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Definitions

According to the United Nations Palermo Protocol, **severe trafficking in persons** refers to, "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs."[1].
Particularly important to child-serving professionals is the qualification that when children (under age 18 years) are involved, there need not be demonstrable force, coercion or other means described above. Further, 'trafficking' need not involve travel from one place to another.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) defines the **commercial sexual exploitation of children (CSEC)** as involving "crimes of a sexual nature committed against juvenile victims for financial or other economic reasons. These crimes include trafficking for sexual purposes, prostitution, sex tourism, mail-order-bride trade and early marriage, pornography, stripping, and performing in sexual venues such as peep shows or clubs."[2] While this definition does not explicitly include children engaging in sex acts in exchange for money, food, shelter or other basic necessities—often called 'survival sex'-- it implies inclusion of this activity, and for the purposes of this guideline, survival sex is considered a form of CSEC. Commercial sexual exploitation may also involve children whose basic needs are met, but who engage in CSEC for extra money to buy desirable items, or for the perceived excitement and adventure[3].

Domestic minor sex trafficking (DMST) involves the commercial sexual exploitation of children who are U.S. citizens or legal residents, and who are exploited within U.S. territory[4,5].

Focus Population: This Clinical Practice Guideline applies, but is not limited to children **≥ 11years**, male or female.

Target Users: This Clinical Practice Guideline is applicable to all Children's Healthcare of Atlanta locations and is intended for use by Physicians, Nurses, Social Workers, Case Managers, Advanced Nurse Practitioners, Interpreters, Pharmacist, members of the Child Protection Team and other staff members as appropriate.

Epidemiology

Human trafficking is a major global health and human rights issue, with one international study reporting victims in 132 countries[6]. The total number of victims is unknown, although estimates range into the millions[7]. Women and children make up a large proportion: in one global study up to 60% of the victims were women and 27% were children[6]. Estimates vary but the average age of entry for child victims of commercial sexual exploitation and sex trafficking is 12-16 years.[8,9,10] Boys and girls are vulnerable. The true female:male ratio is unknown as male victims tend to be unrecognized and under-reported[11]. There are numerous risk factors for CSEC and sex trafficking, and these involve child, family, community and societal conditions[12-15] (see below). But in some cases, child victims have no prominent risk factors; they may be living in stable homes, with no obvious family dysfunction, child vulnerabilities or community stressors.

Because of the prevalence of physical and sexual violence, traumatic stress and psychological abuse and manipulation, child victims may experience a plethora of physical and behavioral health problems, including closed head injury, strangulation with complications of asphyxiation, fractures, abdominal/pelvic trauma, bruising, lacerations, burns, anogenital trauma, sexually transmitted infections (STIs), pregnancy, abortion complications, post-traumatic stress disorder (PTSD), depression and suicidality, panic attacks, drug ingestion/overdose/withdrawal, and other acute conditions. They may also experience exacerbations of untreated chronic disease (diabetes mellitus, asthma, seizure disorder, bipolar disorder), malnutrition or dehydration from chronic deprivation[4,13,15-22]. Clinical studies indicate that many victims will at some point in their trafficking experience present for medical care, often to emergency departments and various clinics, but also to private practitioners and other regular primary care providers[16,18].

Unfortunately, victims rarely walk into emergency departments, clinics and urgent care centers with a chief complaint of 'human trafficking'. In fact, many don't view themselves as victims at all, and others are too intimidated, afraid, ashamed, humiliated or distrustful to disclose. In many cases of girls being controlled by traffickers, the girl has been psychologically manipulated into thinking that her trafficker is her 'boyfriend' and she may be fiercely loyal to him, lying to authorities about his activities and/or rationalizing to herself that his exploitation of her is a small part of their otherwise loving relationship and he will ultimately provide her an ideal life. Therefore, it falls upon the medical provider to be attuned to high risk circumstances and the possibility that a patient may be a victim.

Potential Indicators of Child Commercial Sexual Exploitation

Initial clinical presentation
Presents for evaluation of: Acute sexual assault Suicide attempt Serious injury (other than MVC) Drug/alcohol intoxication Complication of pregnancy/abortion Vaginal or penile discharge/signs and symptoms of PID
Child is accompanied by adult who is Domineering and who speaks for child Apparently intimidating/frightening to child Not the guardian Multiple youth presenting for treatment
Child gives false or changing demographic/historical information (or unable to state where s/he is)
Child appears very submissive, depressed and/or withdrawn
Adult accompanying child pays for visit with cash
Historical factors
Frequent drug use/misuse
History of sexual or physical abuse or neglect
History of running away (esp. >3 times over past year), throwaway* status or homelessness
Prior involvement with child protective services (especially hx. of foster care)
Prior involvement with department of juvenile justice
Truancy or doing poorly in school
History of multiple sexual partners, esp. over short period of time
Multiple prior STIs and/or history of pregnancy (or fathering baby)
LGBTQ youth**
Child has older boyfriend/girlfriend (>4 years older)
Physical exam
Signs concerning for inflicted injury
Tattoos, esp. of man's name or sexually provocative words, or gang insignia
Child has large amount of cash or expensive items incongruous with remainder of appearance
Child has keys to motel room

*Throwaway status refers to child being told to leave home or forbidden to return.
**Lesbian, gay, bisexual, transgender or questioning youth

Issues of Confidentiality and Assent

Confidentiality cannot be guaranteed to the child and it is important to inform the child of the limits of confidentiality. You are obligated to share information with others if the child discloses abuse, neglect or intent to harm themselves or others.

