AMERICAN ACADEMY OF PEDIATRICS

Guidelines for Human Immunodeficiency Virus (HIV)-Infected Children and Their Foster Families

Task Force on Pediatric AIDS

STATEMENT OF THE PROBLEM

At the end of 1990, approximately 2786 cases of acquired immunodeficiency syndrome (AIDS) in children younger than 13 years of age had been reported to the Centers for Disease Control. Many more children are infected with the human immunodeficiency virus (HIV) but have milder or no apparent disease. The majority of young children have acquired their infection through perinatal transmission from HIV-infected mothers. A small minority have acquired their infection through blood transfusions received before 1985 when routine screening of the blood supply for HIV was initiated. Although many infants with perinatally acquired HIV infection will become symptomatic in the first year of life, a significant, but unknown, number of HIV-infected children are affected mildly or show minimal signs of infection for periods of up to 5 to 10 years.1,2 There is evidence to suggest that antiretroviral treatment with Zidovudine prolongs survival, and it is hoped that early treatment will increase the interval between development of infection and symptoms and reduce the severity of symptoms.3 Thus, children with HIV infection increasingly should be able to benefit from preschool and out-of-home child care programs. The social circumstances that may accompany HIV infection include (1) parents who have died or are too ill to care for their children; or (2) parents who are unable or unwilling to care for their children, most often as the result of continuing drug abuse. These situations frequently lead to the need for foster care or adoptive placement.

This statement makes recommendations regarding placement of HIV-infected children in adoptive or foster care homes and in child care settings.

BACKGROUND INFORMATION

Identification of HIV-infected children from birth to 15 to 18 months of age can be difficult because the presence of HIV-specific IgG antibody may be due to passive transfer from the HIV-infected mother.4 By the time an infant is 15 to 18 months old, maternal antibody will have disappeared; therefore, the presence of antibody in a child this age indicates infection. Diagnosis is complicated further by the fact that a small number of infected infants fail to produce HIV-specific antibody, although most of them are symptomatic and some are quite ill. More definitive diagnostic techniques to accurately identify infection in an infant include tests for HIV antigenaemia (p24 antigen), culture of the virus, detection of the viral genome by polymerase chain reaction, in vitro antibody production assays, and HIV-specific IgA antibody assays. However, the sensitivity and specificity of such testing still are being defined.5-6 In children older than 15 to 18 months, the established antibody test (ie, Enzyme-Linked ImmunoSorbent Assay (ELISA)), followed by a confirmatory Western Blot Test is sufficient to detect most cases of HIV infection.

In adults and adolescents, HIV is transmitted most often through sexual intercourse (either homosexual or heterosexual) or through the sharing of needles and other injection equipment by intravenous drug users. Before the testing of blood for transfusions was initiated in 1985, a number of pediatric-age persons and adults were infected through transfusion of blood or blood products. Although anxieties about transmission of HIV in families or school settings exist, a number of studies have shown that HIV is not transmitted through casual or family-type contact, including hugging and kissing or sharing eating utensils, toilets, and bathing facilities with an infected person.7 There has been no suggested transmission through sharing toys (even if they are placed in the mouth), by activities such as changing diapers, or through contamination of the child care environment with urine, stool, or vomitus. A few individuals, primarily health care workers, have become infected through injury with contaminated needles (risk is approximately 1 infection per 250 injuries), or under extremely rare circumstances, through direct contact of blood with the skin (most often broken skin). The risk of infection through direct contact with the skin can be diminished by following recommended precautions.

