GUIDELINES FOR THE
MEDICAL EXAMINATION AND MANAGEMENT
OF THE
SEXUALLY ABUSED CHILD

1. INTRODUCTION:

- Sexual abuse can happen to any child of any age, regardless of culture or creed. The perpetrator is invariably well known to the child. It is a catastrophic event for the child and invariably has serious long-term consequences.

- The child invariably feels ashamed and guilty. They need to be handled with great sensitivity and understanding.

- Every alleged case warrants referral to, and thorough investigations, by a multi-disciplinary team.

2. DEFINITION OF CHILD SEXUAL ABUSE (CSA)

Sexual abuse is any act or acts which result in the exploitation of a child or young person, whether with their consent or not, for the purposes of sexual erotic gratification. This may be by adults or other children or young persons. Sexual abuse may include some of the listed, but is not restricted to the following, behaviour.

- Non-contact abuse: Exhibitionism (flashing), voyeurism (peeping), suggestive behaviours or comments, exposure to pornographic materials or producing visual depictions of such conduct.

- Contact abuse: Genital / anal fondling, masturbation, oral sex, object or finger penetration of the anus / vagina and / or encouraging the child / young person to perform such acts on the perpetrator.

- Involvement of the child / young person in exploitive activities for the purpose of pornography or prostitution.

- Rape, sodomy indecent assault, molestation, prostitution and incest with children.

3. PHYSICAL SIGNS OF ABUSE

- Physical signs of molestation are subtle and rarely diagnostic. Their detection and correct interpretation may be very important in supporting the child’s statement or indicating a need for further multi-disciplinary investigation.
A diagnosis of sexual abuse should rarely if ever be made on physical signs alone
Exceptions
- pregnancy
- finding semen on a child (post-pubertal boys excluded)

A substantial proportion of sexually abused children have no abnormal physical signs because the abuse is often non-violent. The proportion varies with the type of abuse. Absence of such signs does NOT imply absence of abuse.

4. TIMING OF REFERRAL TO A CRISIS CARE CENTRE:

- The sooner the problem of CSA is attended to in a correct and constructive way, the better the outcome will be for the child.
- The child must be attended to immediately irrespective of the time period that has elapsed since the incident i.e. treat injuries and infections and counsel
- The child is a victim of traumatic rape (active bleeding)
- The child is symptomatic e.g. vaginal discharge, severe dysuria, fever or abdominal pain.
- The child exhibits obvious major psychological trauma.

5. THE ROLE AND RESPONSIBILITY OF THE HEALTH CARE PRACTITIONER

- In terms of the Child Act 1983 Section 42 and the Child Care Amendment Act 1996, doctors, nurses, dentists and social workers are required to report any suspicion of child abuse including sexual abuse. Failure to do so constitutes a criminal offence. Persons required by the Act to report such suspicions cannot have legal proceedings instituted against them should the suspicion prove to be wrong
- It is imperative that the clinical findings are documented accurately, that medico-legal evidence is collected, the J88 completed and medical treatment initiated
- Child sexual abuse is often overlooked by doctors because of a lack of awareness resulting in missed diagnosis during consultation
- When confronted by child sexual abuse, HCP’s do not want to become involved. These cases need time, forensic training, experience, emotional energy and a willingness to testify in court. The diagnosis is important for the protection and well being of the child and HCP’s should not avoid these patients
- The HCP must reassure the child and concerned persons (parents) as to the child’s physical health and not cause further trauma / stress to the child.

6. DISCLOSURE

The disclosure of sexual abuse by a male or female child is a time of maximum crisis. The success of future management and rehabilitation of the child will depend to a large extent on the management of the crisis situation.

- Younger children rarely disclose sexual abuse spontaneously
- Older children often disclose sexual abuse by a non-family member if violence was involved
The majority of child sexual abuse cases are not disclosed by a child because of feelings of guilt, secrecy, intimidation and the perpetrator often being well known to the child.

