2 (existing) *(115)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
A 28-day prescription of antiretroviral drugs (ARVs) should be provided for HIV PEP following initial risk assessment.	Low	Strong

R3: Recommendation 3 (existing) *(115)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
A triple-therapy regimen (i.e. with three drugs) of ARVs is preferred, but a two-drug regimen is also effective.	Very low	Conditional

Remarks

- These recommendations apply to those who present within 72 hours of the rape having taken place. Children or adolescents who have been raped and who present later than 72 hours post-exposure would normally not be considered as eligible for HIV PEP. However, in the case of ongoing sexual abuse that occurs over a number of days, the 72-hour time limit should be applied to the most recent exposure to oral, vaginal or anal penetrative intercourse.
- Assessment for eligibility should be based on the HIV status of the source whenever possible and may include consideration of background prevalence and local epidemiological patterns.
  - In some settings with high HIV prevalence or where the source is known to be at high risk for HIV infection, PEP should be offered without risk assessment.
  - In low-prevalence settings, policies on offering routine HIV PEP will need to consider the local context, resources and opportunity and other costs of offering it.
  - Eligibility can be assessed based on whether HIV status of the perpetrator is positive or unknown; whether the child or adolescent exposed to sexual abuse is not known to be HIV positive; and whether they had a defined risk of exposure (e.g. receptive vaginal or anal penetration without a condom or with a condom that broke or slipped, or contact between the perpetrator's blood or ejaculation and mucous membrane or non-intact skin during the abuse, or they were a recipient of oral sex with ejaculation, or they were drugged or unconscious at the time of the alleged abuse, or they were gang-raped).

- With adolescents who have been raped, based on their evolving capacities to understand the information provided, HIV risk should be discussed, to determine the use of HIV PEP. This includes the limitations of PEP; the HIV status and characteristics of the perpetrator if known; and the assault characteristics, including the number of perpetrators, the side-effects of the ARVs used in the PEP regimen and the likelihood of HIV transmission. With infants and younger children, the limitations of PEP, side-effects and likelihood of HIV transmission should be discussed with the non-offending caregivers.
- HIV PEP should be initiated as early as possible to maximize its effectiveness, and ideally provided within 72 hours of exposure. Children and adolescents may not be able to access services within this time, owing to several barriers, and it is important to address the barriers to accessing the health facility within the 72 hours. This includes raising community awareness about the importance of seeking care as early as possible – ideally as soon as possible after the rape and within 72 hours (see **Good practice statement 8** on facilitating timely uptake of services).
- Those presenting more than 72 hours after exposure may still require other treatments and interventions, including referrals, which should be offered.
- HIV testing and counselling should be provided at the initial consultation before offering PEP. HIV testing should be performed using rapid diagnostic tests that can provide definitive results in most cases within 2 hours and often within 20 minutes.
- Assessment of the HIV status of the exposed child or adolescent should not be a barrier to initiating HIV PEP. In emergency situations where HIV testing and counselling are not readily available, but the potential HIV risk is high, or if the exposed person refuses initial testing, HIV PEP should be initiated and HIV testing and counselling undertaken as soon as possible.
- Given the stigma associated with sexual abuse, the first visit to the health-care provider may be the only visit and thus the only opportunity to provide treatment and counselling. Therefore, the full drug regimen required for completing HIV PEP should be provided at first contact rather than only a starter pack that would require the patient to return to the health service.
- The choice of drugs and regimens for HIV PEP should follow national guidance.

R4: Recommendation 4 (Existing, updated for remarks)

Existing recommendations on PEP adherence support in two prior WHO guidelines were considered: the guideline on PEP for HIV (2014) *(115)* and the guideline on responding to intimate partner violence and sexual violence against women (2013) *(39)*. The guideline on PEP for HIV was based on a systematic review to assess the effectiveness of enhanced adherence counselling for all populations exposed to HIV (i.e. occupational and non-occupational exposure) and showed improved adherence as compared to standard PEP-adherence support *(115)*. The guideline on responding to intimate partner violence and sexual violence against women was for a population of sexually assaulted women *(39)*. An update of the 2014 systematic review for the HIV PEP guidelines was conducted for two reasons. First, a separate systematic review and meta-analysis of PEP adherence has highlighted that PEP completion rates are the lowest for populations who have experienced sexual assault (40%) and for adolescents (37%) *(117)*. Second, children and adolescents who have been sexually assaulted or raped face particular trauma and stigma associated with the assault that need to be considered. Therefore, adherence support may improve completion in this population, and also potentially have other indirect benefits through increased contact with services.

For the purposes of this guideline, an update to the systematic review for the 2014 HIV PEP guidelines was conducted, to identify whether enhanced adherence support interventions with the specific population of child and adolescent survivors of sexual assault or rape were found to be effective. On the basis of the available evidence (see evidence summary and evidence to recommendation below), no specific recommendation can be made on enhanced adherence counselling for children and adolescents who have, or may have, been sexually assaulted or raped. Hence, the existing recommendation from the WHO (2013) guideline on responding to intimate partner violence and sexual violence against women has been used instead *(39)*, and the remarks have been updated to reflect specific considerations for children and adolescents.

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Adherence counselling should be an important element in the provision of HIV PEP to survivors of rape.	Very low	Strong

Remarks

- Many survivors of rape who are provided with HIV PEP do not successfully complete the preventive 28-day regimen because HIV PEP results in physical side-effects such as nausea and vomiting. Additionally, taking HIV PEP may trigger painful thoughts or trauma associated with rape, and other issues may overtake the lives of survivors. The stigma associated with rape may also contribute to low adherence among this population (e.g. owing to concerns related to secrecy). Therefore, specific attention should be paid to these issues.
- Health-care providers should be aware that it is very difficult to attain adherence and efforts should be made to ensure that it is maintained. Side-effects should be communicated in a way that is accurate but does not induce fear, and the impact of the traumatic event also needs to be considered.
- It is important to improve or upgrade basic counselling skills to support PEP adherence and to offer ongoing counselling support. While most HIV services will already have the capacity to undertake counselling, at the primary health care level in other types of services, it may be necessary to upgrade the counselling skills of health-care providers.
- Given the stigma associated with rape, the first visit to the health-care provider may be the only visit and, thus, the only opportunity to provide adherence counselling to the child or adolescent. If the decision is made to take HIV PEP, counselling on adherence should be provided as comprehensively as possible.
- Age-specific needs should be taken into consideration in offering adherence counselling to the child or adolescent. Barriers to adherence and completion can be expected to be different for children and adolescents, and interventions to support them and their caregivers will have to differ as relevant. For young children, adherence counselling also needs to involve the caregivers. For adolescents, it is important to engage them in developing an adherence plan, with age-tailored messages and respecting their autonomy (e.g. ascertaining whether or not they wish to engage caregivers).

Evidence summary

An update to the systematic review for the 2014 HIV PEP guidelines *(117)* was conducted, to identify whether enhanced adherence-support interventions with the specific population of survivors of sexual assault, including children and adolescents, were found to be effective. The update addressed the PICO question: *"Among children and adolescents (0–18 years) who*

have, or may have, been exposed to sexual abuse (P), do any interventions to provide enhanced adherence support for HIV PEP (I) as compared to no adherence support (C) prevent HIV and/or improve adherence to PEP (O)?".

Three randomized trials *(118–120)* were included in the updated systematic review that assessed enhanced counselling interventions as a way to improve adherence. Of these, one trial was conducted in South Africa *(118)* with adults taking PEP following sexual assault and two trials, one in the USA *(119)* and one in France *(120)*, were conducted with adults taking PEP following unprotected sexual intercourse, with the latter excluding participants experiencing sexual assault. The frequency, content and mode of delivery of enhanced counselling varied and the sample sizes were small. All three trials showed a trend in improving adherence among participants who received enhanced adherence counselling. However, none of the three trials reported findings specific to children and adolescents who were sexually abused. The trial in South Africa with sexually assaulted adults and female children (not disaggregated for children) reported similarly low levels of adherence in the intervention and comparison groups *(118)*. (See Web Annexes 3, 3a and 3b for the full report, and evidence-to decision and GRADE table).