Biting is a common behavior in preschool child care settings. Although theoretically, biting is a possible mode of transmission of blood-borne illness, such as HIV infection or hepatitis B, actual transmission of HIV infection through biting has never been reported in a child care setting, and the risk of such transmission is thought to be negligible. Only one childhood case has been ascribed to a human bite; this possibility was not confirmed.8,9

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
Because HIV testing is not done routinely, there may be HIV-infected children in homes or child care settings who have not been identified because they are asymptomatic or have only mild symptoms. Because child care personnel will not always know whether a child has HIV infection or any other blood-borne disease (eg, hepatitis B), procedures that effectively protect against the transmission of blood-borne disease should be practiced universally in all child care settings. First, all wounds should be handled in a manner that minimizes direct contact between the blood and skin or mucous membranes of the care giver. In virtually all circumstances, the use of appropriate cloth barriers, such as thick toweling, to apply pressure or clean the wound is adequate. While some care givers may wish to use water-impervious gloves when tending to wounds, such is not required unless the care giver has a skin condition (eg, eczema, cuts, or abrasions) that results in nonintact skin. Second, after all visible blood has been removed, all blood-contaminated environmental surfaces should be disinfected promptly with a fresh bleach solution diluted 1:100 (1 tablespoon bleach to 1 quart of water) or any chemical germicide that is approved by the Environmental Protection Agency for use as a hospital disinfectant. Regular washing of blood-contaminated clothing is sufficient.

Because children who have HIV infection or other chronic illnesses may be immunodeficient, it is important for their care givers to be informed of any infectious illnesses present in the child care setting that might compromise their health, such as measles or chickenpox. Because the child care providers may not know that there is an immunodeficient child present, child care programs should make it a policy to inform all families whenever a highly infectious illness such as measles or chickenpox has been identified in any child in the program.

Families are not required to inform child care providers that their child has HIV infection. However, it is advisable for child care providers to be informed about a child’s HIV status to watch for signs of illness that may need medical attention and to address the child’s and family’s special emotional and social needs. In many jurisdictions this information can be divulged only with the written consent of the child’s parent or legal guardian, and records of such information must be treated as confidential.

To promote foster care or adoptive placement, it is recommended that the HIV status of children born in high seroprevalence areas or in high-risk situations be determined when such testing would facilitate placement. Courts should adopt methods for rapid processing of court orders to allow HIV testing of infants and children awaiting placement whenever such placement would be facilitated by testing. If the child is HIV-seronegative, which will be true in the majority of instances, the adopting or foster care home can be reassured that the child is not at risk for developing AIDS. If a child younger than 18 months of age is HIV-seropositive, the adoptive or foster care family should be informed fully about the risk that the child is truly infected (between 12.9% and 39%12-14), and the procedures by which that child should be followed up and/or treated. If infection has been documented, either by definitive testing (positive virus culture or p24 antigen test) or persistent antibody titers in a child older than the age of 18 months, the receiving family should be informed fully regarding the child’s medical and psychosocial needs, and the community resources available for assisting HIV-infected children and their families. Also, foster care agencies should facilitate HIV testing of high-risk infants and children when medically indicated to promote appropriate medical treatment and follow up of those children who are HIV-seropositive.

RECOMMENDATIONS

Based on this information, the American Academy of Pediatrics makes the following recommendations.

1. There is no reason to restrict foster care or adoptive placement of children who have HIV infection to protect the health of other family members because the risk of transmission of HIV infection in family environments is negligible.

2. There is no need to restrict the placement of HIV-infected children in child care settings to protect child care personnel or other children in these settings, because the risk of transmission of HIV in child care environments is negligible.

3. Child care personnel need not be informed of the HIV status of a child to protect the health of care givers or other children in the child care environment. It should be noted that in some jurisdictions the child’s diagnosis cannot be divulged without the written consent of the parent or legal guardian. Parents may choose to inform the child care provider of the child’s diagnosis to support a request that the care giver observe the child closely for signs of illness that might require medical attention and assist the parents with the child’s special emotional and social needs.

4. All child care settings should follow recommended universal precautions in the handling of blood or bloody fluids to minimize the possibility of transmission of any blood-borne disease.

5. All preschool child care programs routinely should inform all families whenever a highly infectious illness such as measles or chickenpox occurs in any child in that setting. This will help families protect their immunodeficient child.

6. To facilitate foster care or adoptive placement, courts should adopt methods for rapid processing of court orders to allow HIV testing of infants and young children whenever such testing would promote placement. Placement would be promoted most clearly when such court-ordered testing is pursued in areas of high seroprevalence or when the child comes from a high-risk setting.

Task Force on Pediatric AIDS, 1991 to 1992

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