7. SIGNS THAT COULD INDICATE CHILD SEXUAL ABUSE

- **Behavioural Signs:**
  - “Sexualised behaviour”
    - Explicit sexual behaviour
    - Excessive masturbation
  - Change in behaviour
    - Anger, aggression
    - Depression, suicidal attempts
    - Withdrawal or regression
  - Problems with urination (e.g. enuresis) and defaecation (e.g. encopresis, faecal impaction)
  - Deterioration in school performance

- **Physical Symptoms / Signs Or Complications:**
  - Vagina: Discharge, trauma, bleeding, foreign body
  - Rectum: Bleeding, trauma
  - Sexually transmitted diseases
  - Discomfort when walking or sitting
  - Non-accidental injury
  - Pregnancy

8. HISTORY:

- The history of the alleged abuse is important in determining the extent of the medical examination. However, constant repetition of the history by a child to various different professionals involved in the case usually heightens the child’s sense of guilt and shame at what has happened and may be as traumatic as the abuse itself.

- Therefore, where possible the history should be obtained from someone other than the child, such as a parent, caretaker, social worker or police officer to whom the child had already given the history.

- Questions asked by the examining HCP should be those pertinent to the examination unless the HCP is the person to whom the child first disclosed.
  - When taking the history in this instance
    - Observe and note the appearance / mental state of the patient
    - Be relaxed and natural, maintain eye contact and be a good listener
    - Be brief, pertinent and relevant
    - Be careful not to interrogate the child or use leading questions
    - Note and record the actual words and the vocabulary used by the patient
    - Obtain a detailed account of the incident (e.g. acts of oral or anal sex)
9. CONSENT

- Obtain informed consent for the examination, the collection of specimens and the disclosure of information to the investigating officer.

- The form SAP308 may be utilised to record the consent from the parent / guardian in the case of minors; patients 14 years and older may give consent for the examination, collection of specimens and disclosure of results.

- If form 308 is not available the consent must be recorded on a departmental consent form or in writing on a sheet of paper, signed by the person giving the consent and the document witnessed. File a copy in the patient records.

10. EXAMINATION OF THE SEXUALLY ABUSED CHILD:

- The HCP must always remain calm, patient and sympathetic to the child.

- The child should be in control of the examination (no force).

- The child should always be semi-dressed or covered by a blanket / sheet.

- A good focused light source is essential and an auroscope is helpful for magnification.

- Talk to the child, win his or her trust and explain every step of the examination as you go along.

- Start off by doing a thorough general examination. (NB: Detailed written notes and diagrams are essential)
  - Check for life threatening conditions
  - Do the vital signs (check ABC)
  - If the patient requires immediate medical intervention refer to Casualty and delay the forensic examination
  - Note the weight and height of the child
  - Look for signs of previous abuse and specifically the skin and mouth (oral sex)
  - Note the stage of sexual development (Tanner staging)
  - Examination under anaesthesia (acute vaginal bleeding, removal of foreign bodies or in an anxious or frightened child who refuses an examination that is deemed urgent)

11. EXAMINATION AND EVIDENCE COLLECTION FROM SEXUAL ASSAULT SURVIVOR

- Examinations must be done **ONCE ONLY** in a private room that is warm and comfortable. A third person, preferably the mother, guardian or a nurse should always be present.

- Knowledge of the normal appearance of the genitalia and anus of young children is necessary to recognise the subtle abnormal signs in the sexually abused child.

- (Collect specimen as per instruction pamphlets in SEACK)

   **Step 1**

   **Oral swab**
   - Fold up the box provided in kit
   - Swab between the gums and cheeks and under the tongue
   - Insert swabs in the slots within the box
   - Seal box with bar-coded label
Step 2

Clothing (collect clothing as per instruction pamphlet in clothing collection kit)
If assisting the patient to undress, wear gloves.
- Let the patient undress on a clean sheet or collection paper (not on to the floor)
- The patient must remove his / her shoes first; place each article of clothing in a separate heap
- Place each piece of clothing and collection paper in separate paper bags (dry clothing before packaging)
- Seal packet with bar-coded label

Step 3

Evidence on patient's body
- Collect hair combings on catch paper
- Obtain pulled reference head hair (approximately 10) on catch paper
- Collect biological materials from the nails (orange sticks)
- Dry secretions on skin (swab moistened with distilled water)

Foreign debris on body
- Matted hair – cut matted hair specimen and place in catch paper
- Foreign debris

Step 4

Do the HEAD TO TOE ASSESSMENT at this stage
- Examine the entire body for signs of trauma, especially the hidden areas
- Use annotated diagrams and body maps to depict the injuries; photograph the injuries if possible (use a ruler and number tag)
- Describe the features of any injuries observed