It is important to obtain the child's assent for each step of the assessment if at all possible, including the medical history, exam, sexual assault evidence kit, STI/pregnancy/drug testing and pregnancy/STI prophylaxis. If the child does not want any of the above elements of the assessment and their safety or immediate health needs are not jeopardized by foregoing that element, the child's wishes should be respected. While law enforcement may be very eager to obtain the sexual assault evidence kit, this should not be done against the child's wishes. The provider may want to carefully explain the need for the kit or the other procedure the child is rejecting and encourage discussion of their reluctance, but ultimately the decision is the child's. In many cases the child initially rejects one or more elements of the assessment process, but later in the visit assents to it, once rapport has been built and an element of trust has been established.

Obtaining a Medical History

Separating child from adult accompanying patient and ensuring safety

If at all possible, and with the child's assent, the providers should interview the patient alone, without the accompanying parent, guardian, or friend in the room. This is especially important in cases of possible CSEC/sex trafficking as the companion may be a trafficker or someone working for the trafficker. You cannot force the person accompanying the patient to leave the room, but you can tell both child and companion that it is standard practice for the medical provider/social worker to obtain history from the child alone, and ask the companion to wait in the waiting room or another place that is well away from the child's room. Make sure that the exam room door stays closed and staff are not walking in and out. Before beginning the medical history assess the child's feelings regarding safety. ("Is it okay for you to be talking to me now?" or "Will there be any problem with so-and-so if you and I are talking alone for a bit?") In some cases the child may know that any significant time spent alone with a strange adult may lead the trafficker to believe he/she is disclosing forbidden information, which may lead the trafficker to punish the child afterward. If the child hesitates or indicates they don't feel safe consider gently questioning the youth about why the situation is unsafe and take steps to ameliorate the problem. ("Can you tell me what it is that makes it not okay to talk to me alone?" "Is there something we can do to make it all right, so you can feel comfortable talking to me?") Keep track of time and periodically ask the youth if they still feel okay talking with you.

Prepping Interpreters

Children's interpreters are highly qualified. However, in cases of suspected CSEC/trafficking the interview may be challenging so it is best to meet with the interpreter before beginning the interview and review the following:

1. Ensure interpreter does not know the patient or patient's family or come from the same town/region
2. Importance of translating child's and provider's words as closely and completely as possible. Interpreters may need to speak in the 3rd person (versus interpreting in the 1st person as is the most common practice) for younger patients to help child understand that the interpreter is supporting the provider but the questions are coming from the provider, not the interpreter
3. Potential that child will be fearful of disclosing information during interview
4. Potential challenging behaviors of child during interview (e.g., hostile, distrusting, withdrawn)
5. Importance of telling provider if interpreter identifies signs that the child is in distress (word choices, body language, for example)
6. Importance of treating child as victim, not offender
7. Importance of maintaining nonjudgmental, open, supportive attitude and not showing anger, horror, pity, etc.
8. Review glossary of street terms
9. Recommended seating of patient and interpreter varies with the age and maturity of the child. With adolescents, the interpreter may sit beside or behind the patient, interpreting toward the child's ear but not having eye contact with him/her. This keeps the eye contact and rapport with the provider and minimizes the influence of the interpreter. Younger children (under age 6 or 7 years) tend to identify with the interpreter if the latter is seated next to/behind the child, while older children might have the maturity to understand that the questions are coming from the interviewer. Interpreters may be seated next to or directly behind the provider as another way to direct the child's gaze in the direction of the provider. In this set-up, the Interpreter can look down at their lap or notepad to respectfully reduce eye contact between child and interpreter
10. If you identify that the child has an interpreter gender preference, contact Interpreting Services to see if this request can be honored

Glossary of Common Street Terms Used in Sex Trafficking and Commercial Sexual Exploitation

Slang Term	Meaning
The life, the game	Commercial sexual activities, typically involving prostitution
Pay for play (P4P)	Paid sex, term often used by buyers
Daddy, Player	Exploiter, trafficker
Family, stable	The victims under control of trafficker/exploiter; females may be referred to as 'wife-in-laws' or 'sister-in-laws'
Circuit, Track, Runway, Stroll	A given area associated with prostitution (may be streets, cities, states, regions)
Kiddie stroll	Area of prostitution involving victims younger than 16 years
Escort service	An organization that provides sexual services to buyers. This often involves advertising via the internet, appointments made via phone, and services provided by adolescent traveling to site of buyer ('out-call') or buyer coming to site of service ('in-call'); may include brothels, services at hotels, homes, other sites)
Lot lizard	Person being prostituted at a truck stop
Seasoning	The process of preparing a victim for trafficking activities; involves breaking victims' will through use of physical and sexual violence, psychological manipulation and abuse, physical and emotional deprivation, isolation, threats and intimidation.
Gorilla pimp	Exploiter who controls mainly through use of violence
Turn Out	The act of being forced into prostitution
Bottom	Manager/assistant to exploiter; usually female; supervises other victims in 'family' or 'stable'
Out of pocket	Situation when victim makes eye contact with another exploiter (strictly forbidden) or otherwise shows disrespect to her/his exploiter
Pimp circle	Punishment for violation by victim; several exploiters surround the victim and humiliate, verbally and/or physically abuse her.
Water sports, golden showers	Urinating on trafficking victim during paid sexual activity
Ho line	A communication network used by pimps between cities/states/regions; used to buy/sell victims

Protocol for Medical Exam and Evaluation

With *rare exceptions, provider needs child's assent for exam, testing, evidence kit*

The medical exam and evaluation is typically conducted by a nurse practitioner or physician from the child protection team. See the "doc-on-call" schedule for a list of providers (either "Child Advocacy Outpatient Consults" or "Child Advocacy inpatient consults".) If child is any Children's out-patient clinic or Urgent Care, call the Transfer Center and ask to talk to the physician on call for Child Protection. H/she will discuss the case and determine where the child should go for the exam.

On rare occasions, the After Hours NP for the child protection team may be unavailable to come to the ED so the attending physician will need to conduct the evaluation. The physician on call for the child protection team is always available to discuss the case, however.

