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Letter to the Editor Open Access

Sexual Assaults in Children: The Role of HIV Post-Exposure Prophylaxis

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Letter to the Editor

Violence against children is a major concern in South Africa. During the period 1 April 2004 and 31 March 2005, 1128 children were murdered, 24 189 children were the victim of assault with the intention to commit grievous bodily harm, 31 607 children were commonly assaulted, 22 486 children were raped, 4289 children were indecently assaulted and 1569 cases of tempted murder of children were reported to the South African Police Services [1].

The Red Cross War Memorial Children's Hospital (RCWMCH) in Cape Town has the only trauma unit in Africa dedicated to the care of children under the age of 13 years and in 2000, became the first hospital in South Africa to routinely prescribe HIV post-exposure prophylaxis (HIV PEP) to children who are victims of sexual assault. (According to our Provincial Policy, children from the age of 13 years onwards are routinely treated in hospitals for adults and do not attend our hospital).

Since there is presently little published data on effectiveness of HIV PEP in sexually abused children [2], the objective of this study was to determine the effectiveness of HIV PEP in children after sexual assault.

We performed a retrospective chart review of 818 children treated for sexual assault at the RCWMCH trauma unit between January 2000 and September 2009.

All sexual assault cases presenting within the first 72 hours were given HIV PEP on admission, except cases in which the child was already known to be HIV-infected and on treatment (these children were referred to our HIV clinic) or if the child had been the victim of repeated (chronic) sexual abuse by the same perpetrator. Baseline testing for HIV took place in all cases. Prophylaxis was commenced as soon as the HIV test results became available. Prophylaxis consisted of zidovudine 180 mg/m^2 body surface area (BSA) by mouth every 12 hours, and lamivudine 4 mg/kg by mouth every 12 hours for 28 days. In 2008, lopinavir/ritonavir 230 mg/m^2 every 12 hours was added to the regimen.

According to UNAIDS the prevalence of HIV/AIDS in South Africa among 15-49 year olds was 17.8% at the end of 2009. Since we do not receive any information on the HIV status of the perpetrator we feel obliged to treat all child victims as potentially infected [4].

Research at our institution in 2005 showed that only 22.6% of the patients returned for all their follow up visits, while 39.6% did not return for any of their scheduled follow up visits [3]. Consequently, all patients are given enough medication for 28 days at discharge. Since 2007 the follow up rates have improved (2007: 59.1%; 2008: 71,4%; 2009: 69,7%).

The antiretroviral therapy (ART) database at Red Cross War Memorial Children's Hospital which contains presently information on 1748 children started on ART at the hospital since August 2002 does not include any children who failed PEP after a sexual assault. Although we do not have data on the period before 2000, seroconversions were documented in the era before PEP was used [5]. We have not recorded any seroconversions in the last decade while we provide PEP routinely.

We therefore conclude that this represents indirect evidence that the provision of PEP may lead to lower rates of HIV seroconversion and advocate PEP to be administered to all sexually assaulted children.

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