To provide further information about barriers to PEP adherence faced by children and adolescents exposed to sexual abuse, a qualitative review on barriers and facilitators for PEP adherence was conducted. A total of 12 studies were included *(121–132)*, mostly from the USA ($n = 6$), followed by South Africa ($n = 3$) and one study each from Brazil, Canada and Malawi. Six studies included outcomes for children and adolescents aged 19 years or younger only, while the remainder were mixed studies including adults. All studies included respondents who had been sexually assaulted. The most frequently reported barriers to adherence/completion of PEP were reported to be concerns related to side-effects; forgetting to take the medicines; fear of being stigmatized or blamed; being busy; traumatic associations with the sexual assault or rape; poor knowledge; and mental health problems. Among the most frequently reported facilitating factors associated with PEP adherence/completion were health-care provider encouragement to take PEP; survivor attending counselling; being reminded to take PEP by family or peers; and one-stop services that offered both HIV testing and PEP at the initial consultation (see Web Annex 3).

From evidence to recommendation

The GDG considered the evidence for effectiveness of "*enhanced adherence*" counselling, as well as the qualitative data on barriers and facilitators. They noted the evidence that PEP adherence/completion following sexual assault has been found to be lower than in the general population and that it can be a challenge for children and adolescents who have been sexually abused because they are often traumatized. Therefore, the GDG agreed that support and counselling for PEP adherence is important and must be flagged as an important element of PEP provision. They did not, however, agree that the evidence for "*enhanced adherence*" counselling was sufficiently convincing to recommend it for children and adolescents who have been sexually abused:

- The evidence on the effectiveness of "*enhanced adherence*" for the population of children and adolescents who have been sexually abused has very low certainty, owing to indirectness of the evidence. Specifically, two out of the three included trials were carried out in patients presenting for sexual exposure and not sexual assault, and included only adult patients. The third trial included adult women and female children who had been sexually assaulted, but did not disaggregate for children, and found no statistically significant differences in adherence rates across the intervention and comparison groups.

- Moreover, owing to small sample sizes relative to the number of events for all trials, the resulting confidence interval around the pooled point estimate was wide (i.e. imprecise effect size). Therefore, it cannot be ruled out that the trend in improved adherence was due to chance.
- The exact nature, intensity and resource implications of "*enhanced adherence*" counselling could not be ascertained, as the strategies varied across the three trials; however, it is likely to require additional resources.
- While the evidence on harms versus benefits could not be ascertained from the studies as they relied on populations that were exposed to HIV (and not necessarily to sexual assault), the GDG flagged concerns for potential harms because children and adolescents who have been sexually abused may also be dealing with trauma, stigma and concerns for safety that are distinct from those of most other patients who may require HIV PEP.
- There were no included studies to ascertain the feasibility and resource requirements for "*enhanced adherence*".

D. Pregnancy prevention and management among girls who have been sexually abused

Adolescent girls who have attained menarche or are of reproductive age and who have experienced, or are experiencing, sexual abuse may be at risk of unwanted pregnancy. While little research exists on the likelihood of pregnancy after rape, the National Women's Study in the USA found that 5.3% of the rapes of adolescent girls aged 12–17 years resulted in pregnancy, similar to the rate in adult women who have been raped *(133)*. Of all the girls and women in that study where rape resulted in pregnancy, 50% opted for abortion.

R5: Recommendation 5 (existing) *(134)*

The GDG accepted that the existing recommendation for emergency contraception for the general population of women is applicable to girls who have attained menarche and who are in the beginning stages of puberty (i.e. reached Tanner stage 2 or 3) and who have, or may have, been exposed to sexual abuse involving penile-vaginal penetration (i.e. rape or coerced/forced sexual intercourse).

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Offer emergency contraception to girls who have been raped involving peno-vaginal penetration and who present within 120 hours (5 days) of the incident.	Moderate	Strong

Remarks

- The following emergency contraceptive pills (ECPs) can be offered to girls who have attained menarche (i.e. post-menarche), as well as those who are in the beginning stages of puberty (i.e. have reached Tanner stage 2 or 3)[1] without any restrictions:
  - ulipristal acetate (UPA): single dose (one 30 mg tablet); OR
  - levonorgestrel-only (LNG): single dose (one 1.5 mg or two 0.75 mg tablets) is preferred; alternatively, split the dose (one dose of 0.75 mg, followed by a second dose of 0.75 mg 12 hours later);

— if UPA or LNG are not available, then offer combined oral estrogen–progestogen contraceptives (COCs): split dose (one dose of 100 µg ethinyl estradiol plus 0.50 mg LNG, followed by a second dose of 100 µg ethinyl estradiol plus 0.50 mg LNG 12 hours later); these should be offered with anti-emetics if available.

- The risk of ECPs on the market is negligible to zero; they are extremely safe and well tolerated and meet the criteria for over-the-counter provision (i.e. medical eligibility criteria category 1 *(134)*). Moreover, the harms (e.g. risk to the mother's health, stigma) of an unplanned or unwanted pregnancy for this age group as an outcome of rape very likely outweigh the risks.
- A copper-bearing intra-uterine device (Cu-IUD) can also be used as an emergency contraceptive measure, with no restrictions for girls who have attained menarche (i.e. post-menarche) if there is a low risk of STI. In the case of a high risk of STI, the use of a Cu-IUD as an emergency contraceptive is usually not recommended unless other more appropriate methods are not available or acceptable. The Cu-IUD can be inserted up to 120 hours after unprotected sexual intercourse.
- Ideally, emergency contraception (UPA, LNG or COC ECPs) should be initiated as soon as possible after exposure, in order to maximize its effectiveness, although it can be given up to 5 days (120 hours) after exposure. Based on her capacity to understand the information provided, the adolescent girl and/or her non-offending caregivers should be advised that the effectiveness reduces with the length of the interval between exposure to penetration and taking the emergency contraception.
- A pregnancy test is not required, but if one is done and the result confirms pregnancy, emergency contraception should not be provided.

GP5: GOOD PRACTICE STATEMENT 5 (existing) *(39, 135)*[1]

If a girl is pregnant as a result of the rape, she should be offered safe abortion to the full extent of the law.

Remarks

- Administrative requirements (e.g. forensic evidence or police reports) for obtaining safe abortion should be minimized, with clear protocols established with the police and the health-care providers, in order to facilitate timely referral and access to safe abortion within the gestational time limits.
- Where abortion is not permitted, or if the pregnancy is too advanced for abortion at presentation, the pregnant girl should be supported through her pregnancy and delivery, and other options such as adoption should be explored with her.

E. Post-exposure prophylaxis for curable and vaccine-preventable sexually transmitted infections

Children and adolescents who experience sexual abuse may become infected with a STI. A systematic review carried out for this guideline included 23 publications reporting on the detection of STIs among children and adolescents in LMICs who were suspected of having experienced sexual abuse, most of which were retrospective studies *(136–158)*. Studies reported

high levels of penetrative sex among children and adolescents who were sexually abused. The review highlights variable but high rates of some STIs among children and adolescents exposed to sexual abuse and who present to health-care facilities. The review yielded a wide range of STI infection rates that varied by type of STI. For example, STI detection rates ranged between <1% and 61% in girls and <1% and 48% in boys, with higher detection rates for neisseria gonorrhoeae in girls and syphilis in boys.