1. Consult with SW and attending to identify info already obtained
2. Attempt to obtain info on Child Health Questionnaire, as feasible and as time allows (after discussing limits of confidentiality, and assuring child answering questions is optional). It is not necessary to ask all questions on survey, and questions should be tailored to child and circumstances.
3. *With child's assent*, complete general physical exam with documentation of:
    - A. General health, nutritional status
    - B. Injuries, old and recent
    - C. Tattoos, brands, gang insignia, unusual clothing or appearance
    - D. Anogenital exam with magnification and video/photo documentation
    - E. Sexual assault evidence kit (last contact <72 hours)
    - F. STI testing (of appropriate sites)
        1. GC cx throat
        2. Urine GC/Chlamydia/Trich NAAT
        3. T vag pouch/wet prep
        4. Anal cx GC/Chlamydia
        5. Serum for HIV, RPR, HBV, HCV (with pre-test HIV counseling)
        6. Other testing as indicated (ex, herpes cx)
    - G. Pregnancy testing
    - H. Drug-facilitated sexual assault urine drug screen and standard urine drug screen if indicated, and with patient assent if feasible
    - I. Other diagnostic testing as indicated (e.g., for suspected trauma or other infection)
4. Offer STI and pregnancy prophylaxis (see appendix A)
5. Consider HIV prophylaxis and discuss with patient (see appendix B)
6. Social Work to report to authorities and to Georgia Cares (see below)

Reporting to Authorities

In Georgia, healthcare providers are mandated reporters of child abuse and neglect. Commercial sexual exploitation/sex trafficking is considered a form of child abuse. Therefore, when providers have a reasonable suspicion that a child is a victim of CSEC or sex trafficking, they are mandated to contact authorities. At Children's, the social worker is the designated reporter. At least three referrals need to be made by social work:

1) Division of Family and Children's Services (DFCS): central intake number: 1-855-GA CHILD (1-855-422-4453)
2) Law enforcement (any one option):
    a. Police or Sheriff in jurisdiction where trafficking/exploitation occurred (if known)
        i. GBI: Child Exploitation and Computer Crimes Unit - 404-270-8870 (0ffice)

        ii. FBI Match Task Force - 4046799000 (Office)

3) Georgia Cares: (404) 602-0068
    a. Organization that serves as the entry point for providing a complete assessment and service plan for suspected victims. It is essential to contact this organization as soon as possible so they can begin working with DFCS and law enforcement to find safe housing after discharge from medical care and address other immediate issues, as well as begin their assessment of child's comprehensive needs.
4) For transnational victims, contact
    a. U.S. Immigration and Customs Enforcement: (1-866-872-4973). This agency can provide immediate assistance with victim support, legal advocacy and needs assessment.

When a suspected victim is greater than 18 years of age, CSEC/sex trafficking is considered a crime but does not require a mandated report to authorities. If the patient agrees, the provider may contact law enforcement (social work to make referral), but at any rate, should offer services. Adult resources include:

1) Out of Darkness: 404-719-4854 (rescue hotline)
2) Wellspring Living: 404-427-3100 (hotline)
3) Human trafficking National Hotline: 1-888-3737-888 (provides guidance to providers as well as to victims, and can help provider find services)
4) For transnational victims: U.S. Immigration and Customs Enforcement: (1-866-872-4973). This agency can provide immediate assistance with victim support, legal advocacy and needs assessment.