Take swabs of bite marks and breast / nipples

Pubic hair combings and reference pubic hair
- If hair is matted cut matted hair specimen and place in catch paper
- Place collection paper under patient’s buttocks
- Comb hair towards paper
- Fold up the collection paper containing pubic hair specimen
- Obtain reference hairs (approximately 10) from pubic region (use fingers to collect hair)

Steps 5 and 6 - GENITAL AND ANAL EXAMINATIONS:

- **POSITION:**
  - Frog position; i.e. child supine, knees apart, feet together. A small child can be examined on an adult’s lap (see diagram 1)
  - Warthog position (knee – chest position) – (see diagram 3)
Step 5

**Anal examination and evidence collection**
- To identify and record any trauma and obtain biological material for DNA analysis that may help to identify the suspect / perpetrator

NB: The anus must be examined in all cases of sexual abuse

The examination may be done with the patient in the knee-chest position or in the left lateral position.

- Note injuries (lacerations, haematomas or scars) using the clock face notation to record injuries

- The only absolute indicator of anal abuse is laceration or healed scar extending beyond the anal mucosa onto the peri-anal skin in the absence of a reasonable alternative explanation e.g. major trauma. Scars are seen in only a small proportion (less than 10%) of children with positive anal findings.

- Collect peri-anal and rectal swabs

Step 6

**Genital examination and evidence collection**
- To perform a thorough examination to identify and record any trauma and obtain biological material for DNA analysis that may help to identify the suspect / perpetrator

**INSPECTION, SEPARATION AND TRACTION**

**INSPECTION**
- Assess development
- Collect pubic hair specimens if not already done (step 4)
- Collect external swab from labia and clitoral region
- Inspect the external genitalia for bruises, swelling, lacerations, burns, scars, warts and vesicles
Use the acronym ‘TEARS’

T = tenderness
E = ecchymosis (bruising)
A = abrasions
R = redness
S = swelling

- Document injuries using the clock face notation and size

SEPARATION
Examine
- The crease / trough between the labia majora and minora
- Clitoris and hood / prepuce
- Urethra
- Hymen injuries (posterior or lower half)
  Congenital absence of the hymen has not been documented in the literature; therefore an
  absent or rudimentary hymen usually indicates previous penetration
- Posterior fourchette (common site for injury)

Diagram 2 – Examination of the external genitalia

Diagram 3 – Examination in the knee-chest (warthog) position
TRACTION

NB: Do not use traction in children under the age of 1 year

- Gently separate the labia majora by placing the thumbs lateral to the labia majora. By pulling sideways and downwards, the labia minora, clitoris, hymen and urethra will come into view.
- Check for injuries; document injuries using the clock face notation

NB: TINE evaluation in prepubescent child

T - thickening
I - Irregularity of posterior edge
N - narrowing of the rim
E - exposure of posterior vaginal vault.

SPECULUM EXAMINATION

NB: No speculum examination in prepubescent children

Use toluidine blue dye to visualize minor or microscopic injuries
- Paint toluidine blue dye on vulval area only (avoid the vaginal mucosa)
- Use dilute acetic acid to remove excess dye (injured areas retain a deep blue colour)
- View with magnifying glass (or colposcope if available) to visualise injuries

Collect 1 swab from
- the deep vaginal area (posterior fornix)
- the cervical os

NB: A white vaginal discharge may be present at the peri-pubertal stage as a result of oestrogenisation of the vagina

Hymen examination
Check for injuries (bruises, abrasions and lacerations)
- Insert a Foley catheter, inflate the bulb with a small amount of air and withdraw slightly so that hymenal tissue can be visualised; document any injuries observed using the clock face notation.
  Deflate the bulb and remove the catheter at the conclusion of the examination
- Document injuries using the clock notation

NB: The oestrogenised hymen becomes more elastic

Step 7

The goal of step 7 is to provide a reference DNA sample utilising a Marshal cassette or blotting paper

- Collect a sample of blood in the EDTA tube provided
- Using the blood dispensing device place a drop of blood in each of the 3 wells on the cassette / blotting paper
- Allow to dry for 10 minutes before packing in the padded envelope provided

12. GENERAL PRINCIPLES IN MANAGEMENT

- The total management of child abuse and especially of childhood sexual abuse is difficult and complicated, requiring a multi-disciplinary team approach. In the management of abused children the interest of the child are paramount. It is important to reassure the child and show him or her respect and kindness.
The physical examination of the abused child is essential and it is imperative that it be conducted in such a manner that both the patient and justice are properly served. The examination should be performed by an appropriately trained HCP. Notes must be completed in detail and documentation by means of annotated diagrams and/or photographs are essential.