WHO guidelines (2013) recommend presumptive STI prophylaxis for women who have been sexually assaulted *(39)*. However, CDC guidelines recommend testing for STIs using nucleic acid amplification tests (NAATs) and treating children and adolescents who have been sexually abused, based on the rationale that STI rates in this population in the USA are low and NAATs tests are available *(159)*. The national guidelines in the United Kingdom of Great Britain and Northern Ireland (UK) do not routinely recommend presumptive treatment for neisseria gonorrhoeae and chlamydia trachomatis in children and young people following sexual abuse, but it may be considered where tests are not performed or declined; where the child or adolescent is unlikely to return for treatment if an STI is detected; or if the risk of infection is high *(160)*. Therefore, the GDG agreed that new recommendations should be developed for offering STI prophylaxis for curable STIs for the particular population of children and adolescents who have been sexually abused. On the other hand, WHO recommendations from 2017 exist for vaccine preventable STIs such as HPV and Hepatitis B and these are not likely to be significantly different for sexually abused children and adolescents. Hence, for the latter, the GDG accepted to use the existing WHO recommendations.

R6: Recommendation 6 (new)

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Presumptive (or prophylactic) treatment for gonorrhoea, chlamydia and syphilis is suggested for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis, or oral sex, particularly in settings where laboratory testing is not feasible.	Very low, indirect evidence	Conditional

R7: Recommendation 7 (new)

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
For children and adolescents who have been sexually abused and who present with clinical symptoms, syndromic case management is suggested for vaginal/urethral discharge (gonorrhoea, chlamydia, trichomoniasis), and for genital ulcers (herpes simplex virus, syphilis, and chancroid), particularly in settings where laboratory testing is not feasible.	Very low, indirect evidence	Conditional

Remarks

- The drug regimens and dosages for syndromic case management and presumptive STI treatment should be based on national guidelines.
- For more information, see also WHO guidelines on gonorrhoea *(161)*, chlamydia *(162)*, syphilis *(163)* and herpes simplex virus *(164)* (2016).

- Where feasible, collect specimens for either confirmation of diagnosis or forensic use.
- Where rapid, point-of-care tests for syphilis are available, test for syphilis. If the test results are positive, treatment should be offered even though confirmation may still be needed. However, if test results are negative and presumptive treatment is not offered, tests should be repeated after 4 weeks, as per WHO syphilis guidelines *(163)*.
- Efforts are under way to develop point-of-care tests for other STIs that will augment syndromic management of symptomatic cases and increase the ability to identify asymptomatic infections.
- In the presence of clinical symptoms (e.g. genital ulcer syndrome, genital discharge syndrome, presence of ano-genital warts), presumptive treatment, in the form of a syndromic approach, would be the more obvious course of action, whether or not samples can also be collected (e.g. for confirmation of diagnosis or for forensic purposes).
- Equity and human rights considerations: no studies evaluated issues related to equity. However, the GDG flagged that requiring laboratory tests for gonorrhoea and chlamydia (i.e. NAATs), in order to offer treatment, would limit access (e.g. in settings where such tests are not available or accessible for some groups). Moreover, requiring children or adolescents to return for laboratory results in order to obtain treatment might lower uptake, as studies in the review suggested a high loss to follow-up of survivors in subsequent visits. On the other hand, in situations of ongoing abuse with no particular symptoms, testing, particularly for STIs that are long-lasting/chronic, may be warranted, and as much as possible should be done at the first point of contact. Similarly, in settings where laboratory testing is generally feasible, it may be important to test before offering treatment.

Evidence summary

Given the lack of direct evidence on best approaches to manage STI among children and adolescents who have been sexually abused, a systematic review was commissioned to address the PICO question: *"Among children and adolescents (0–18 years) who have or may have been exposed to sexual abuse (P), is screening and treatment (i.e. test and treat) for STIs (I) more effective than presumptive treatment for STIs (C), in order to prevent and manage the adverse outcomes of STI (O)?"*.

To respond to this question, a systematic review of the evidence was conducted for this guideline. The search did not identify any study that directly addressed the PICO question – i.e. comparing the effectiveness, acceptability or preference for test-and-treat versus presumptive STI treatment. Therefore, to develop the recommendation, indirect evidence relying on observational prevalence studies had to be considered. First, the evidence on the risk of STI among the population of children and adolescents who had been sexually abused was considered. The review found 23 studies from LMICs with variable, but considerably high STI detection rates among sexually abused children and adolescents in some settings *(136–158)*. For example, in eight studies identified from sub-Saharan Africa *(136–138, 140–144)*, rates varied from 0.7% in one study in South Africa *(136)* to a high of 43% of children in Togo *(143)*. In nine retrospective studies from south Asia and the Middle East *(139, 145–148, 150–152, 158)*, STI detection rates among sexually abused children coming to STI clinics ranged from 2% in one study from Bahrain *(147)* to a high of 38% in another study from India *(150)* (see Web Annex 4 for the full report). Quality assessments of individual observational studies (not of case reports) was conducted using the Critical Appraisal Skills Programme (CASP) checklist (see Web Annex 4, supplementary tables 1–8).

Second, the GDG considered the evidence from studies that highlighted that very few children and adolescents who were sexually abused presented to health services in a timely manner. For example, in studies from the Democratic Republic of Congo *(165)* and Uganda *(142)*, less than one third of the child sexual abuse cases recorded presented within 3–5 days of the assault. In a study from Thailand *(166)*, this figure was 56% and in one study from Brazil *(167)*, it was 80% of the cases. However, in all of these studies, most patients were lost to follow-up for STI treatment, highlighting the limited window of opportunity to offer STI treatment at the first visit itself *(137, 142, 165–168)*.

Lastly, the GDG considered the evidence on the costs of testing for STIs and treatment, including the equity considerations. The cost of STI testing based on NAATs for gonorrhoea and chlamydia is US$ 30 per test and for syphilis US$ 0.13 to US$ 1.75 (rapid plasma reagent test). The cost of presumptive treatment for STI, which largely involves the cost of drugs, ranges from USS 0.35 to US$ 2.25 for antibiotic drugs, and hence is much lower than that of a test-and-treat approach *(169)* (see Web Annex 4 for the full report).

From evidence to recommendation

Because of the lack of direct evidence, the GDG considered the indirect evidence summarized above. The group noted that there is important uncertainty about the evidence, as there are no studies comparing the test-and-treat-approach to presumptive treatment. Therefore, the quality of evidence was rated as very low, based on indirect evidence. The indirect evidence points to the conclusions listed next.

- Despite the heterogeneous evidence across regions on STI-detection rates among children and adolescents who have been sexually abused, high rates of some types of STIs have been observed in this population in some settings.
- STIs are very frequently asymptomatic and can lead to serious complications when untreated.
- Most survivors of sexual abuse do not present within the first 3–5 days and those who do often do not return for follow-up visits; therefore, the opportunity to treat for STIs needs to be maximized in the first visit.
- The undesirable effects of presumptive treatment include potential side-effects, particularly when combined with PEP and emergency contraception, and the potential for development of pathogen resistance for gut pathogens. However, the side-effects may be short-lived for STI drugs, and the potential for pathogen resistance can be minimized with a single supervised dose.
- The costs of presumptive treatment are far lower than those of test-and-treat, which requires availability and accessibility of NAAT. The GDG debated the issue of cost and availability extensively, as they did not want to have different standards of care for different resource settings. They also highlighted that for syphilis, screening is available and affordable and should ideally be done.
- For the reasons given above, the strength of the recommendation was rated as conditional.

R8: Recommendation 8 (existing) *(170)*

It was agreed that existing recommendations for vaccine-preventable STIs (i.e. hepatitis B and human papillomavirus (HPV) for the general population are applicable to children and adolescents who have been sexually abused and who have not been previously vaccinated.

