TITLE PAGE

The association between sexually transmitted infections and child sexual exploitation in under 16

year-olds attending sexual health clinics in England: Findings from a case-control study

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ABSTRACT

Objectives: Child sexual exploitation (CSE) can be difficult to identify, as there may be few reliable indicators. Although they may be used in decision-making, there is no evidence that sexually transmitted infections (STIs) are predictors of CSE. We investigated the relationship between STI presentation at sexual health clinics (SHCs) and CSE.

Methods: SHCs with 18 or more STI diagnoses in 13-15 year-olds in 2012 were identified using the GUMCAD STI surveillance System. Cases with confirmed bacterial or protozoal STIs were matched by age, gender and clinic with non-STI controls. Lead clinicians were asked to complete an online questionnaire on CSE-related risk factors of cases and controls irrespective of STI presence. Associations between STI outcome and CSE-related risk factors were analysed using conditional logistic regression.

Results: Data were provided on 466 13-15 year-olds; 414 (89%) were female, 340 (80%) were aged 15, 108 (23%) 14 and 18 (3.9%) 13 years. In matched univariate analysis, an STI diagnosis was significantly associated with 'highly-likely/confirmed' CSE (OR 3.87, p=0.017) and safeguarding concerns (OR 1.94, p=0.022). Evidence of an association between STI diagnosis and 'highly-likely/confirmed' CSE persisted after adjustment for partner numbers and prior clinic attendance (OR 3.85, p=0.053).

Conclusion: Presentation with bacterial or protozoal STIs by 13-15 year-olds at SHCs may be considered a potential marker for CSE. It would be prudent to consider CSE, in depth assessment and potential referral for any under 16 year-old presenting with a bacterial or protozoal STI.

INTRODUCTION

Many young people enjoy consensual sexual relationships. Unfortunately, many children are the victims of sexual abuse (CSA) or sexual exploitation (CSE). CSE is a form of CSA that occurs "…where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity…."[1]. An estimated 5-16% of UK children under 16 years may experience CSA but a third may not disclose it.[2] CSE can be even harder to identify: 16,500 children in England were estimated to be at risk of CSE in 2010, but far fewer cases were confirmed.[3]

Sexual health clinics (SHCs) can be the first access point for vulnerable young people and may provide a safe environment for CSE disclosure. 'Spotting the Signs[4]' is a standardised risk assessment tool to support clinicians in SHCs in the UK with CSE identification. The tool comprises a national proforma that covers the child's overall well-being, schooling, home circumstances and sexual life.

Sexually transmitted infections (STIs) have been suggested as markers of CSE [3 5] but currently there is no evidence for this. Nonetheless, STIs may be used in clinical practice to aid CSE decisions and influence safeguarding referrals. In addition to risk assessment, SHCs routinely perform testing for STIs. We investigated associations between STIs and CSE risk factors in England in order to refine clinic-based risk algorithms and improve CSE detection and management.

METHODS

Data source

All SHCs in England routinely report pseudonymised, patient-level data on attendances, STI testing and laboratory-confirmed STI diagnoses to the national STI Surveillance System, GUMCAD, managed by Public Health England[6]. Pseudonymised data include patient ID numbers which can be linked to

hospital records, but no information on patient name, date of birth or address. SHCs reporting attendances by ≥18 13-15 year-olds with a bacterial/protozoal STI diagnosis in 2012 in GUMCAD were selected for inclusion. The 18 patient cut-off was pragmatic enabling a sufficient sample size from a logistically manageable number of clinics. Children younger than 13 years were excluded as in law they cannot consent to sexual activity.

Defining cases and controls

Cases were defined as children aged between 13 and 15 years with a confirmed bacterial or protozoal STI diagnosis (*Chlamydia trachomatis* [CT], *Neisseria gonorrhoeae* [Ng] and *Trichomonas vaginalis* [Tv]). Viral STIs were excluded as these may not reflect acute infection. Cases were randomly matched to controls in GUMCAD at a ratio of 1:1 on age, gender, year (2012) and clinic using the 'ccmatch' command in STATA. Children with STIs other than CT, Ng or Tv were excluded from the controls.

Survey development and data collection

Selected SHCs were contacted by email and telephone. Those which agreed to participate were sent a list of cases and controls including patient ID numbers and first attendance dates via secure email. SHC staff were not told which patients were cases and controls.

An online data collection survey based on the *"Spotting the Signs"* proforma[4] was created using SelectSurvey, which allows secure data transfer (Appendix 1). The survey was piloted in April 2015 by two clinicians at different clinics to ensure relevance, accuracy and usability. Minor modifications were made following feedback to improve completion.