If the HCP is unsure of his/her competence to examine a child who has been sexually abused and is unsure on how to complete a J88 medico-legal form, he/she should either consult with an experienced colleague or refer the patient to a specialist.

The J88 form must be completed in duplicate – the findings are more important than possible deductions. Hand the original copy of the J88 to the Investigating Officer and retain the copy in the patient’s records.

It is vital that the child’s future safety is ensured. He or she must on no account be returned to a place where further abuse can occur. If no other place of safety is available, the child should be admitted to a hospital until arrangements are made for placement. If admission is refused a detention order can be placed on the child by a social worker or police officer.

Refer the patient to a social worker or the child abuse management team, if not already seen.

Notify all suspicion of child sexual abuse to the Department of Social Welfare on the appropriate form (Article 42a of Child Care Act).

Manage medical and/or surgical problems appropriately.

Psychiatric/psychological referral: This will depend on the age of the child, the extent of the abuse and psychological problems identified in the child. Older children will benefit from referral.

13. SPECIFIC ISSUES FOR ADOLESCENTS

Adult treatment guidelines are appropriate for post-pubertal adolescents (Tanner stage 5)

For adolescents in early puberty (Tanner stages 1 and 2) use paediatric guidelines.

For intermediate puberty, monitor closely and choose either adult or paediatric guidelines.

Non-compliance is problematic and strategies should be introduced to promote adherence and more frequent visits and intensive counselling.
14. TANNER STAGING

TANNER STAGING FOR BOYS

<table>
<thead>
<tr>
<th>Stage</th>
<th>Pubic Hair</th>
<th>Penis</th>
<th>Testes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None</td>
<td>Pre-adolescent</td>
<td>Pre-adolescent</td>
</tr>
<tr>
<td>2</td>
<td>Scanty, long, slightly pigmented</td>
<td>Slight enlargement</td>
<td>Enlarged scrotum, pink texture altered</td>
</tr>
<tr>
<td>3</td>
<td>Darker, starts to curl, small amount</td>
<td>Longer</td>
<td>Larger</td>
</tr>
<tr>
<td>4</td>
<td>Resembles adult, less than adult</td>
<td>Larger, glans and breadth increase in size</td>
<td>Larger, scrotum dark</td>
</tr>
<tr>
<td>5</td>
<td>Adult distribution, spread to medial surface of thighs</td>
<td>Adult</td>
<td>Adult</td>
</tr>
</tbody>
</table>

TANNER STAGING FOR GIRLS

<table>
<thead>
<tr>
<th>Stage</th>
<th>Pubic Hair</th>
<th>Breasts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-adolescent</td>
<td>Pre-adolescent</td>
</tr>
<tr>
<td>2</td>
<td>Sparse, lightly pigmented, straight, medial border labia</td>
<td>Breast and papilla elevated as small mound; areola diameter increased</td>
</tr>
<tr>
<td>3</td>
<td>Darker, beginning to curl, increased amount</td>
<td>Breast and areola enlarged, no contour separation</td>
</tr>
<tr>
<td>4</td>
<td>Coarse, curly, abundant but less than adult</td>
<td>Areola and papilla form secondary mound</td>
</tr>
<tr>
<td>5</td>
<td>Adult feminine triangle, spread to medial surface of thighs</td>
<td>Mature; nipple projects, areola part of general breast contour</td>
</tr>
</tbody>
</table>
Table 1 – LABORATORY INVESTIGATIONS – ROUTINE TESTS

1. **SWABS:**
   - In all cases take swabs from vagina and penis and anus if indicated, for the detection of:
     - Gonococcus
     - Trichomonas
     - Other organisms
   - Moisten swab in transport medium before inserting in child’s vagina and/or anus. Place back in transport medium and send to the laboratory.
   - Use Ca algenate or orange tipped Copan Swab and Ames transport medium.
   - Repeat swabs as indicated clinically.

2. **SLIDES:**
   - If a discharge is present, use a Ca Algenate or Copan Swab to obtain a specimen of the discharge and roll lightly on a clean glass slide to make a smear for gram staining. Send the slide to the laboratory.

3. **URINE:**
   - MCS (microscopy, culture and sensitivity)
   - Pregnancy test (if indicated)
   - Repeat urine test if indicated clinically.