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Hepatitis B vaccination without hepatitis B immunoglobulin should be offered, as per national guidance.	Very low, indirect evidence	Strong

Remarks

- Pre-vaccination serological testing is not recommended as routine practice. However, in settings where laboratory facilities are available and are cost effective, if it is not known whether the child or adolescent has been vaccinated against hepatitis B, blood should be taken for hepatitis B status prior to administering the first vaccine dose *(170)*.
- If immune, no further course of vaccination is required.

R9: Recommendation 9 (existing) *(171)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
HPV vaccination should be offered to girls in the age group 9–14 years, as per national guidance.	Moderate	Strong

Remarks

- It is not necessary to screen prior to HPV vaccination. If two or three doses have been received, depending on age and national schedule, no further course of vaccination is required.
- While the HPV vaccination is intended for girls who are naïve to vaccine-related HPV types (i.e. before the onset of sexual activity involving vaginal penetration), girls who are raped may still benefit from the vaccine. The reason is that the girl could be infected either by a strain that is not in the vaccine or by one of the four strains covered by the quadrivalent vaccine (i.e. protects against four strands of HPV).
- Girls receiving the first dose of HPV before the age of 15 years can use a two-dose schedule. The interval between doses should be 6 months. While there is no maximum interval, an interval of 12–15 months is suggested. For girls aged 15 years and older, a three-dose schedule (0, 1–2, 6 months) should be given *(171)*.
- HPV vaccine may be administered concomitantly with hepatitis B vaccine. If HPV vaccine is given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites using separate syringes.

F. Psychological and mental health interventions in the short term and longer term

Sexual abuse of children and adolescents has both short- and long-term mental health consequences. A systematic review that looked at 14 reviews found child sexual abuse to be significantly associated with the following symptoms: depression, anxiety, post-traumatic stress, dissociation, eating disorders, sleep disorders, low self-esteem, anger, externalizing symptoms, ideation and behaviours related to suicide and self-harm, interpersonal problems, and engagement in high-risk behaviours (e.g. substance use, unsafe sexual behaviours, alcohol misuse) later in life *(19)*. Children or adolescents presenting with such symptoms or disclosing sexual abuse need to be provided both immediate psychological support as well as longer-term mental health care.

GP6: Good practice statement 6 (new)

For children and adolescents who have recently been sexually abused, and who experience symptoms of acute traumatic stress (within the first month), health-care providers should offer/continue to offer first-line support that is gender sensitive and child or adolescent centred, as described in **Good practice statement 1**.

R10: Recommendation 10 (existing) *(172)*

For exposure to a recent traumatic event that produces stress-related symptoms, WHO does not recommend psychological debriefing.[1] This is also applicable to children and adolescents who have been recently sexually abused.

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Psychological debriefing should not be used in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.	Very low	Strong

Remarks

- In addition to first-line support, children or adolescents who have been sexually abused, and their non-offending caregivers, also need other psychosocial support to promote well-being and functioning, involving psycho-education, support for managing and coping with stress, and promoting daily functioning as they recover from their traumatic experience over time. For detailed guidance on how to do this, see the section in the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (2016) *(5)*.[2]
- It is important to provide to non-offending caregivers of young children information about possible signs or symptoms of post-traumatic stress disorder (PTSD) and/or behaviours or emotions that the child may show in the coming days or months and when to seek further help. Similarly, for an adolescent, depending on their capacity and maturity to understand information about their symptoms, information should be offered about likely signs or symptoms or emotions that they are likely to experience and when to seek further help.
- Explain to the child or adolescent (as appropriate), and/or their non-offending caregivers, that they are likely to improve over time. Offer follow-up appointments.

R11: Recommendation 11 (new)

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Cognitive behavioural therapy (CBT) with a trauma focus should be considered for children and adolescents who have been sexually abused and are experiencing symptoms of PTSD.	Very low	Conditional

R12: Recommendation 12 (new)

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
When safe and appropriate to involve at least one non-offending caregiver, CBT with a trauma focus should be considered for both: (i) children and adolescents who have been sexually abused and are experiencing symptoms of PTSD; and (ii) their non-offending caregiver(s).	Low	Conditional

Remarks

- The safety of the child or adolescent who has been sexually abused is paramount. Those providing psychological interventions should be aware of the potential risks for children or adolescents. The involvement of caregivers should be guided by concerns for the safety and well-being of the child or adolescent and, therefore, the recommendation is focused on non-offending caregivers. Health-care providers should assess the safety implications of the treatment/care they provide and take actions to minimize the risk of harms.
- Minimum requirements for delivering psychological interventions, particularly CBT with a trauma focus, include the need for thorough training and ongoing supportive supervision of personnel, particularly for non-specialized providers.
- Children and adolescents should have an assessment by someone who is qualified to assess whether they have PTSD or symptoms of PTSD.
- CBT with a trauma focus can be offered to both those diagnosed with PTSD and those who have symptoms of PTSD.
- Where a trained provider is not available, children and adolescents should be referred after the assessment.
- Stress management may also be beneficial for children and adolescents with PTSD or symptoms of PTSD.
- Subgroup considerations: the intervention will need to be adapted with diverse approaches to the different levels of maturity and cognitive development of children and adolescents. There is also some evidence that suggests that the mental health impacts may be more severe for those children who were exposed to sexual abuse at a younger age *(173, 174)*.
- Equity and human rights considerations: in some settings, girls may be more frequently victimized than boys, although this may vary by setting *(13, 15)*. On the other hand, boys are less likely to seek services than girls, and may face additional barriers related to stereotypes and lack of acceptance that boys can be sexually abused, or fear of having their masculinity questioned *(15, 175, 176)*. Mental health outcomes for non-offending caregivers will also need attention. Access to psychological interventions may be challenging in LMICs and rural areas where there is limited availability of skilled health-care providers or trained specialists; where physical access to facilities is limited; where costs are prohibitive; and for families who may have to take time off from work to attend or take their children to sessions. Access may similarly be limited for indigenous groups, children or adolescents with disabilities and other minority groups. Therefore, extra effort may be needed to reach out and improve access for all of these groups.

Evidence summary

Existing WHO guidelines for post-traumatic stress (2013) recommend individual or cognitive behavioural therapy (CBT) with a trauma focus (see glossary), or eye movement desensitization and reprocessing (EMDR), for children and adolescents with PTSD *(172)*. WHO guidelines for responding to intimate partner violence and sexual violence against women (2013) recommend CBT and EMDR for adult women exposed to sexual assault *(39)*. The UK National Institute for Health and Care Excellence guidelines (2017) recommend trauma-focused cognitive behavioural therapy (TF-CBT) for children with chronic PTSD, including those who have been sexually abused *(177)*. However, the evidence in these prior guidelines included all populations of children exposed to different types of trauma and PTSD and/or was not specific to children or adolescents who had been sexually abused. Therefore, evidence was updated for the present guideline, focusing on studies conducted with children or adolescents who had been sexually abused. Interventions that also included non-offending caregivers were also considered. A systematic review was conducted to answer two PICO questions:

- *Among children and adolescents who have or may have been exposed to sexual abuse and who are diagnosed with mental disorders (P), do any psychosocial interventions (e.g. psychological counselling or psychotherapeutic interventions) (I), as compared to no or any other psychosocial interventions (C), improve the child's or adolescent's mental health outcomes (e.g. emotional, behavioural disorders, PTSD, depression, subjective well-being, daily functioning) and/or parent/caregiver outcomes (O)?*
- *Do psychosocial support interventions (I) involving children/adolescents who are likely to have been sexually abused, and their non-offending parents/caregivers (P), as compared to no or any other intervention (C), improve the psychological well-being of parents/caregivers (e.g. stress, stigmatizing behaviours, healthy parent–child interactions, uptake of services) and/or mental health of children (O)?*

