

Guideline created March 2019, revised Feb 2024, May 2025. Next revision due: May 2027

## Post Exposure Prophylaxis (PEP) for HIV in child sexual abuse

In most cases of child sexual abuse the risk of HIV transmission is low and it is rare for children to need Post-Exposure Prophylaxis (PEP), as the risk of side-effects would outweigh any benefits. The decision about whether to give PEP should be based on national guidance, including the British Association for Sexual Health and HIV ([\(BASHH\) guideline](#)) and the Children's HIV Association ([CHIVA\) guidelines](#). The guidelines should be consulted in all cases, but particularly where there is a history of possible unprotected penetration of the anus. CHIVA guidelines are accepted nationally as the authority for the prescription of PEP.

### Timing

PEP should be initiated as soon as possible after exposure to HIV, preferably within 24 hours. PEP should not be initiated beyond 72 hours after exposure. It is important to ascertain all the medication a child may be taking and consider drug interactions with PEP medicines.

### Investigations

HIV serology (HIV-1/2 Ag/Ab, HIV RNA PCR) should be obtained before starting PEP. Results are not needed before initiating treatment. FBC, U&Es, and LFTs should also be requested as baseline and there must be close monitoring for toxicity and compliance whilst the child is on therapy. Children at high risk of HIV exposure will also be at high risk of other sexually transmitted infections (STIs). Serology for HBV, HCV and syphilis should be requested with HIV serology, and testing for chlamydia and gonococcus should also ideally be requested at baseline. Full STI testing is carried out two weeks after sexual assault, with follow up tests according to The Royal College of Paediatrics and Child Health (RCPCH) [Purple book](#) and [BASHH](#) guidelines

### Referral to Paediatric Infectious Diseases team

Once PEP has been initiated, the paediatric infectious diseases team at UHS must be contacted **as soon as possible** within working hours. Their contact number is 07824417993. They will arrange a follow up appointment for the child, ideally within 24-72 hours. The result of HIV serology and the other blood tests should be passed to them.

### A note about hepatitis B

Following exposure to blood-borne viruses, it should be remembered that the risk of transmission is highest for Hepatitis B, then Hepatitis C and then HIV. Prophylactic hepatitis B vaccination is more likely to be of value in unvaccinated patients after a single episode of assault and is most effective if given within 24 hours and useful up to a week following exposure. Routine hepatitis B vaccination was introduced into primary vaccination schedule in August 2017.

1. Consider an accelerated course (either 0, 7 and 21 days or 0, 1 and 2 months) of active hepatitis B vaccination for all patients who have not previously been vaccinated who present within 6 weeks of last possible episode of penile-anal or penile-vaginal penetration.
2. HBIG should also be considered if the reported abuser is known to have acute or newly diagnosed chronic Hepatitis B

### Medical assessment and management of children at risk of HIV infection

The arrangements for the medical assessment of suspected child sexual abuse (CSA) are outlined in HIPS procedures: [Guide to medical examinations in suspected child sexual abuse](#). The paediatrician or Sexual Offence Examiner leading on the CSA assessment will arrange the first dose of PEP. **Please see the flow chart below for PEP management children and young people at high risk of HIV exposure following sexual assault.**