4. **BLOOD**
   - HIV test: Repeat in 6, 12 and 24 weeks
   - VDRL Repeat in 12 and 24 weeks
   - Hepatitis B screen
   - B-HCG (if indicated)

   4.1 Minimum time for HIV and VDRL to become positive is 20-24 days.

   4.2 If condyloma lata is present, the initial VDRL may be negative if there is a high antibody titre (prozone effect). Request the laboratory to do dilutions.

5. **It is NOT necessary to do the following test:**
   - Chlamydazyme – unreliable test. Can get false positives and false negatives. The only reliable test for chlamydia is an LCR on a first catch urine specimen.
# TREATMENT OF CHILD SURVIVORS OF VIOLENCE, ABUSE AND RAPE

## TABLE 1: MEDICAL MANAGEMENT

<table>
<thead>
<tr>
<th>REASON FOR TREATMENT</th>
<th>PRESCRIBED TREATMENT</th>
</tr>
</thead>
</table>
| 1 Physical injuries                  | Treat wounds – cleanse, dress or suture  
Analgesia – Paracetamol  
Antibiotic if warranted (deep wounds that are contaminated / old wounds >24 hours / septic wounds).  
Anti-tetanus globulin within 72 hours if clinically warranted (as above)  
Tetanus toxoid 0.25 ml stat, then at 6 weeks and 6 months (if no booster doses in last 5 years) |
| 2 Pregnancy prevention               | Less than 72 hours:  
2 Ovral stat and again 12 hours later (provide an anti-emetic and inform patient of the side effects)  
More than 72 hours and less than 7 days:  
Counsel the patient on the options available  
- IUCD  
- ‘Medical’ TOP (misoprostol) if the next period is missed |
| 3 Prevention of sexually transmitted diseases | Ceftriaxone 125 mg IMI stat  
Metronidazole 15 mg / kg / day for 7 days |
| 4 Prophylaxis against HIV infection  | See ANNEXURE 1 - protocol for PEP  
ANNEXURE 2 - consent for HIV testing TABLE 3 |
| 5 Treatment of sexually transmitted diseases | See TABLE 2 |
## TABLE 2: TREATMENT OF S.T.D. IN CHILDREN

<table>
<thead>
<tr>
<th>ORGANISM</th>
<th>INCUBATION PERIOD</th>
<th>RECOMMENDED TREATMENT</th>
</tr>
</thead>
</table>
| 1. Gonococcus             | 4-5 Days         | - Ceftriaxone 50 mg/kg - single IMI stat dose.  
- Treat those with gonorrhoea routinely for chlamydia                                                                                   |
| 2. Syphilis               | 9-90 Days        | - Benzathine penicillin (Bicillin) 50 000 units per kg IMI stat. (Maximum 2,4 million units)                                                                 |
| 3. Chlamydia              | 7-14 Days        | - Erythromycin 50 mg/kg/day divided into 4 doses (maximum 2 g/day) for 7-14 days                                                                       |
| 4. Trichomonas            | 7 Days           | - Metronidazole 7 mg/kg/dose tds for 7 days                                                                                                           |
| 5. Herpes                 | 5-10 Days        | - Acyclovir 5 mg/kg/dose tds for 5-7 days.  
- In immuno-compromised cases increase to 10 mg/kg/dose                                                                                     |
| 6. Gardnerella (Bacterial vaginosis) | | - Metronidazole 7mg/kg/dose tds for 7 days (Trichomonas is often associated with bacterial vaginosis)                                                 |
| 7. Lymphogranuloma venereum |                | - Erythromycin 50mg/kg/day divided into 4 doses x 14 days. (maximum dose 2 g/day)                                                                      |
| 8. Chancroid              | 7 Days           | - Erythromycin 40 mg/kg/day divided into 4 doses (maximum dose 2g/day x 5 days)                                                                       
- Cotrimoxazole (Trimethoprim / sulphamethoxazole) 10mg/kg/day divided into 2 doses x 10 days                                                 |
|                           |                  | AGE:  
- 6 weeks to 5 months = 2,5 ml/dose  
- 6 months to 5 years = 5 ml/dose  
- 6-12 years = 10 ml/dose  
See literature                                                                                                                                |
| 9. Pelvic inflammatory disease |                | - Ceftriaxone 20-80 mg/kg single IMI stat dose.  
- Metronidazole 7 mg/kg/dose tds for 7-10 days  
- Erythromycin 50mg/kg/day divided into 4 doses x 10 days                                                                                  |
ANNEXURE 1: PROTOCOL FOR POST EXPOSURE PROPHYLAXIS (PEP) FOR HIV

- Prophylaxis is indicated after exposure to HIV-infected body fluids and should commence as soon as possible. The decision to use ART must be accompanied by a commitment to complete the course and should only be considered where the caregiver is motivated and compliant. Skipping doses or sharing medication with other patients will result in rapid loss of efficacy because of resistance.