The outcomes that were considered to be critical included PTSD; depression; internalizing disorders; externalizing disorders; anxiety; school functioning; and child subjective well-being. To address both the PICO questions, a systematic review was conducted updating the 2013 Agency for Healthcare Quality (AHRQ) report on child exposure to trauma, to specifically focus on child sexual abuse and expand to include adolescents who had been sexually abused, including those who experienced sexual abuse from peers *(178)*. The review for the first PICO question above resulted in 10 articles with eight randomized controlled trials that met the inclusion criteria *(179–188)*. Only two of these trials were conducted in LMIC settings. The review included interventions that addressed CBT with a trauma focus, prolonged exposure therapy, stress inoculation training and gradual exposure (SIT), and individual and group psychotherapy. The studies compared CBT with a trauma focus to wait list; TF-CBT to community control; CBT with a trauma focus to EMDR; SIT to conventional therapy; prolonged exposure to conventional therapy; and individual psychotherapy to no treatment or to group psychotherapy. In a majority of studies involving CBT with a trauma focus, the therapy was found to have medium to large benefits for PTSD and small to medium benefits for other symptoms (e.g. depression, internalizing or externalizing symptoms) among children or adolescents who had been exposed to sexual abuse. However, the evidence was considered to be of very low certainty/quality (see Web Annexes 5, 5a and b for the full report, evidence-to-decision table and GRADE table).

For the second PICO question, which also included interventions with a caregiver component, the systematic review found 18 articles with 10 randomized controlled trials (none from LMICs) that met the inclusion criteria *(184, 186, 187, 189–203)*. Most of the included studies assessed a form or component of CBT with a trauma focus or a combination of CBT with a trauma

focus along with other programme components. The studies compared risk reduction through family therapy (RRFT) with treatment as usual; CBT with a trauma focus with a wait-list control or TF-CBT with non-CBT interventions; TF-CBT with compared to without a trauma narrative; CBT with supportive counselling; and family/network meetings combined with or without group work. The findings suggest an overall medium benefit for the different types of psychological interventions, and medium to large benefits specifically of TF-CBT on PTSD symptoms as compared to non-CBT-type therapies. The evidence was graded as low certainty/quality. Limited evidence from Australia and the UK showed high costs for providing CBT and TF-CBT. For example, one cost–utility study from the Australian mental health-care system showed that the per person cost for TF-CBT for a 12-month period after adjusting for incremental cost for quality-adjusted life years, was Australian $ 22 790 *(204)*. In the UK, a study from 2006 suggested that the cost of CBT for adults is approximately £750 per person (see Web Annexes 6, 6a and 6b for the full report, evidence-to-decision table and GRADE table) *(205)*.

From evidence to recommendation

In formulating the recommendations, the adverse mental health consequences of child and adolescent sexual abuse are an important consideration.

- For psychological interventions aimed at children or adolescents only, the GDG considered the evidence that there are more included studies of CBT with a trauma focus with evidence of medium-to-large benefits on PTSD, along with promising evidence (from one study) of other CBT-type therapies that include a trauma component (e.g. prolonged exposure). No studies provided information about potential harms of this intervention, although the GDG highlighted the importance of safety of the child or adolescent who has been sexually abused. On balance, the evidence was in favour of recommending CBT with a trauma focus for this population.
- However, there is very low certainty/quality of the evidence overall, owing to serious concerns about the risk of bias; small sample sizes; and imprecise effect sizes. Moreover, there is evidence of large costs, limited feasibility and limited cost effectiveness for implementing CBT with a trauma focus. There is also evidence of other barriers to implementation (e.g. lack of specialized and trained health-care providers; effort to train, mentor and supervise lay personnel; costs of transport; loss of wages of caregivers; and time required for frequent visits). All of these considerations make it challenging for CBT with a trauma focus to be applicable everywhere. Therefore, the strength of the recommendation is rated as conditional.
- Limited evidence suggests that the interventions may be acceptable to health-care providers, but young people receiving the intervention may be concerned with stigma. It also suggests that in different cultural contexts there may be reluctance on the part of caregivers to allow their children to be given information about sexual intercourse; and to change culturally accepted parenting skills.
- For the psychological interventions that include a child or adolescent as well as a caregiver component, the GDG considered the evidence that CBT with a trauma focus, particularly Cohen's TF-CBT *(8)*, showed medium to large benefits over non-CBT-type therapies for PTSD. The evidence also showed small to medium benefits for other symptoms (e.g. depression, anxiety, internalizing and externalizing symptoms). The balance favoured recommending CBT with a trauma focus that involved the non-offending caregiver, for treatment of PTSD. The potential harms are also linked to safety which have to be addressed, but the balance remains in favour of the intervention as above.

- However, there is low-certainty/quality evidence, owing to serious concerns about the risk of bias and indirectness of evidence. Evidence also showed large costs of implementing the intervention and limited cost effectiveness for TF-CBT. Other barriers are similar to those for child- or adolescent-only interventions. Therefore, the strength of the recommendation is rated as conditional.
- There is not enough evidence from this population group to recommend psychotherapy broadly for emotional disorders,[1] or for behavioural disorders.[2] However, sexual abuse of children and adolescents is frequently accompanied by other adversities that are also risk factors associated with emotional disorders and some types of behavioural disorders. Therefore, existing mHGAP recommendations for emotional and behavioural disorders are applicable for this population (see below) *(206)*.

R13: Recommendation 13 (existing) *(206)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Psychological interventions, such as CBT, may be offered to children and adolescents with behavioural disorders, and caregiver skills training to their non-offending caregivers.[a]	Low	Conditional

[a] While child sexual abuse may not have anything to do with caregiver skills, this component nonetheless may help in the recovery of the child or adolescent.

R14: Recommendation 14 (existing) *(206)*

RECOMMENDATION	QUALITY OF EVIDENCE	STRENGTH OF RECOMMENDATION
Psychological interventions, such as CBT and interpersonal psychotherapy (IPT), may be offered to children and adolescents with emotional disorders, and caregiver skills training to their non-offending caregivers.	Low	Conditional

Remarks

- The choice of psychological or behavioural intervention and how it is implemented should be based on the type of behavioural disorder(s) or emotional problem(s) respectively, and on the age and developmental stage of the child or adolescent *(206)*.
- In adolescents, to assess other mental disorders including risk of suicide, self-harm, depression, alcohol and drug-use problems and their management/treatment, follow the mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings, version 2.0 (2016) *(5)*.

G. Ethical principles and human rights standards for reporting child or adolescent sexual abuse

Requirements to report child or adolescent sexual abuse to child protection agencies (or other relevant authorities) vary across countries, but may be present in up to three forms. In some settings, health-care providers may have a legal requirement to report (i.e. mandatory reporting) known or suspected cases of sexual abuse of children or adolescents to designated relevant authorities, such as the police or child protection/welfare agencies. Secondly, there

may be a policy requirement to report to a designated person established by the health-care providers' employers or by an industry body. Third, health-care providers may be bound by an ethical obligation, whether derived from a personal belief or a professional norm, to report cases of child or adolescent sexual abuse. The issue of whether or not mandatory reporting of child or adolescent sexual abuse is effective was considered by the GDG to be beyond the scope of this guideline. Instead, the focus is on the guiding principles and practical dos and don'ts to guide health-care providers with respect to reporting of child and adolescent sexual abuse in a range of settings – i.e. whether there is a legal or policy requirement or no formal obligation, but an ethical duty, to report.