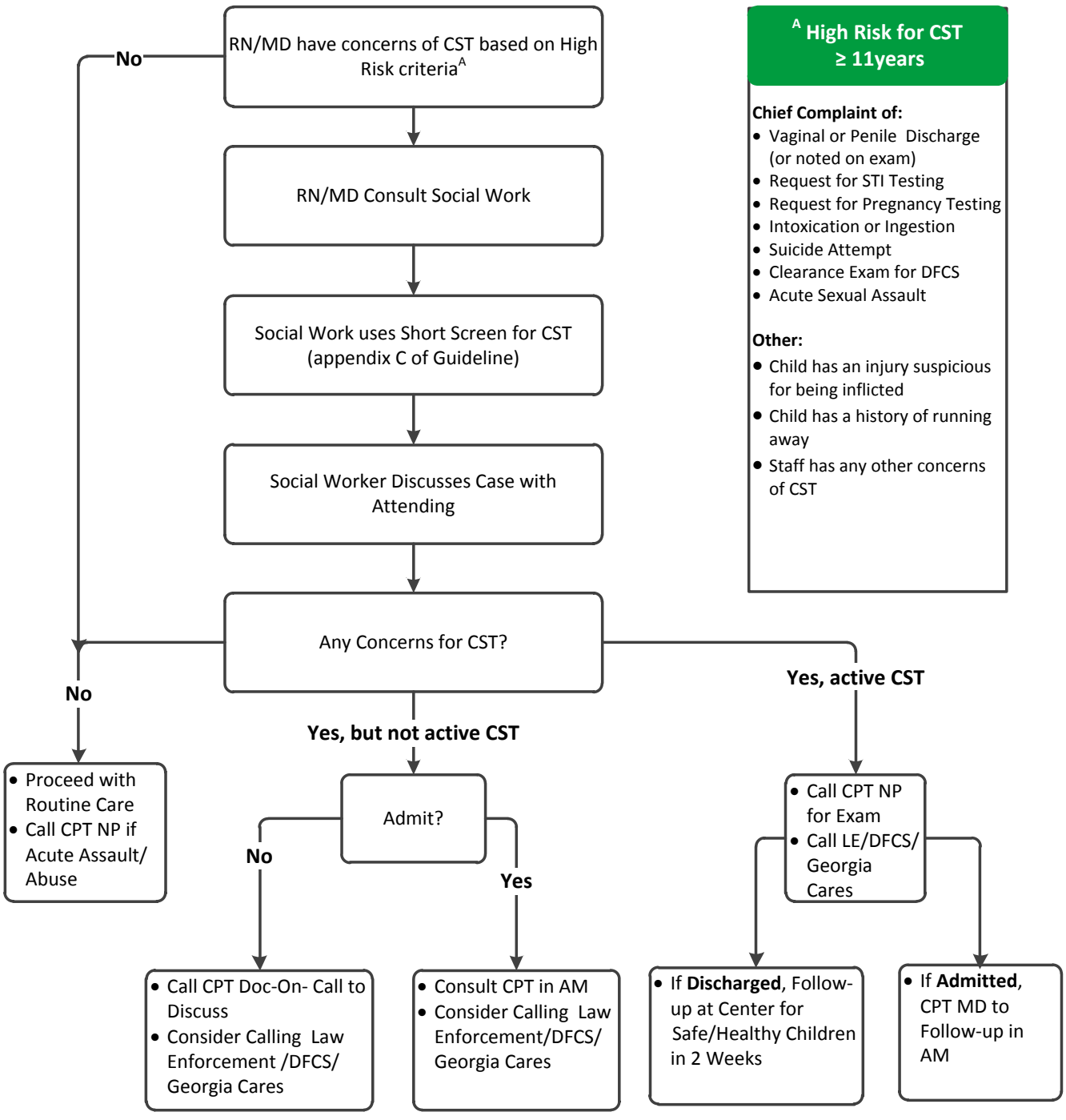
Other Referrals

As healthcare providers we need to make specific recommendations and referrals for follow up medical and behavioral health care. Some potential referrals include:

1. Psychiatric consult if there are immediate concerns of self-harm or harm to others
2. F/U at CHOA Blank Center for Safe and Healthy Children in 2 weeks
3. Trauma-focused behavioral health assessment and therapy
4. Primary care follow-up to include HPV vaccination if needed and periodic STI testing at department of public health clinic, teen clinic, PCP or other primary care site
5. OB/GYN Care
6. Family planning
7. Subspecialist if other medical issues are identified

5/3/14

Child Sex Trafficking (CST) and Commercial Sexual Exploitation Inpatient Guideline (CSEC)
Emergency Department

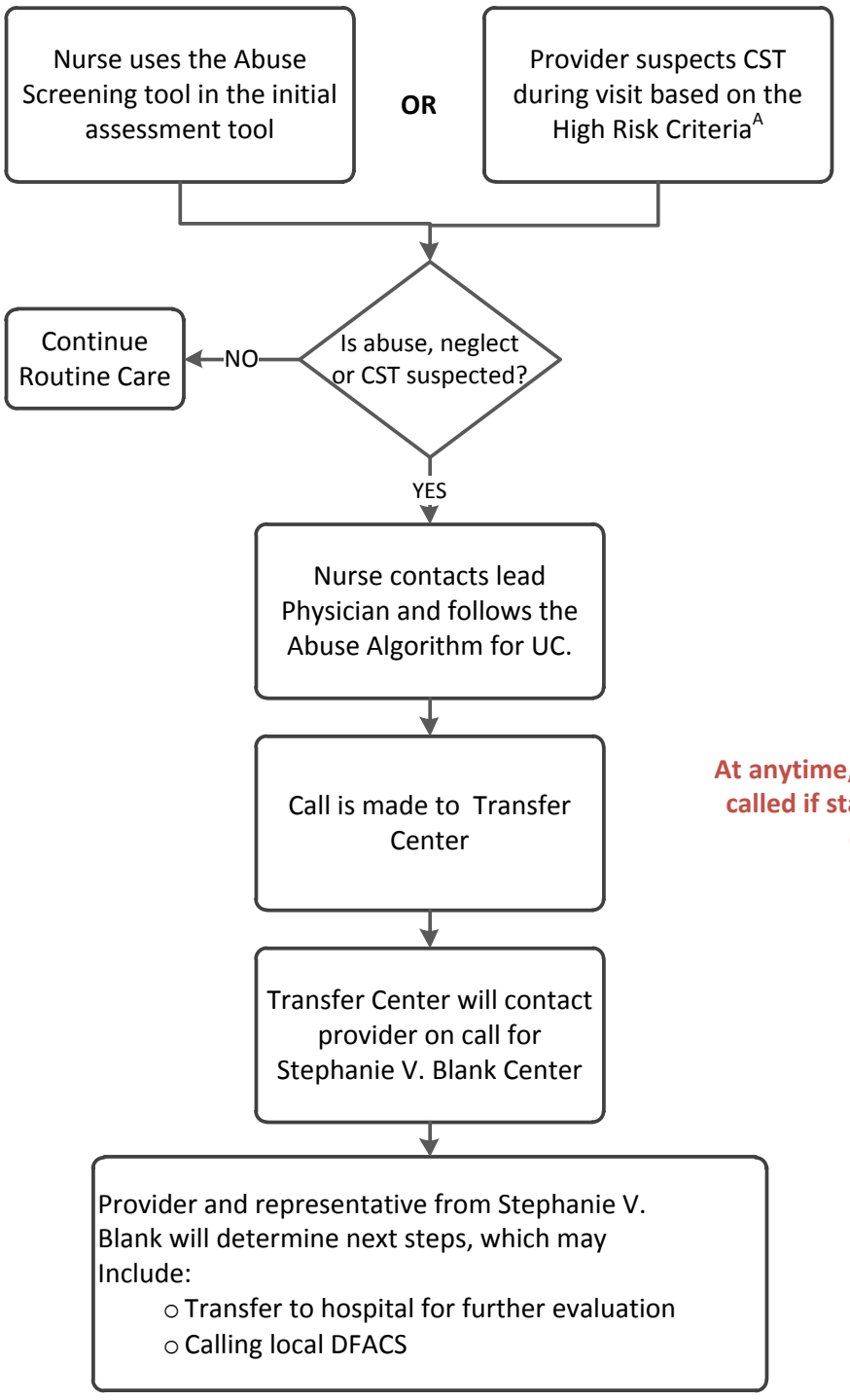


Terms:
CST – Child Sex Trafficking
CPT – Child Protection Team

5.3.14

Child Sex Trafficking (CST) and Commercial Sexual Exploitation Inpatient Guideline (CSEC)