- At present 2 classes of ART are available for PEP – Nucleoside Reverse Transcriptase Inhibitors (NRTIs) e.g. AZT (zidovudine) and 3TC (lamivudine) and Non- Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) e.g. nevirapine.

- The current policy is to use dual therapy with 2 NRTIs viz. AZT and 3 TC.

- The duration of prophylactic treatment should be for four weeks.

- If exposure occurs on the weekend or after-hours, ensure that the patient gets the necessary medication. Begin with a starter pack and recall the patient for collection of further medicine supplies.

CONSENT FOR HIV TESTING

- Obtain written informed consent for HIV testing; place form in patient record (Annexure 2).
  - A parent or guardian must consent on behalf of a child under the age of 14 years.
  - A person who is 14 years of age or older may consent to HIV testing. The test results must be given to the child and not to the parents or any other person, unless the child consents to such disclosure.

HIV TESTING AND COUNSELLING

- Pre- and post-HIV test counselling is required for all persons undergoing HIV testing regardless of the testing method.

- HCP’s and counsellors must ensure that HIV testing is done within the accepted norms and standards of proper patient care.

- Rapid tests to detect antibodies to HIV enables HCP’s to supply definitive negative and preliminary positive results to patients at the time of testing.

- Rapid testing allows people to be counselled, tested and given test results in a single visit. This is particularly useful in rural areas where returning for the test results may be costly and difficult.

- Rapid testing may be appropriate and cost effective in rural areas where diagnostic laboratories are often far away, resulting in delays in submitting specimens or obtaining results.

- Adequate training of HCP’s and experience is necessary before use of the rapid testing kits. Quality and strict stock control procedures should be instituted to ensure that the kits are properly stored, used and accounted for.

- If an initial rapid HIV test is positive, a confirmatory rapid HIV test using a different test should be performed. If the second test is positive the patient may be informed of the result.
  - If the second test is negative (discrepant result from the first test), then a blood sample should be sent for a formal laboratory confirmatory test. Schedule a return visit for the patient to get the results and verify the patient’s contact details (address, telephone number etc.).
CONSENT FOR HIV TESTING AND / OR TREATMENT

Case Number / Health Facility Number: __________________________________________

I, ____________________________________________________________________________

(being the parent / guardian of __________________________________________)     Age________

hereby consent to myself / him / her being subjected to HIV testing.

I confirm that:

- Pre-test counselling was received before undergoing testing

- The risks of contracting HIV infection has been explained to me

- The nature of the tests to be performed have been explained to me

- If I test positive for HIV I will not be given anti-retroviral drugs

- If I test negative for HIV I have the option of taking anti-retroviral drugs

- Anti-retroviral drugs may prevent me from becoming HIV positive

- That further HIV tests and other blood tests will be performed over the coming weeks

- The possible side effects of taking anti-retroviral drugs have been explained to me

- The results of the tests performed will not be disclosed to anyone without my consent

Furthermore, I undertake to:

- Complete the full 28 day course of treatment

- Return if side effects to the drugs develop

- Keep follow-up appointments

Date:    ____________________________________

Place:   ____________________________________

Signature / thumb print (of patient/parent/guardian) __________________________________

Details of Interpreter (if applicable)

Print name: ________________________________

Designation: ________________________________

Signature: ________________________________

Witness

Print name: ________________________________

Designation: ________________________________

Signature: ________________________________
**TABLE 3 - PROPHYLAXIS AGAINST HIV INFECTION**

- **If the HIV test is negative – initiate PEP**
  - Do baseline tests (FBC, U&E and LFT)
  - Initiate treatment (dual therapy)
    