GP7: GOOD PRACTICE STATEMENT 7

Whether health-care providers have to comply with a legal or policy requirement, or are guided by an ethical duty to report known or suspected cases of child or adolescent sexual abuse, they should balance the need to take into account the best interests of that child or adolescent and their evolving capacity to make autonomous decisions. These actions include the following:

- assessing the implications of reporting for the health and safety of that child or adolescent and taking steps to promote their safety; there may be situations in which it may not be in the best interests of the child to report the abuse;
- protecting the privacy of the child or adolescent (for example, in dealing with the media);
- taking steps to promote the child or adolescent's health, by providing immediate medical care and first-line support;
- providing information to that child or adolescent (before interviewing or taking the history from them), and to their non-offending caregivers, on:
  - the obligations to report the situation;
  - the limits of confidentiality;
  - what information will be reported and to whom;
  - what may happen next, practically and legally;
- documenting the reporting and maintaining confidentiality of the documented information with extra precautions where the perpetrator is a caregiver who could access the child's or adolescent's file;
- in cases where the sexual abuse has been committed by another child or adolescent, referring them to appropriate health or other (e.g. welfare or social) services as needed.

Health managers and policy-makers should:

- be aware of any legal requirements to report known or suspected cases of child or adolescent sexual abuse. In situations where there are no functioning legal or child welfare/protection systems to act on a report, or where the perpetrator is part of the formal system, the usefulness of mandatory reporting may be reduced *(207)*. In such situations, health managers may need to balance the need to comply with reporting requirements with considerations of and steps for mitigating potential harms of reporting;

- facilitate health-care providers to receive training on the guiding principles for reporting, and whether, when, to whom and how to report;
- address health-care providers' beliefs and values that can adversely affect their reporting practices; these include stigma and cultural taboos related to sexual abuse; attitudes perpetuating gender inequality and blaming victims; and disapproval of consensual sexual activity between adolescents;
- establish systems and policies for record-keeping and information-sharing that ensure that information is kept confidential and relevant information is only shared with persons who need to know;
- recognize that reporting occurs within a systemic response involving multiple actors and formal and informal systems, and work with different agencies or institutions, including the child protection and police services, in order to coordinate an appropriate response.

Actions that are not in line with applying the principle of evolving capacities include:

- reporting clearly consensual sexual activity between adolescents (i.e. non-abusive sexual relations),[1] unless the adolescent's safety is at risk;
- informing parents or caregivers or seeking parental/caregiver consent, where adolescents, depending on their age and maturity, express their preference to not involve or notify their parents/caregivers, unless the adolescent's safety is at risk.

Evidence summary

A systematic review of the literature was commissioned to answer the following four questions:

- *What are the values and preferences of health-care providers or health-care institutions that are required by either law or policy to report, or that may otherwise wish to report?*
- *What are the values and preferences of children or adolescents and their caregivers or parents with respect to reporting of sexual abuse?*
- *How do/should the age of sexual consent or statutory rape laws shape reporting practices of health-care providers, and what is good clinical practice in these situations?*
- *What are the ethical, safety and human rights principles that are relevant in guiding clinical practice?*

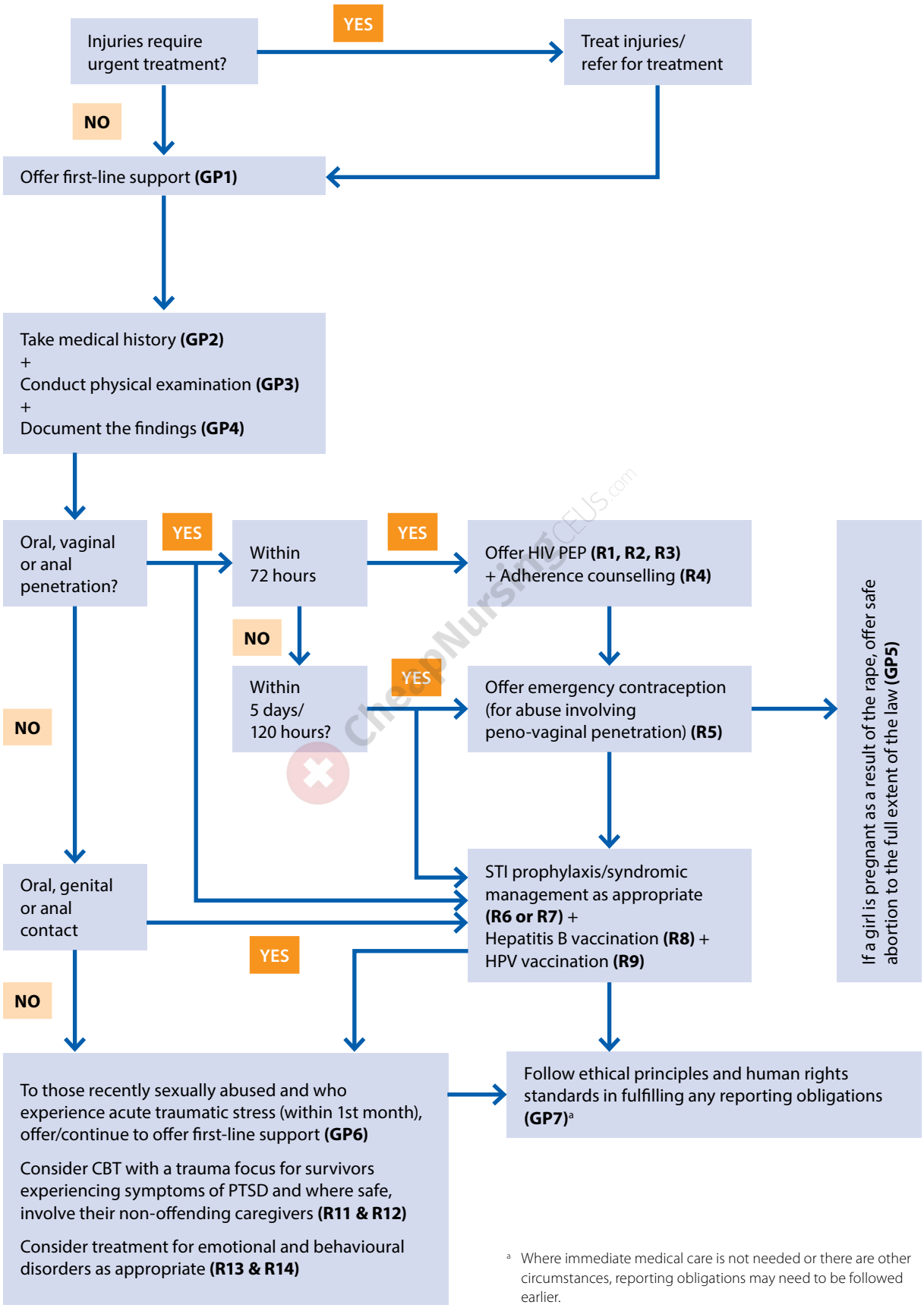
The review yielded one qualitative and 10 quantitative studies that addressed the values and preferences of health-care providers regarding the reporting of child or adolescent sexual abuse – all except one from high-income country settings *(208–218)*. These studies found that the factors that shaped a higher likelihood of health-care providers reporting child or adolescent sexual abuse included the following: health-care providers perceived sexual abuse of children or adolescents to be a serious problem; health-care providers expressed a strong intention or previous history of reporting such cases; and health-care providers had strong attitudinal support for a duty to report child or adolescent sexual abuse. Some of the studies also provided information about the barriers and ethical dilemmas faced by health-care providers in reporting. For example, one study highlighted how health-care providers felt

that they were not adequately trained or prepared to handle reporting *(208)*. Another study flagged that health-care providers may subscribe to some of the cultural values, including beliefs about parental rights, family integrity and privacy and the desire not to disrupt family relationships *(209)*.