Urgent Care & Primary Care



[A] High Risk for CST ≥ 11years

Chief Complaint of:

- Vaginal or Penile Discharge (or noted on exam)
- Request for STI Testing
- Request for Pregnancy Testing
- Intoxication or Ingestion
- Suicide Attempt
- Clearance Exam for DFCS
- Acute Sexual Assault

Other:

- Child has an injury suspicious for being inflicted
- Child has a history of running away
- Staff has any other concerns of CST

At anytime, local law enforcement may be called if staff feels there is a flight risk or dangerous situation

Terms:
CST – Child Sex Trafficking
CPT – Child Protection Team

Child Sex Trafficking (CST) and Commercial Sexual Exploitation Inpatient Guideline (CSEC)

Applied to Hospital Personnel who have Concerns of CPT and Not Addressed in the Emergency Department

Staff member(s) Develop Concerns that Child may be a CST Victim based on High Risk Criteria[A]
OR
Social Work Identifies Patient as "High Risk"
AND
Child is ≥ 11 Years Old

↓

Consult Social Work
Social Work uses Short Screen for CST
(appendix C of Guideline)

↓

If CST suspected, Consult CPT Doc-On-Call

[A] High Risk for CST ≥ 11years

Chief Complaint of:
- Vaginal or Penile Discharge (or noted on exam)
- Request for STI Testing
- Request for Pregnancy Testing
- Intoxication or Ingestion
- Suicide Attempt
- Clearance Exam for DFCS
- Acute Sexual Assault

Other:
- Child has an injury suspicious for being inflicted
- Child has a history of running away
- Staff has any other concerns of CST

Terms:
CST – Child Sex Trafficking
CPT – Child Protection Team

Appendix A: Prophylaxis for pregnancy and STI

Uncomplicated gonococcal infections of the cervix, urethra, rectum and pharynx

☐ Ceftriaxone 125 mg IM x one (≤ 45 kg)
☐ Ceftriaxone 250 mg IM x one (> 45 kg)
PLUS
☐ Azithromycin 1 gm po x one (≥ 45 kg)
☐ Azithromycin 20 mg/kg up to 1gm po x one (<45 kg)
OR
☐ Doxycycline 100 mg po BID x 7 days (≥ 45 kg and ≥ 8 years old)
OR
☐ Erythromycin base or ethylsuccinate 50 mg/kg/day po ÷ QID x 14 days
(max 500mg/dose)

If the patient is Cepahlosporin allergic:
☐ Azithromycin 2gm orally once
Plus Test of cure in a week

Uncomplicated chlamydial infections of the cervix and urethra

☐ Azithromycin 1 gm po x one (≥ 45 kg)
☐ Azithromycin 20 mg/kg up to 1gm po x one (<45 kg)
Or
☐ Doxycycline 100 mg po BID x 7 days (≥ 45 kg and ≥ 8 years old)
Or
☐ Erythromycin base or ethylsuccinate 50 mg/kg/day po ÷ QID x 14 days
(max 500mg/dose)

Trichomonas

☐ Metronidazole 15 mg/kg/day ÷ TID x 7 days (children, up to 250mg/dose)
☐ Metronidazole 2 gm po x 1 (adults and adolescents >45 kg)

Pregnancy Prevention

☐ Plan B (If pregnancy test negative) (need MD order at CHOA; policy may differ at other institutions)

Anti-Emetic

☐ Ondansetron 8 mg po x one

Treatment for Other Potential Infections

Hepatitis B HBIG 0.06 mL/kg

☐ 1st dose vaccine (if unimmunized, then complete series)
☐ 1st dose vaccine + HBIG (if unimmunized/status unknown & alleged perpetrator is HB ag+)

Bacterial Vaginosis

☐ Metronidazole 500 mg po BID x 7 days

Herpes Simplex urethritis

First clinical episode
☐ Acyclovir 400 mg po TID X 7-10 days OR
☐ Famcyclovir 250 mg po TID X 7-10 days OR
☐ Valacyclovir 1 gram po BID x 7-10 days

HPV

☐ Podofilox 0.5% Solution or Gel AAA BID x 3 days, rest x 4days (4 cycles max) OR
☐ Imiquimod 5% Cream AAA once HS, wash off after 6-10 hrs 3x/week QOD
(max 16 weeks)

Vaginal Candidiasis

☐ Fluconazole 150 mg po x one

Appendix B: HIV Post-Exposure Prophylaxis (PEP)

General Considerations for the Clinician
Several factors impact the medical recommendation for PEP and affect the assault survivor's acceptance of that recommendation, including:

- Likelihood of the assailant having HIV
- Any exposure characteristics that might increase the risk for HIV transmission
- Time elapsed after the event
- Potential benefits and risks associated with the PEP

When an assailant's HIV status is unknown, **factors** that should be considered in determining whether an **increased risk for HIV transmission** exists include:

