



AMERICAN ACADEMY OF PEDIATRICS

Task Force on Pediatrics AIDS

Infants and Children With Acquired Immunodeficiency Syndrome: Placement in Adoption and Foster Care

The transmission of human immunodeficiency virus (HIV) from infected mothers to their infants has been well established. The majority of infants so infected are born to women who have acquired HIV through IV drug use or through sexual contact with IV drug-using partners. Some of these mothers are unable to care for their infants. In addition, many infected mothers become seriously ill or die, leaving children who must be cared for by others. Thus, many infants and children who are infected or are at high risk for infection may require placement in an adoptive or foster care setting. The HIV-infected infant or child places a serious burden on any family. This burden, when anticipated, may make adoption and foster care placement exceedingly difficult. However, such family-based care is clearly in the best interest of the child.

CARE FOR THE CHILD WITH ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

If an infant or child is known to be infected with HIV or is already ill with AIDS, what are some of the implications for the care givers, including adopting or foster care families?

First, the family must bear the physical and emotional burden of caring for a child who will require ongoing medical treatment, will suffer from intermittent bouts of increasingly severe illness, and, in most cases, will ultimately die. A majority of these children can be expected to have developmental delay and many may also show behavioral

regression, resulting in increased care-giving demands.

A second issue is the fear of spread of the viral infection to family members, friends, and classmates. The evidence to date indicates that this type of spread of HIV infection is virtually nonexistent. In a number of studies involving more than 17,000 family members in contact with AIDS patients, only one documented case of casual, nonsexual household transmission has occurred. In this case, a 4-year-old boy, who lived in the same household as his younger brother who had become infected by transfusion at age 18 months, became infected. A mechanism of transmission has not been established in this case.¹ The types of family contact that have not resulted in the spread of HIV infection include sharing of eating utensils, bathroom facilities, and toothbrushes; and hugging, kissing, and other types of nonsexual physical affection. However, it is theoretically possible that blood from an infected child coming in contact with broken skin surface or mucous membranes of a noninfected person could result in transmission of HIV infection. There is no evidence that transmission has occurred through contact with body fluids other than blood, eg, saliva, urine, or feces. Most experts consider transmission by contact with these fluids to be highly unlikely¹; therefore, both infected and noninfected children may safely be placed in the same foster care or adoptive home.

A third issue, with powerful emotional implications, is the social stigma associated with AIDS. The public's fear of contagion plus the association of AIDS with homosexuality, promiscuity, and drug abuse have created the social stigma that extends to the child with AIDS. The child who is known to harbor the virus or who is ill with the disease may expect to experience ridicule, avoidance by others in the community, and restriction from many non-

The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.

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mal childhood activities. Many parents, therefore, choose to keep their child's condition a secret, even from their child, who, they fear, may divulge the information.

RECOMMENDATIONS

Infected Infant or Child

All infants or children who are identified as HIV infected or in whom AIDS has been diagnosed should receive special support services regardless of who the legal guardian is. If such children are being considered for adoption or foster care placement, the adoptive or foster care family should be accurately informed of the child's health status prior to placement and these additional support services should be provided.

Education and Counseling. Families should be fully informed of the nature of medical treatments that will be required and the child's probable medical course. They should receive up-to-date information regarding immunizations, management of potential exposure to childhood infections, and the pros and cons of current therapies.

The family should also receive extensive education regarding the risks of transmission of the virus from the child to others. Family members should be reassured that HIV infection is not spread through casual contact and thus there is virtually no risk of transmission. The families should be given specific guidelines for the procedures to be used when caring for the child. Lacerations or other bleeding lesions should be managed in a manner that prevents contact of the care giver's skin or mucous membranes with blood. In most circumstances, the proper use of bandages (or other cloth materials) will be sufficient. Wearing latex gloves is also a useful means for preventing contact. The care giver's hands should be washed promptly after caring for bloody lesions, and spilled blood should be cleaned with a bleach solution (household bleach at a dilution of 1:10). As in the care of any child, hand washing should promptly follow the handling of body fluids such as urine, stool, vomitus, and oral and nasal secretions. In child care settings, general disinfection of body fluids other than blood should be accomplished with a weak solution of bleach (60 mL [$\frac{1}{4}$ cup, 2 oz] of bleach to 3.8 L [1 gal] of water).² This mixture constitutes a 1:64 dilution of 5.25% sodium hypochlorite. These precautions are aimed at preventing the spread of viral and bacterial infections and are not specifically required to prevent the transmission of AIDS. Although biting has not been shown to result in HIV transmission, if the infected child bites, appropriate behavior management aimed at ending this behav-

ior, including the provision of closer supervision, should be taught to the parents. Again, this approach is appropriate for all families, not just those who have a child infected with HIV.

Along with these precautions, normal family interaction, especially physical affection, should be encouraged.