Between May to September 2015, experienced doctors (usually a consultant) were asked to review health records pertaining to the specified date of attendance of cases and controls and complete the online survey. CSE likelihood in each patient was stratified into possible/highly likely/definite using pre-determined definitions adapted from the National Working Group for Sexually Exploited Children and Young People (https://www.nwgnetwork.org/#), and the Pan-London Child Sexual Exploitation Operating Protocol (Appendix 2).

The study protocol emphasised that STI presence or absence had to be excluded from the decision-making process on CSE likelihood. Any patient attendance for STI results and treatment would in most cases have been at a subsequent date and be held separately in the patient's record (either paper or electronic). The study coordinator stressed to clinicians the importance of not looking up STI tests results to maintain study integrity. Where the child had attended services more than once during 2012, data on the first attendance were included.

Analysis

Associations between STI outcome and demographic, behavioural and CSE-related risk factors were analysed using univariate and multivariable conditional logistic regression in STATA v13. In multivariable analysis, the association between STI and CSE was adjusted for risk factors significant in univariate analyses at $p<0.05$, except where these were considered stages in CSE diagnosis. Variables with >25% missing values were excluded.

Ethical considerations

The study was reviewed by PHE Research and Development and confirmed to be a service evaluation of the standard of care for assessing CSE, involving an intervention currently in use, without treatment, samples or additional investigations.

RESULTS

There are 209 sexual health clinics in England and 44 (22%) clinics were identified as having ≥18 13-15 year olds with a bacterial or protozoan STI diagnosed during 2012. 18/44 (41%) agreed to participate and were recruited. Non-participation was due to limited staff availability, non-response and/or record accessibility. Participating clinics included large urban teaching hospitals, district general hospital settings and community clinics.

Participating clinics provided data on 466 13-15 year-olds, comprising 233 cases with an STI and 233 age-, sex- and clinic-matched controls (Table). Of the 466 children, 414 (89%) were female; 18 (4%) were aged 13, 108 (23%) 14, and 340 (80%) 15 years. Of the 233 cases, 191 (82%) had CT, 37 (16%) Ng and 5 (2.1%) Tv. Among STI cases, 37 (16%) had suspected CSE, of which 16 (7%) was highly likely or confirmed, compared to 23 (10%) suspected CSE, of which 5 (2%) was highly likely or confirmed, in non-STI controls.

Matched analysis (Table)

In unadjusted matched analyses, children diagnosed with an STI were more likely to have prior attendance at the same clinic within the past year (OR 4.46, 95% confidence intervals [CI] 2.45-8.14, p<0.001) and report ≥1 sexual partners in the past 3 months (OR 3.00, CI 1.35-6.67, p=0.007 for 1 partner; OR 10.9, CI 4.18-28.4, p<0.001 for > 1 partner) compared to non-STI controls. Children with an STI were also more likely to have other service involvement (OR 1.72, CI 1.05-2.82, p=0.03), reported vulnerabilities (OR 1.63, CI 1.06-2.52, p=0.026), safeguarding concerns (OR 1.94, CI 1.01 to 3.43, p=0.02), and to be highly likely or confirmed CSE cases (OR 3.87, CI 1.28-11.7, p=0.017) and compared to non-STI controls. After adjustment for partner numbers and prior clinic attendance, there remained some evidence of an association between STI diagnosis and highly likely/confirmed CSE (OR 3.85, CI 0.98-15.1, p=0.053). ('Other service involvement', 'vulnerability' and 'safeguarding concerns' were excluded from the adjusted analysis as considered stages in CSE diagnosis).

DISCUSSION

Key findings

In our study, 7% of 13-15 year-old children attending SHCs in England with a bacterial or protozoal STI were highly likely or confirmed to have experienced CSE, and their odds of CSE were almost four times higher than in non-STI controls.

Strengths and limitations

This is the first study to investigate and show evidence of an association between the presence of STIs and CSE. Our study supports recommendations that STIs are markers of CSE, and helps validate clinical decisions on CSE and safeguarding referrals using an STI diagnosis.

Our study has several limitations. We selected an STI diagnosis as the analysis outcome as it was not possible to identify CSE cases from the national surveillance system. Recent implementation of CSE codes will enable future studies using reported CSE as the study outcome. Furthermore, although we stressed to clinicians the need to discount STI diagnosis when assessing for CSE and to avoid accessing case notes for test results, we could not stop a clinician from reviewing the patient's entire record and identifying cases, and indeed they may have done this inadvertently. If this occurred, it is possible that knowledge of the presence of an STI influenced their decision-making, leading to over-estimation of the association between CSE and STIs.