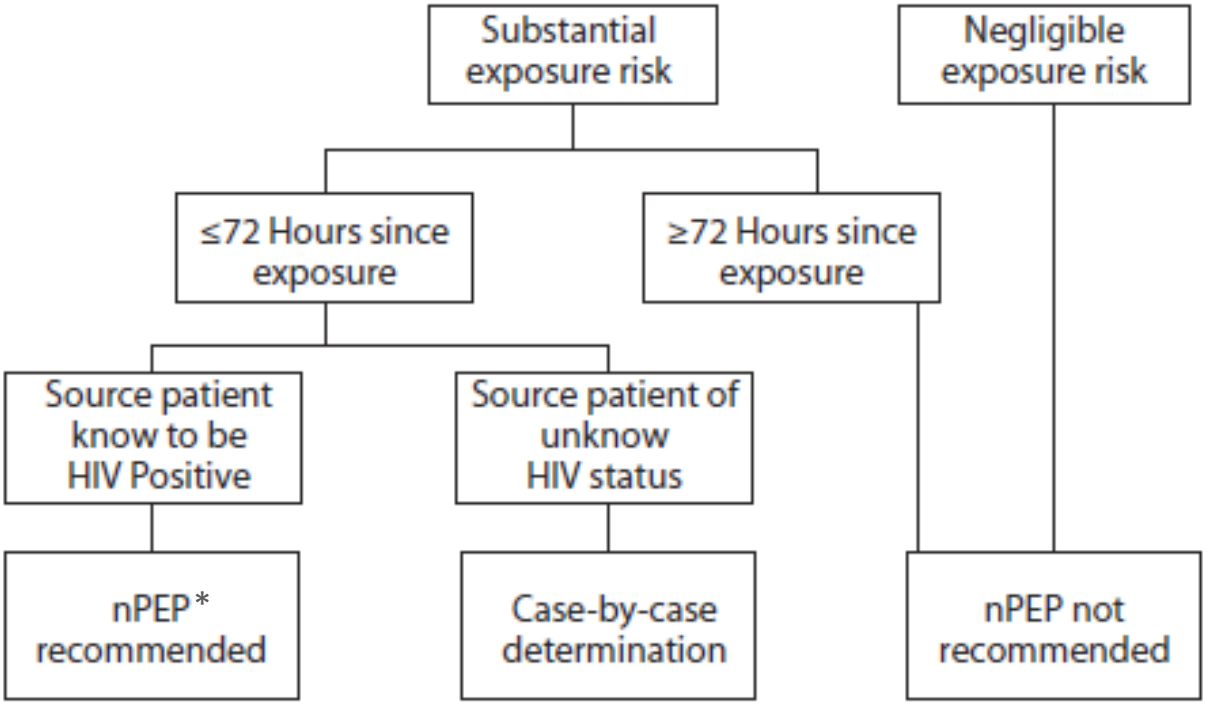
- Vaginal or anal penetration occurred
- Ejaculation occurred on mucous membranes
- Multiple assailants were involved
- Mucosal lesions are present in the assailant or survivor
- Direct contact of vagina, anus, penis, or mouth or cases when victims' broken skin or mucous membranes were in contact with semen, vaginal fluid, or blood of alleged assailant
- Human bites occur resulting in visible blood
- Any other characteristics of the assault, survivor, or assailant that might increase risk for HIV transmission

If PEP is offered, the following information should be discussed with the patient:

- Unproven benefit and known toxicities of anti-retrovirals.
  Providers should emphasize that PEP appears to be well-tolerated and often effective in both adults and children and that severe adverse effects are rare.
- Importance of close follow-up
- Benefit of adherence to recommended dosing
- Necessity of early initiation of PEP to optimize potential benefits
  (i.e., as soon as possible after and up to 72 hours after the assault)
  The sooner PEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission if HIV exposure occurred.

If advice regarding a case is desired, the clinician should call the Peds ID consult service on call for CHOA. Alternatively, they could call the UCSF PEPline at 888-448-4911 (available from 09:00 AM -02:00 AM).

ALGORITHM FOR EVALUATION AND TREATMENT OF POSSIBLE NONOCCUPATIONAL HIV EXPOSURES



Substantial Risk for HIV Exposure

Exposure of
vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, percutaneous contact

With
blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

When
the source is know to be HIV-infected

Negligible Risk for HIV Exposure

Exposure of
vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, percutaneous contact

With
urine, nasal secretions, saliva, sweat, or tears if not visible contaminated with blood

Regardless
of the known or suspected HIV status of the source

CDC. Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. MMWR 2005; 54(RR-02):1.

* nPEP refers to nonoccupational post-exposure prophylaxis

Child Sex Trafficking And Commercial Sexual Exploitation Guideline
Medications Chart

2/26/2015

HIV PEP Medications. (Need negative hCG. If hCG positive, consult Peds ID service.)

All drugs should be given for 30 days and administered within 72 hours following the assault. Tables and doses are adapted from the Panel on Antiretroviral Therapy and Medical Management of HIV-Infected Children. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection [23]

Age		Medications
Adults and Adolescents **(age 13 years and older including pregnant women) with normal renal function (creatinine clearance ≥60 ml/min)**	Preferred	Truvada (Tenofovir DF 300mg and Emtricitabine 200mg) Once Daily With Raltegravir 400 mg Twice Daily
	Alternative	Truvada (Tenofovir DF 300mg and Emtricitabine 200mg) Once Daily With Darunavir 800mg Once Daily and Ritonavir 100mg Once Daily
Children age 2-12 years	Preferred	Tenofovir DF, Emtricitabine and Raltegravir *Each dosed to Age and Weight- (Table xx)*
	Alternative	Zidovudine and Lamivudine With Raltegravir **OR** Lopinarvir/Ritonavir *Each dosed to Age and Weight- (Table xx)*
	Alternative	Tenofovir DF, Emtricitabine and Lopinavir/Ritonavir *Each dosed to Age and Weight- (Table xx)*
Children age 3-12 years	Alternative	Tenofovir DF, Emtricitabine and Darunavir/Ritonavir *Each dosed to Age and Weight- (Table xx)*
Children age at least 4 week* to <2 years	Preferred	Zidovudine Oral Solution and Lamivudine Oral Solution With Raltegravir or Lopinavir/Ritonavir Oral Solution (Kaletra®) ***Each Dosed to Age and Weight (Table 6)***
	Alternative	Zidovudine Oral Solution and Emtricitabine Oral Solution With Raltegravir or Lopinavir/Ritonavir Oral Solution (Kaletra®) ***Each Dosed to Age and Weight (Table 6)***
Children from Birth to 27 days of age	Consult a Pediatric HIV-Specialist	

<table>
<tr><th>Drug Name</th><th>Formulations</th><th>Dosing</th><th>Comments</th></tr>
<tr><td>Emtricitabine</td><td>Pediatric Oral Solution: 10 mg/mL, Capsules: 200 mg</td><td>Pediatric Dose (Aged ≥3 Months to 17 Years): Oral Solution: 6 mg/kg. Maximum adult/adolescent dose 240 mg once daily if patient is >18 years.