The lack of, or ineffective, child welfare agencies was also found to be a barrier to reporting. Additionally, two reviews highlighted the cultural barriers for children and adolescents to disclose the sexual abuse they experienced, including the stigma and shame that would be brought to the survivors and their families (e.g. notions of family dishonour linked to girls losing their virginity, or blaming of girls for inviting abuse) *(219, 220)*. Such barriers may also create ethical dilemmas for health-care providers regarding reporting abuse if disclosed or identified. No studies were found that addressed the values and preferences of children, adolescents or their caregivers with respect to reporting the abuse, and no studies were found that addressed the issue of age of sexual consent in shaping the reporting practices of health-care providers (see Web Annex 7 for the full report).

The recommendations and good practices in section 4 are summarized in Fig. 1, in a flowchart depicting the pathways of care that can be used as a job aid by health-care providers.

Fig. 1. Pathways of care for child or adolescent survivors of sexual abuse



[a] Where immediate medical care is not needed or there are other circumstances, reporting obligations may need to be followed earlier.

5. Implementation considerations

This guideline focuses on recommendations and good practices for clinical aspects of care provision aimed at health-care providers. The scope did not include policy recommendations. However, some implementation considerations that enable health-care providers to deliver appropriate clinical care are included here. Two areas that were flagged by the GDG as being particularly important are: (i) facilitating the timely uptake of services by child or adolescent survivors of sexual abuse; and (ii) creating a supportive and enabling service-delivery environment for health-care providers.

A. Facilitating timely uptake of services

Timely uptake of services for those who have experienced penetrative sexual abuse is critical, in order to provide certain treatments such as HIV PEP, which is only effective if provided within 72 hours, or emergency contraception if provided within 120 hours.

GP8: GOOD PRACTICE STATEMENT 8

Health-care providers, including those working in communities, should facilitate the timely uptake of services by children and adolescents who have been sexually abused. These actions include the following:

- raising public awareness of risk, signs and symptoms and health consequences of sexual abuse and the need to seek timely care;
- making available comprehensive and integrated care that reduces the need for visiting several places for different aspects of services;
- publicizing the availability of services, once services are established and available, through concerted efforts including community-based and media campaigns and outreach activities. Such efforts also need especially to reach out to minority, indigenous or marginalized communities who may have less access and who need culturally tailored care;
- working with communities, survivors and their families to address the stigma of sexual abuse and of seeking mental health care; and to improve the acceptability of services and trust in health-care providers;
- advocating with policy-makers and management to reduce policy-level and practical barriers to accessing care (for example, requiring police reports as a condition for providing medical care and psychological support, or cost-related issues);
- strengthening referrals within and between health services and other sector services (for example, police, child protection and legal services).

Evidence summary

A systematic review of the literature identified 17 studies that responded to the question: "*What are good practices for providing information and education about sexual abuse to children, adolescents and their caregivers, in order to increase the timely uptake of health services?*" *(54, 56, 137, 221–234)*. Of these, a majority (*n* = 12) were from high-income countries and the rest (*n* = 5) from LMICs. The common relevant themes identified across these studies included the need to improve public awareness of the signs and risks of sexual abuse and availability of services; implement coordinated services; work with marginalized groups in communities to develop culturally appropriate services; and reduce barriers to timely provision of services, such as requiring police reports as a prerequisite to providing health services. The GDG also emphasized the importance of strengthening referrals within health services and with other services, including the police and justice sectors. They also noted the importance of addressing the double burden of stigma associated with abuse, as well as seeking mental health services for those who might need the latter (see Web Annex 2 for the full report).

B. Creating a supportive and enabling service-delivery environment for health-care providers

For health-care providers to provide clinical care effectively and implement the recommendations from this guideline, they need to be supported by ongoing training, mentoring and supervision, as well as resource allocation for provision of care, and standardized protocols to guide care provision and strengthened multisectoral linkages.

GP9: GOOD PRACTICE STATEMENT 9

Health managers and policy-makers should create an enabling service-delivery environment and support health-care providers in carrying out their tasks and responsibilities related to caring for children and adolescents who have been sexually abused. These actions include the following:

- making available and prioritizing the provision of high-quality care in health-care settings for children and adolescents who have been sexually abused;
- facilitating ongoing training, supervision and mentoring:
  - emphasis needs to be on general assessment, child- or adolescent-centred first-line support and medical history/interviewing as minimum requirements in low-resource settings;
  - skills or competencies in assessing, examining and managing sexual abuse in a gender-sensitive and child- or adolescent-friendly manner, and in documentation, including how to interpret examination findings, need to be provided to all health-care providers who see children or adolescents; the exact cadre of health-care providers to be trained will vary depending on the context;
  - training needs to address attitudes of health-care providers, including those perpetuating gender inequality, stigmatizing adolescents based on their sexual orientation or gender identity, or blaming the survivor. It also needs to address health-care providers' reluctance to be involved in the care and management of children or adolescents who have been sexually abused;
  - training needs to address the nature of health-care provider obligations to report child or adolescent sexual abuse (see **Good practice statement 7**).

— ideally, multidisciplinary teams can be trained together, with a clear delineation of roles, responsibilities and expectations;

— for training to be sustainable, it needs to be integrated into pre-service and in-service curricula for medical, nursing, midwifery and other health providers' education and involve the relevant professional bodies.

- addressing needs for adequate staffing, with attention to retention of trained staff, along with adequate infrastructure, supplies and financial resources, including budgets, in order to support provision of services in a timely manner;
- supporting health-care providers who provide care for children and adolescents who have been sexually abused and who are called upon to give evidence in court. It is important to also provide a working environment to prevent burnout and support coping with burnout and vicarious trauma. This can be done by making available specialists on sexual abuse and medical evaluation, for advice and to reduce professional isolation. In some settings, this kind of professional support has been facilitated online or through peer support, or a helpline for professionals and mobile health (mHealth) approaches;
- strengthening referrals and linkages with other allied services can facilitate a multi-disciplinary and multisectoral approach and improve access to comprehensive care;
- developing protocols or clinical care pathways which can be useful tools or job aids for health-care providers in systematically guiding care provision;
- conducting monitoring and evaluation of care provision, including by providing tools for collection of age-disaggregated data.

Evidence summary

The systematic review of the literature identified 43 studies that addressed the question: "*What strategies can create supportive or enabling health systems for health-care providers to provide care to children and adolescents who have or may have been sexually abused?*". Of these, a majority were from high-income countries (n = 35) *(47, 48, 56, 58, 59, 61, 62, 67, 104, 105, 107, 223, 227, 235–264)*. The most relevant issues identified were providing ongoing, high-quality training to health workers, particularly in examination, interpretation of findings and documentation; making experts on sexual abuse available; adequately staffing, supplying and financing the facilities; establishing multidisciplinary care teams that are coordinated; establishing protocols for management of the abuse; and supporting the care providers who may suffer burnout. The GDG highlighted additional points about the training of health-care providers that included an emphasis on addressing attitudes, skills and competencies; improving sustainability of training by integrating it into pre- and in-service training curricula; and helping them fulfil any reporting obligations. They also raised the issue of monitoring and evaluation and providing tools for assessing the quality of care provision, including age-disaggregated data (see Web Annex 2 for the full report).