Findings in context

Our study makes an important contribution in a field with weak scientific evidence. A previous UK and Irish study showed that in children under thirteen years presenting with a bacterial or protozoal STI, CSA was highly likely in most cases.[7 8] In adolescents, however, sexual activity may be consensual, potentially limiting the value of STI diagnosis in CSE investigations.[9] A US study has

shown an association between confirmed or self-reported STI in adolescent women and previous physical neglect and sexual abuse (respectively) in childhood.[10] In contrast, we show an association between STI diagnosis and **concurrent** CSE, which could be used to improve CSE detection.

Implications for practice

The association between STI diagnosis and CSE has important implications for clinical practice. It would be prudent to consider CSE, in depth assessment and potential referral for any under 16 year-old diagnosed with a bacterial or protozoal STI. Our findings should be used to shape larger, in-depth studies to further strengthen the evidence base on the association between STIs and CSE in SHCs, other settings and including viral STIs.

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Key messages

- There are few reliable indicators of child sexual exploitation (CSE)
- Among 13-15 years old clinic-attendees, we found evidence of an association between the presence of bacterial or protozoal STIs and CSE

- It is important to consider CSE, in depth assessment and potential referral for any under 16 year-old diagnosed with a bacterial or protozoal STI

Author contributions

CW, GH and KR conceived the study and all authors contributed to study design. CW led the study, developed the questionnaire and coordinated data collection. HM identified eligible patients and matched controls in the GUMCAD surveillance system and preformed statistical analyses. All authors were involved in interpretation and presentation of results. CW drafted the manuscript with critical input from GH, HM and KR.

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Table: Univariate and multivariable analysis of socio-demographic, behavioural and CSE-related factors associated with an STI diagnosis among 13-15 year olds relative to age, gender and clinic-matched controls. OR=Odds ratio; CI=Confidence Interval.

Risk factor	No STI		STI		Unadjusted OR (95% CI)*	P value	Adjusted OR (95%CI)**	Adjusted p value
	n	(%)	n	(%)				
Ethnic group	**207**		**211**					
White	141	(68.1)	138	(65.4)	1			
Asian	7	(3.4)	10	(4.7)	1.79 (0.56-5.72)	0.325	-	-
Black	36	(17.4)	39	(18.5)	1.32 (0.64-2.69)	0.451		
Mixed/other	23	(11.1)	24	(11.4)	1.19 (0.55-2.57)	0.664		
Word Region of birth	**212**		**226**					
UK	194	(91.5)	209	(92.5)	1		-	-
Non-UK	18	(8.5)	17	(7.5)	0.78 (0.39-1.56)	0.481		
Deprivation Quintile	**220**		**219**					
1 Most deprived	109	(49.5)	107	(48.9)	1			
2	48	(21.8)	53	(24.2)	1.11 (0.66-1.85)	0.693		
3	35	(15.9)	27	(12.3)	0.77 (0.40-1.49)	0.439	-	-
4	17	(7.7)	19	(8.7)	1.16 (0.53-2.50)	0.714		
5 Least deprived	11	(5.0)	13	(5.9)	1.18 (0.48-2.92)	0.717		
Intellectual understanding	**221**		**231**					
No	6	(2.7)	6	(2.6)	1		-	-
Yes	215	(97.3)	225	(97.4)	1.25 (0.34-4.65)	0.739		
Attended clinic in past year	**233**		**233**					
No	213	(91.4)	168	(72.1)	1		1	
Yes	20	(8.6)	65	(27.9)	4.46 (2.45-8.14)	**<0.001**	6.17 (2.99-12.7)	**<0.001**
Drink alcohol	**204**		**196**				-	-
No	133	(65.2)	117	(59.7)	1			