Capsules (for Children who Weigh >33 kg): 200 mg once daily</td><td></td></tr>
<tr><td>Lamivudine</td><td>Pediatric Oral Solution: 10 mg/mL (Epivir), Tablets: 150 mg (scored) and 300 mg (Generic).</td><td>Neonate/Infant Dose (Aged <4 Weeks) for Prevention of Transmission or Treatment: 2 mg/kg twice daily. Pediatric Dose (Aged ≥4 Weeks): 4 mg/kg (up to 150 mg) twice daily

Adolescent/Adult Dose 150 mg twice daily with body weight <50 kg and 300 mg once daily with body weight >50 kg.</td><td>
<table>
<tr><th>Weight (kg)</th><th>AM Dose</th><th>PM Dose</th><th>Total Daily Dose</th></tr>
<tr><td>14-21</td><td>1/2 tablet (75 mg)</td><td>1/2 tablet (75 mg)</td><td>150 mg</td></tr>
<tr><td>>21 to <30</td><td>½ tablet (75 mg)</td><td>1 tablet (150 mg)</td><td>225 mg</td></tr>
<tr><td>≥30 kg</td><td>1 tablet (150 mg)</td><td>1 tablet (150 mg)</td><td>300 mg</td></tr>
</table>
</td></tr>
<tr><td>Tenofovir</td><td>Pediatric Oral Powder: 40 mg per 1 g of oral powder (1 level scoop = 1 g oral powder; supplied with dosing scoop). Tablet: 150 mg, 200 mg, 250 mg, and 300 mg. Combination Tablet Truvada: with Emtricitabine 200 mg plus 300 mg Tenofovir.</td><td>Neonate/Infant Dose: Not FDA approved for use in neonates/infants aged <2 years.

Pediatric Dose (Aged ≥2 Years to <12 Years): 8 mg/kg/dose once daily</td><td>Link to Table
Oral powder should be measured only with the supplied dosing scoop: 1 level scoop =1 g powder = 40 mg Tenofovir.

Mix oral powder in 2 to 4 ounces of soft food that does not require chewing (e.g., applesauce, yogurt).

Administer immediately after mixing to avoid the bitter taste. Do not try to mix the oral powder with liquid: the powder may float on the top even after vigorous stirring.

Tenofovir can be administered without regard to food, although absorption is enhanced when administered with a high-fat meal.</td></tr>
</table>

<table>
<tr><th>Drug Name</th><th>Formulations</th><th>Dosing</th><th>Comments</th></tr>
<tr><td>Zidovudine</td><td>Capsules: 100 mg, Tablets: 300 mg, Syrup: 10 mg/mL</td><td>Oral Body Surface Area Dosing: 240 mg/m^2 body surface area every 12 hours</td><td>Weight-Based Dosing
<table><tr><th>Body Weight (kg)</th><th>Twice-Daily Dosing</th></tr><tr><td>4 kg to <9</td><td>12 mg/kg</td></tr><tr><td>9 kg to <30</td><td>9 mg/kg</td></tr><tr><td>≥30 kg</td><td>300 mg</td></tr></table></td></tr>
<tr><td>Darunavir</td><td>Tablets: 75 mg, 150 mg, 400 mg, 600 mg, 800 mg
Oral suspension: 100 mg/mL</td><td>DRV should not be used without low-dose boosting ritonavir (RTV). RTV 80 g/mL oral solution
Do not use DRV in children aged <3 years or weighing <10 kg.

Adult/Adolescent dose and > 40 kg: 800 mg (as two 400 mg tablets) once daily and Ritonavir 100 mg once daily</td><td>Link to Table</td></tr>
<tr><td>Kaletra (Lopinavir - LPV/Ritonavir -RTV)</td><td>Pediatric Oral Solution: 80 mg /20 mg LPV/RTV per mL
Tablets: 100 mg /25 mg LPV/RTV, 200 mg/50 mg LPV/RTV</td><td>Ritonavir-boosted Lopinavir oral solution should be administered with food because a high-fat meal increases absorption.
14 Days–18 years: Once-daily dosing is not recommended.
300 mg /75 mg ritonavir-boosted Lopinavir per m^2 of body surface area twice daily maximum dose 400mg/100mg twice daily.

Ritonavir-boosted Lopinavir tablets must be swallowed whole. Do not crush or split tablets.
Weight-Band Dosing for 100 mg/25 mg Ritonavir-Boosted Lopinavir Pediatric Tablets for Children/ Adolescents. Adult dosing 400 mg/100 mg twice daily.</td><td>Recommended number of 100-mg/25-mg ritona vir-boosted lopinavir tablets given twice daily<table><tr><th>Dosing target</th><th>300 mg/m2/dose given twice daily</th></tr><tr><td>15 to 20 kg</td><td><u>2</u></td></tr><tr><td>>20 to 25 kg</td><td><u>3</u></td></tr><tr><td>>25 to 30 kg</td><td><u>3</u></td></tr><tr><td>>30</td><td><u>4</u></td></tr></table></td></tr>
<tr><td>Raltegravir</td><td>Tablets: 400 mg

Chewable Tablets: 100 mg (scored) and 25 mg
For Oral Suspension: Single-use packet of 100 mg (expected fall 2014)</td><td>Oral Suspension Dosing Table for Children at least 4 weeks of age and weighing 3 kg to < 20 kg