    **AZT syrup:** 8mg / kg / day divided in 2 doses for 7 days (or use age as per Table 4)
    
    **3TC syrup:** 4mg / kg / day divided in 2 doses for 7 days (or use age as per Table 4)
  
  - Provide anti-emetic and inform patient of side effects
  
  - Common side effects of antiretroviral drugs
    
    - **AZT:** Nausea, headache, fatigue, neutropenia, anaemia, myalgia
    
    - **3TC:** Headaches, nausea

- **Thereafter**
  
  - Dispense treatment for 7 days at a time (up to 28 days)

- **Follow-up monitoring**
  
  - HIV serology
    Repeat at 6, 12 and 24 weeks
  
  - Repeat baseline tests
    Necessary to get baseline results at 2 weeks and 4 weeks after exposure to ascertain if there are adverse side effects e.g. bone marrow suppression

**CONTACT INFORMATION**

- Pharmaceutical Services, Natalia, Pietermaritzburg
- District / Regional Pharmacist
- AIDS Training, Information and Counselling Centres (ATICCS)

<table>
<thead>
<tr>
<th>Location</th>
<th>Contact Number</th>
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<tr>
<td>DURBAN</td>
<td>031-3003014</td>
</tr>
<tr>
<td>PIETERMARITZBURG</td>
<td>033-3951612 / 3</td>
</tr>
<tr>
<td>EMPANGENI</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 4 – PROPOSED DOSE SCHEDULE FOR AZT AND 3TC PER AGE

**AZT**  
*160mg / meter squared / dose daily*  
*Divided in 2 dose (i.e. 12 hourly or bd)*

<table>
<thead>
<tr>
<th>AGE</th>
<th>AZT</th>
<th>3TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3 months</td>
<td>4.0 ml</td>
<td>1.0 ml</td>
</tr>
<tr>
<td>3 months</td>
<td>5.0 ml</td>
<td>2.0 ml</td>
</tr>
<tr>
<td>6 months</td>
<td>5.0 ml</td>
<td>3.0 ml</td>
</tr>
<tr>
<td>9 months</td>
<td>5.0 ml</td>
<td>3.5 ml</td>
</tr>
<tr>
<td>12 months</td>
<td>7.5 ml</td>
<td>4.0 ml</td>
</tr>
<tr>
<td>18 months</td>
<td>7.5 ml</td>
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</tr>
<tr>
<td>2 years</td>
<td>10.0 ml</td>
<td>5.0 ml</td>
</tr>
<tr>
<td>3 years</td>
<td>10.0 ml</td>
<td>5.0 ml</td>
</tr>
<tr>
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</tr>
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</tr>
<tr>
<td>6 years</td>
<td>10.0 ml</td>
<td>7.5 ml</td>
</tr>
<tr>
<td>7 years</td>
<td>0.5 tablet</td>
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</tr>
<tr>
<td>8 years</td>
<td>0.5 tablet</td>
<td>10.0 ml</td>
</tr>
<tr>
<td>9 years</td>
<td>0.5 tablet</td>
<td>10.0 ml</td>
</tr>
<tr>
<td>10 years</td>
<td>0.5 tablet</td>
<td>12.5 ml</td>
</tr>
<tr>
<td>11 years</td>
<td>2 capsules</td>
<td>12.5 ml</td>
</tr>
<tr>
<td>12 years</td>
<td>2 capsules</td>
<td>1 tablet</td>
</tr>
<tr>
<td>13 years</td>
<td>2 capsules</td>
<td>1 tablet</td>
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</tbody>
</table>

**3TC**  
*4mg / kg / dose daily*  
*Divided in 2 dose (i.e. 12 hourly or bd)*

<table>
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<tr>
<th>AGE</th>
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<th>3TC</th>
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<tr>
<td>3 months</td>
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<tr>
<td>6 months</td>
<td>5.0 ml</td>
<td>3.0 ml</td>
</tr>
<tr>
<td>9 months</td>
<td>5.0 ml</td>
<td>3.5 ml</td>
</tr>
<tr>
<td>12 months</td>
<td>7.5 ml</td>
<td>4.0 ml</td>
</tr>
<tr>
<td>18 months</td>
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<td>4.5 ml</td>
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<tr>
<td>2 years</td>
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<td>5.0 ml</td>
</tr>
<tr>
<td>3 years</td>
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**RECOMMENDATION:**  
Packings of 50mls of AZT syrup and 3TC oral solution be placed in the casualty ‘EMERGENCY CUPBOARD’ for use when the pharmacy is closed.