Yes	71	(34.8)	79	(40.3)	1.33 (0.85-2.09)	0.212	
Drug use	**204**		**197**				
No	182	(89.2)	168	(85.3)	1	-	-
Yes	22	(10.8)	29	(14.7)	1.35 (0.72-2.53)	0.345	
Home circumstances of concern	**200**		**204**				
No	177	(88.5)	174	(85.3)	1	-	-
Yes	23	(11.5)	30	(14.7)	1.33 (0.68-2.60)	0.4	
Other services involved	**207**		**212**				
No	154	(74.4)	142	(67.0)	1	-	-
Yes	53	(25.6)	70	(33.0)	1.72 (1.05-2.82)	**0.031**	
Looked after child	**216**		**219**				
No	205	(94.9)	201	(91.8)	1	-	-
Yes	11	(5.1)	18	(8.2)	2.29 (0.94-5.56)	0.068	
Mental health issues	**194**		**201**				
No	170	(87.6)	174	(86.6)	1	-	-
Yes	24	(12.4)	27	(13.4)	1.13 (0.57-2.21)	0.732	
History of self-harm	**175**		**179**				
No	161	(92.0)	158	(88.3)	1	-	-
Yes	14	(8.0)	21	(11.7)	2.14 (0.87-5.26)	0.096	
Current self-harm	**176**		**183**				
No	169	(96.0)	174	(95.1)	1	-	-
Yes	7	(4.0)	9	(4.9)	2.0 (0.50-7.99)	0.327	
Sexual contact currently	**227**		**232**				
No	61	(26.9)	56	(24.1)	1	-	-
Yes	166	(73.1)	176	(75.9)	1.18 (0.77-1.81)	0.448	
Parental awareness of sexual activity	**189**		**211**			-	-
No	72	(38.1)	76	(36.0)	1		

Yes	117	(61.9)	135	(64.0)	1.08 (0.69-1.70)	0.729		
Number of partners in last 3 months	**220**		**230**					
None	27	(12.3)	9	(3.9)	1		1	
1	162	(73.6)	142	(61.7)	3.00 (1.35-6.67)	**0.007**	3.84(1.57-9.40)	**0.003**
>1	31	(14.1)	79	(34.3)	10.9 (4.18-28.4)	**<0.001**	15.1(5.05-44.6)	**<0.001**
Current involuntary sex	**211**		**214**					
No	204	(96.7)	205	(95.8)	1		-	-
Yes	7	(3.3)	9	(4.2)	1.14 (0.41-3.15)	0.796		
Previous involuntary sex	**210**		**209**					
No	189	(90.0)	187	(89.5)	1		-	-
Yes	21	(10.0)	22	(10.5)	0.938 (0.464-1.90)	0.857		
History of sexual abuse	**218**		**216**					
No	207	(95.0)	197	(91.2)	1		-	-
Yes	11	(5.0)	19	(8.8)	2.33 (0.90-6.07	0.082		
Power imbalance	**199**		**207**					
No	189	(95.0)	185	(89.4)	1		-	-
Yes	10	(5.0)	22	(10.6)	2.00 (0.90-4.45)	0.09		
Vulnerability	**232**		**232**					
No	178	(76.7)	157	(67.7)	1		-	-
Yes	54	(23.3)	75	(32.3)	1.63 (1.06-2.52)	**0.026**		
Safeguarding concerns	**233**		**233**					
No	206	(88.4)	189	(81.1)	1		-	-
Yes	27	(11.6)	44	(18.9)	1.94 (1.10-3.43)	**0.022**		
CSE stratification	**233**		**233**					
No	210	(90.1)	196	(84.1)	1		1	
Possible	18	(7.7)	21	(9.0)	1.32 (0.64-2.70)	0.451	0.97 (0.37-2.52)	0.954
Highly Likely/Confirmed	5	(2.1)	16	(6.9)	3.87 (1.28-11.7)	**0.017**	3.85 (0.98-15.1)	**0.053**

*OR: Odds Ratio adjusted for age, sex, year and clinic location by matching.

**Adjusted OR: Additional adjustment for number of partners and prior clinic attendance, which were significant in univariate analyses at p<0.05. 'Other service involvement', 'vulnerability' and 'safeguarding concerns' were also significant at p<0.05 but were excluded as considered stages in CSE diagnosis, the primary variable of interest.
Total numbers vary for each variable due to missing data: survey questions that were not asked (due to routing) or answered.

Appendix 1. CSE risk factor data collection tool.

The following questions are based on the BASHH young person's sexual health proforma, which is recommended to be routinely used in clinics.

QUESTIONS (all mandatory)		
ID Number: ………………………………………… Clinic name: ……………… (Drop down box)		
Age		
Parental awareness of sexual activity	No	Yes
History of involuntary sexual activity		
Current	Yes	No
Previous	Yes	No
More than 1 partner currently	Yes	No
Partners ages (specify)		
Is the partner in a position of trust	Yes	No
Alcohol use?	Yes	No
Drug abuse?	Yes	No
Is patient Pre-puberty	Yes	No
Does the patient have intellectual understanding	No	Yes
Other young people/children at risk at home or known about	Yes	No
The following are questions about vulnerability		
Involvement of other services	Yes	No
Details – who?		
Are home circumstances of concern (e.g. in care/looked after)	Yes	No
Does patient miss school regularly	Yes	No

Any evidence of partner aggression / coercion / bribery / grooming	Yes	No
Any Mental health issues	Yes	No
The following are questions about any safeguarding action taken		
Need to disclose to other agencies	Yes	No
Reasons		
Consent to disclose from patient	Yes	No
Discussed with/seen by senior doctor	Yes	No
Action taken		
Referred to Health Adviser	Yes	No
Follow up	Yes	No
Name of Doctor/Nurse/HA		
Date:		

The following questions may be data that the clinic is not routinely asking but may be relevant to CSE. These are based on the Spotting the Signs proforma, which has been recommended by BASHH. Please complete as best as you are able.