Adolescent (Aged ≥12 Years)/Adult Dose: 400-mg film-coated tablet twice daily</td><td>Link to Table</td></tr>
</table>

Dosing Tables

Tenofovir Dosing Table:

Oral Powder Dosing Table

Body Weight kg	Oral Powder Once Daily Scoops of Powder
10 to <12	**2**
12 to <14	**2.5**
14 to <17	**3**
17 to <19	**3.5**
19 to <22	**4**
22 to <24	**4.5**
24 to <27	**5**
27 to <29	**5.5**
29 to <32	**6**
32 to <34	**6.5**
34 to <35	**7**
≥35	**7.5**

Tablet Dosing Table

Body Weight (kg)	Tablet Once Daily (mg)
17 to <22	150
22 to <28	200
28 to <35	250
≥35	300

Darunavir Dosing Table:

Body Weight (kg)	Twice-Daily Dosing with food
10 to <11	DRV 200 mg (2.0 mL) plus RTV 32 mg (0.4 mL)
11 to <12	DRV 220 mg (2.2 mL) plus RTV 32 mg (0.4 mL)
12 to <13	DRV 240 mg (2.4 mL) plus RTV 40 mg (0.5 mL)
13 to <14	DRV 260 mg (2.6 mL) plus RTV 40 mg (0.5 mL)
14 to <15	DRV 280 mg (2.8 mL) plus RTV 48 mg (0.6 mL)
15 to <30	DRV 375 mg (combination of tablets or 3.8 mL) plus RTV 48 mg (0.6 mL)
30 to <40	DRV 450 mg (combination of tablets or 4.6 mL) plus RTV 100 mg (tablet or 1.25 mL)

Raltegravir Dosing Table:

Body Weight (kg)	Volume (Dose) of Suspension to be Administered
3 to <4	1 mL (20 mg) twice daily
4 to <6	1.5 mL (30 mg) twice daily
6 to <8	2 mL (40 mg) twice daily
8 to <11	3 mL (60 mg) twice daily
11 to <14	4 mL (80 mg) twice daily
14 to <20	5 mL (100 mg) twice daily

Chewable Tablet Dosing Table Dosinga of chewable tablets in children aged 2 to<12 years:

Body Weight (kg)	Dose
11 to <14	75 mg twice daily
14 to <20	100 mg twice daily
20 to <28	150 mg twice daily
28 to <40	200 mg twice daily
≥40	300 mg twice daily

Provider should contact Social Work if the patient/family requires medication assistance

MONITORING FOR ACUTE SEXUAL ASSAULT/CSEC PATIENTS

	Medical Exam	HCG	Hep B	Hep C	HIV	HSV	RPR	CBC	CMP	GC	Chlamydia	Trich
Baseline	X	X	X	X[3]	X	X[4]	X	X[5]	X[5]	X	X	X
1-2 Weeks	X	X						X[6]	X[6]	X[7]	X[7]	X[7]
4-6 Weeks	X[6]	X	X[1,2]	X[3]	X		X	X[6]	X[6]			
3 Months			X[2]	X[3]	X		X					
6 Months			X[2]	X[3]	X		X					

If Hep B surf ab negative → give 3 doses of vaccine

[1] If Hep B surf ab indeterminate

[2] If Hep B surf ag negative and high risk

[3] If high risk

[4] If clinically indicated

[5] If starting PEP

[6] If taking PEP

[7] If symptoms or no prophylaxis taken

Appendix C: Short Screen for Child Sex Trafficking (CST)

Prior to beginning the survey, build rapport with the patient. Indicate that you routinely ask these questions of adolescents so that you can find out whether or not they may need help, and if so, how you might be able to help them. Emphasize that the *child does not have to answer the questions* if he/she doesn't want to. Also remind them of *limits of confidentiality* (cannot guarantee that caregivers or others won't eventually get access to the chart and see information; you are obliged to tell authorities if child reveals possible abuse or thoughts/actions related to hurting themselves, or others). Consider having a chaperone in the room, although this should be a shared decision between provider and child.

For each question with a "Yes" answer, follow up with questions about details.

1. Have you ever broken any bones, been knocked unconscious or had any injuries that required stitches? (If yes, "Can you tell me about those times?"—determine if abuse, peer violence, dating violence, or CSEC)

2. Some kids have a hard time living at home and feel that they need to run away. Have you ever run away from home? (If yes, "have you stayed out all night, or longer?" "How many times have you run away?" "How long is the longest time you've been gone from home?" When you were gone, how did you get money for food? Where did you stay? etc.)

3. Kids often use drugs or drink alcohol these days, and different kids use different drugs. Do you use drugs or drink alcohol? (and follow up with specifics--frequency of use, type of drug, reason for using drugs/alcohol--recreation, self-medication)

4. Sometimes kids have run-ins with police. Maybe for running away, for breaking curfew, for shoplifting. There can be lots of different reasons. Have you ever had any problems with the police? Do you feel comfortable telling me about them?

5. Kids starting getting involved with sex at different ages. They start having oral sex, or vaginal sex or anal sex at different times. Have you been sexually active in the past, and by that I mean having oral, vaginal or anal sex?" If child answers, Yes, then ask, "Have you had more than 5 sexual partners?"

6. Have you ever had any sexually transmitted diseases? Yes/No.

If child has answered YES to 2 or more questions, then ask the following questions:

1) Has a boyfriend, a girlfriend or anyone else ever asked you, or forced you to have sex with them or another person?

2) Sometimes kids are in a position where they really need money, or they need drugs, or they need food or a place to stay. They feel they have no option except to exchange sex or some sort of sex activity for the money or the other thing they need. Have you ever had to exchange sex for money, food, shelter or something else you wanted?

If "YES" to either question, ask for details to determine if child is potential victim of CSEC.

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Submitted by:

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