6. Research implications

Important knowledge gaps were identified in the process of developing this guideline that need to be addressed through research. However, these do not represent a comprehensive assessment of research gaps. All the new recommendations developed for this guideline are based on evidence that has been labelled "very low" or "low" quality, indicating the need for further research. In some areas (e.g. STIs), direct evidence from evaluated interventions was unavailable. Hence, indirect evidence in the form of descriptive studies or case reports had to be used. Most of the evidence is from a handful of high-income countries, with LMICs being underrepresented. There are also gaps in:

- knowledge of the prevalence of child and adolescent sexual abuse in many regions, including risk and protective factors and help-seeking behaviours;
- information about the longer-term impacts of child and adolescent sexual abuse, including the long-term health service needs; these are not understood and require longitudinal studies;
- understanding of the different needs for services or care, barriers faced and impacts of interventions on girls and boys, across different age groups and among those facing discrimination (e.g. on the basis of sex, race, ethnicity, religion, sexual orientation or gender identity, disability or socioeconomic status). Much less evidence was available for boys and LGBTI adolescents as compared to girls. Such information will help improve access to services and tailor interventions.

For each area considered in this guideline, additional topics requiring further research are presented under following headings.

A. Child- or adolescent-centred care/first-line support

- Explore how first-line support strategies can take into account the different needs and experiences of children and adolescents from different groups that may face discrimination (as in previous bullet point).

B. Medical history, physical examination and documentation of findings

- Identify approaches or practices that promote child- or adolescent-centred and sensitive interviewing, examination and documentation techniques and also how to counter harmful (e.g. two-finger or virginity testing) or incorrect practices.

C. HIV post-exposure prophylaxis treatment and adherence

- Identify how to improve adherence counselling and support and evaluate its effectiveness in child and adolescent survivors of sexual abuse.
- Conduct research to understand the barriers to PEP adherence among survivors of sexual assault, including adolescents and children.

D. Post-exposure prophylaxis for curable and vaccine-preventable sexually transmitted infections

- Include systematic laboratory STI testing among children and adolescents who have been sexually abused and who are asymptomatic when providing prophylactic treatment of STIs.
- Improve collection of data on STI rates among children and adolescents from LMICs who have been exposed to sexual abuse.

E. Psychological and mental health interventions in the short term and longer term

- Identify and evaluate psychological and mental health interventions that can be implemented in low-resource settings, as most of the evidence is based on interventions from high-resource settings and interventions that are resource intensive.
- Assess the scalability and how to scale up psychological and mental health interventions that have shown efficacy on a small scale, particularly in low-resource settings.

F. Ethical principles and human rights standards for reporting child or adolescent sexual abuse

- Collect information on the values and preferences of children, adolescents and their parents/caregivers about reporting of sexual abuse.
- Conduct research on the benefits and harms of mandatory reporting of child and adolescent sexual abuse, as well as on non-reporting.
- Conduct research on the effectiveness of mandatory reporting practices.
- Conduct policy reviews on the impact of requirements to obtain police reports in order to be able to provide care to survivors.
- Conduct research on the impact of statutory rape laws or laws on the age of sexual consent on health-care providers' reporting practices and on how these laws shape access to health services for children and adolescents who have been exposed to sexual abuse.

G. Implementation considerations

Facilitating timely uptake of services

- Conduct evaluations of strategies, especially from LMICs, to increase timely uptake of services. While the literature suggests that simply providing comprehensive care could increase uptake, research is required to explore this association.
- Conduct research to understand better who is accessing services, how are they learning about services and which communities are being left out.
- Evaluate different models of care and service delivery, to assess how they improve uptake and access.

Creating a supportive and enabling service-delivery environment for health-care providers

- Evaluate different training modalities and their effectiveness.
- Identify how innovations such as offering access to experts through online approaches can contribute to strengthening health-care-provider capacity.
- Assess how to promote the well-being of, and address burnout or vicarious trauma among health-care providers involved in this work.
- Assess how to strengthen provision of care in private as well as public-sector services.
- Identify how to strengthen intersectoral coordination by working together with other sectors (e.g. child welfare/protection, education) and improve options and outcomes for children and adolescents who are referred to other services.
- Document and evaluate field-based practices of programme implementers that could offer valuable lessons learnt about implementation of services.

7. Dissemination, implementation, monitoring and evaluation

The dissemination and implementation of this guideline will build on the work that has gone into disseminating and implementing the WHO guideline for responding to intimate partner violence and sexual violence against women (2013) *(39)*. The guideline for women has been widely rolled out through several regional dissemination workshops, including in countries from east and southern Africa, Asia-Pacific, the Middle-East, north Africa and the Caribbean. Several countries have used the 2013 guidelines to update their national guidelines or protocols, and have requested guidance to address child and adolescent sexual abuse, which provides an entry point for disseminating and implementing this guideline.

A formal knowledge-to-action framework will also be used to disseminate the guideline for responding to children and adolescents who have been sexually abused. This guideline will be disseminated through a broad network of partners, including ministries of health; other United Nations agencies (e.g. United Nations Children's Fund [UNICEF], United Nations Population Fund [UNFPA]); nongovernmental organizations; global initiatives on violence against women (e.g. Essential Services Package for violence against women and girls) and on violence against children (e.g. Together for Girls, Global Partnership to Prevent Violence against Children, PEPFAR's DREAMS initiative and the Adolescent Girls and Young Women Catalytic Initiative of the Global Fund for AIDS, TB and Malaria), as well as on adolescent health and reproductive health (e.g. implementing best practices or IBP); professional associations; and WHO collaborating centres. It will also be published on the WHO Reproductive Health Library and disseminated through webinars, as well as through relevant conferences.

To facilitate the uptake of this guideline, derivative products will be developed, including an update of the clinical handbook for responding to intimate partner violence and sexual violence against women *(265)* that will include specific considerations for children and adolescents who have been sexually abused. The recommendations contained in this guideline will also be included in the consolidated guidelines for responding to child maltreatment (i.e. addressing physical abuse, emotional abuse and neglect) under development by the WHO Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention.

A systematic and formal knowledge-to-action framework will be applied to the implementation of this guideline, which involves the following steps:

- introduction of the guideline to national stakeholders through a participatory and consensus-driven process, which involves identifying whether existing national guidelines or protocols need to be updated or new guidelines need to be developed;
- adaptation of the guideline to context, based on inputs from national stakeholders so that it can meet the needs of the country and take into account available human and financial resources, the organization of the health system, national laws and policies, clinical guidance and cultural and social factors. It is important that the adaptation process and any changes made, including to those recommendations that are conditional, are explicit and conducted in a transparent manner;

- use of updated or adapted national guidelines to train health-care providers in selected sites;
- monitoring of whether the knowledge and skills of health-care providers has improved, and documenting lessons learnt and barriers faced;
- on the basis of lessons learnt, identifying with national stakeholders how to further roll out the guideline; it is important that such a process identifies and addresses barriers that need to be addressed for creating an enabling environment for health-care providers to deliver clinical care.

The aim of such a process is to ensure a systematic approach to facilitate uptake and scale-up of guidelines, and to identify lessons learnt that can be applied in other settings. The monitoring and evaluation of the implementation process is a critical component of ensuring not only that health-care providers are improving their knowledge and skills but also that the health system is delivering quality care to children and adolescents experiencing abuse. Information can be gathered through periodic evaluations of service delivery, including by assessing how children and adolescents experience the care they receive and whether there has been improved and timely uptake of services over time. As much as possible, indicators that are to be reported internationally *(266)* are to be based on existing agreed indicators, and these include:

- the number of countries that have developed or updated their national guidelines or protocols or standard operating procedures for the health-system response to intimate partner violence and/or sexual violence and/or child maltreatment, consistent with international human rights standards and WHO guidelines;
- the number of countries that provide comprehensive post-rape care in a medical facility/department in every territorial and/or administrative unit, consistent with WHO guidelines.

8. Updating the guideline

This guideline will be updated in 7–10 years, or following the identification of new evidence that reflects the need for changing any recommendations. Where possible, the timing of the updates will also consider any opportunities to produce consolidated guidelines for children and adolescents and the response to violence. WHO welcomes suggestions regarding additional topics for inclusion in future guidelines. Please email these to:

reproductivehealth@who.int.