Financial Support. The burden of caring for a sick child should not be compounded by the threat of financial hardship. The family should be provided with continued support covering 100% of the medical care expenses of their sick child. At the least, this support entails Medicaid coverage. In addition, the recently enacted Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) contains provisions to supplement this support for young children with HIV infection, with coverage for services frequently not included within Medicaid. Moreover, financial support should not be limited to medical costs. Children with HIV infection and their families have interrelated psychosocial, medical, and educational needs. Therefore, additional financial aid in the form of supplemental maintenance payments, as provided through Title IV-E programs (Foster Care and Adoptive Assistance Act) should be used to support the adoptive or foster care placement of these children. Foster care and adoption agencies should also seek additional funding for special services, such as the following, through grants from federal, state, and local sources.

Support for Respite Care. Children with HIV infection can be expected to tax the energies and emotional stamina of their care givers. Yet, periodic relief from this burden in the form of evening or weekend baby-sitting or day care may be difficult to obtain because of the social stigma associated with the illness. Adoptive or foster care agencies, in collaboration with other community resources, should develop respite care services such as day-care programs or baby-sitting services for these families. In some communities with a high prevalence of pediatric AIDS, special day-care programs have been developed specifically to serve children with this diagnosis. Such programs can provide valuable psychologic support as well as respite care. However, when such special programs are not available, existing day-care services should be open to those HIV-infected or HIV-seropositive children who are well enough to participate in day-care activities and who do not need to be protected from the threat of infection from other children. Families are not obligated to inform day-care staff of the child's HIV status inasmuch as the evidence, to date, indicates that casual transmission of HIV infection is virtually nonexistent.¹

Psychologic Counseling. Care-giving families should have access to knowledgeable psychologic counseling services without financial obligation. When several families with children who have HIV infection live in close proximity, family group support services should be developed.

Social and Legal Counseling. Care-giving families of HIV-infected children can be expected to encounter difficulties with community services or institutions that may require expert legal counsel or social service support. Examples of such situations include local regulations regarding school attendance and policies of landlords toward rental housing for families with an AIDS patient. Social service and legal counsel with expertise in issues associated with AIDS should be available to these families without financial obligation.

Infant or Child at Risk, But Not Yet Determined to Have HIV Infection

Foster care or adoption may be anticipated in situations in which the infant or child is currently healthy but may be at risk for later HIV infection due to perinatal transmission.³ Because some parents may be reluctant or refuse to accept an infant or child in whom there is substantial risk of AIDS developing, foster care placement or adoption may be difficult or impossible unless this risk is partially alleviated by HIV antibody testing. When HIV antibody test results are negative, the infant or child has a low risk for perinatally transmitted HIV infection (although an occasional infant will test antibody negative even though they are infected with the virus). However, positive results on an HIV antibody test are difficult to interpret for infants 15 to 18 months of age because HIV antibody moves freely across the placenta, and its presence in the infant may reflect only the mother's infection. Current estimates of the proportion of infants with positive results on an HIV antibody test who will later manifest HIV infection range from 30% to 50%.³ The need to clarify risk to improve the possibility of an adoptive or foster care placement, should be tempered by: (1) understanding the complexity and limitations of HIV antibody testing in identifying the HIV status of the very young child and (2) awareness of the ethical issues posed by the fact that a positive result on an HIV antibody test of the infant identifies the biologic mother as having HIV infection.

The widespread testing of all infants and children awaiting adoption or foster placement is not warranted, given the variability of prevalence of AIDS infection in childbearing women.³ However, in pop-

ulations that have high seropositive prevalence among women of childbearing age, foster and adoptive parents should have access to information about antibody status. Access to this information may improve the ability of agencies to place into foster or adoptive care such high-risk infants and children who prove to be uninfected.

The Task Force believes that the determinations of what constitutes "high prevalence" cannot be made as a hard and fast rule that governs all jurisdictions. One example of a local factor that might influence this determination is the mobility of the population that will affect the ability of any health care unit to predict the status of patients it serves. Anonymous seroprevalence surveys of the relevant population (women of childbearing age) is the best way to establish the current prevalence of HIV seropositivity in any jurisdiction. It will then be necessary for those health care professionals in that locale with the greatest expertise in HIV infection and epidemiology, to establish necessary practice based on known prevalence and other local factors.³

In response to the legitimate need for preplacement HIV testing of the infant or child in areas of high prevalence of HIV infection in childbearing women, procedures should be established by foster care and adoption agencies in collaboration with health care facilities, to accomplish the following.

1. Develop the expertise to provide prospective foster care or adoptive families with comprehensive and up-to-date information regarding all aspects of pediatric HIV infection.

2. Establish a process that would accomplish, with the appropriate consent of the infant's legal guardian, the preplacement HIV testing of infants or children, initiated either: (a) at the request of the prospective adopting or foster care parents through the physician who is responsible for that child's care, or (b) through the request of the infant's physician in response to his or her judgment that the mother is at high risk for HIV infection and that the infant's health supervision and/or placement may be affected by knowing the infant's antibody status.

3. Provide comprehensive and up-to-date interpretation of the meaning of test results, taking into account the age and health status of the child and the reliability of the test.

4. Establish a record-keeping system to contain information regarding the child's test results with access to such information strictly limited to those who need to know, but specifically including the informed adoptive or foster care family and the physician responsible for the infant's medical care.

5. Establish a procedure whereby all infants who have positive results on HIV antibody tests are

retested on a regular basis to distinguish between passively transmitted antibody and true HIV infection in the infant.

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