Questions about Education		
Do they attend school regularly	Yes	No
Do they enjoy school	Yes	No
Is there anyone at school to talk to	Yes	No
Questions about Family relationships		
Who do they live with		
How are things at home		
Anyone to talk to about sex/relationships	Yes	No
Are they a Young carer	Yes	No
Are they a Looked after child	Yes	No

Are they Homeless	Yes	No
Are they a Runaway	Yes	No
History of Family bereavement	Yes	No
Any Learning or physical disability	Yes	No
Question about Friendships		
Do they have Friends their own age to talk to	Yes	No
Do friends know the sexual partner	Yes	No
Do friends like the sexual partner	Yes	No
Questions about current Relationship		
Are they having sexual contact currently	Yes	No
If Yes are they happy with this person	Yes	No
Where did they meet them		
Where do they spend time together		
Where do they have sex		
If No when was last time had sexual contact		
Number of contacts last 3 months		
Number of contacts last 12 months		
Questions about Consent		
Ever scared or uncomfortable by partner	Yes	No
Do they feel they can say no to sex	Yes	No
Are others present during sex	Yes	No
Questions about Sexual health		
Can they discuss contraception with partner	Yes	No
Do they use drink or drugs before sex	Yes	No
Any history of Depression/Low mood	Yes	No
Any Self-harm	Yes	No
Have they Sent/received sexual messages	Yes	No

Does anyone have sexual pictures of patient	Yes	No

Please complete the following questions documenting the decision made at the time about safeguarding concerns and CSE suspicions.

PROFFESSIONAL ANALYSIS at the time		
Evidence of sexual abuse	Yes	No
Evidence of power imbalance	Yes	No
Other vulnerabilities		
Safeguarding concerns raised	Yes	No
Was CSE suspected **at the time**	Yes	No
If Yes how likely according to local protocol	Possible	Highly likely	Definite/confirmed
According to Pan London protocol definition	Category 1	Category 2	Category 3
Who was it discussed with		
What action taken		

Please complete the following questions documenting your current opinion of whether CSE was suspected excluding any STI diagnosis. Would your decision be different if you ignored presence/absence of an STI?

PROFFESSIONAL ANALYSIS		
Would CSE be suspected if you excluded the presence of an STI	Yes	No
If Yes how likely according to local protocol	Possible	Highly likely	Definite/confirmed
Pan London protocol definition	Category 1	Category 2	Category 3

Appendix 2. CSE definitions, stratification and Pan-London Protocol definitions (https://www.scie-socialcareonline.org.uk/pan-london-child-sexual-exploitation-operating-protocol/r/a11G0000003CYejIAG).

Definition of CSE

The sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/or others performing on them, sexual activities.

Child sexual exploitation can occur through use of technology without the child's immediate recognition, for example the persuasion to post sexual images on the internet/mobile phones with no immediate payment or gain. In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability

Definitions of level of CSE:

CSE Stratification	Definition
CSE not likely	Sexual behaviour is age appropriate, consensual and no evidence of coercion
Possible CSE	Indicators that suggest CSE may be occurring through presence of some indicators for concern
Highly Likely CSE	Health Practitioner/social care/police suspect CSE is actually occurring but no confirmation as below
Definite/Confirmed CSE	Confirmed by court/social care/police/disclosure by young person/confession by perpetrator(s)

Pan London Protocol definitions	Definition
Category 0	No risk, no CSE
Category 1	A vulnerable child or young person, where there are concerns they are being targeted and groomed and where any of the CSE warning signs have been identified. However, at this stage there is no evidence of any offences.
Category 2	Evidence a child or young person is being targeted for opportunistic abuse through the exchange of sex for drugs, perceived affection, sense of belonging, accommodation (overnight stays), money and goods etc. The likelihood of coercions and control is significant.
Category 3	A child or young person, whose sexual exploitation is habitual, often self-denied and where coercion/ control is implicit.