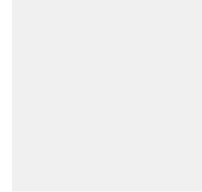
Walsall Council

Walsall Children's Services
Better Together for Children

HIV and AIDS



RELEVANT GUIDANCE

NCB / Emily Hamblin, Practice Guidance: supporting young people with HIV testing and prevention (2016)

AIDSMAP - Information on HIV and AIDS

DHSC Guidance: 'Children in Need and Blood-borne Viruses: HIV and Hepatitis' (2004)

AMENDMENT

This chapter was updated in February 2017 to add **NCB / Emily Hamblin, Practice Guidance: supporting young people with HIV testing and prevention (2016)**. (See Relevant Guidance).

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1. Introduction

HIV is not in itself an issue for child protection, and there is no evidence that **Significant Harm** is more likely in families affected by HIV.

As HIV is such an emotive issue, it is vital that a balanced and consistent approach is adopted in considering whether HIV should be a factor in any assessment, enquiry or work with children and families.

The issues need careful consideration, and workers should take time to seek specialist advice and guidance.

2. When Should HIV be a Consideration?

In circumstances where workers believe that a child may have been placed at risk of acquiring HIV, an informed decision must be made about whether to raise the concern with the child or parents.

Before taking this initiative, workers must seek good factual advice from the appropriate professional. This decision would not just be for the social worker, but for all professionals involved in the child case.

Consultant paediatricians and other doctors with reasonable experience would expect to make the decision at the time with the family in front of them

Where a number of children are involved, a consistent approach to the raising of issues about HIV is important and must be coordinated and agreed between workers.

In cases of suspected Significant Harm, it may be helpful to invite a specialist worker to assist the **Strategy Discussion/Meeting** in considering any HIV risk involved. On extremely rare occasions if a perpetrator is known to be HIV positive and there has been a risk to a child, it may be appropriate to consider sharing this information even if the perpetrator does not give consent. If a child has been very recently sexually abused, specialist medical advice should be sought urgently and then the child should be given the opportunity of Post Exposure Prophylaxis. In that situation this should be given as soon as possible but within 72 hours, and there would not be time at that stage for a meeting.

Any decision to reveal a **Looked After** Child's HIV status can only be made by the **Designated Manager (HIV and AIDS)** with the manager for the social work team for the child and the parents of the child if the Local Authority does not have **Parental Responsibility**.

3. Testing for HIV

HIV is a treatable disease, and therefore the positive effects of having an HIV test should be emphasised. The treatment available is highly effective, offering children long-term healthy lives.

A positive HIV antibody test demonstrates the child has been infected with HIV if the child is more than 18 months of age. In younger infants special HIV PCR tests have to be used to identify HIV infection as the antibody test may be positive due to the transfer of maternal antibodies across the placenta. These maternal antibodies can be present in the infant up to 18 months of age. The majority of HIV positive children are infected vertically from their mothers.

If it is suspected the child may have been exposed to HIV by blood/body fluid exposure at a later time, then as soon as possible after the exposure the child should be seen for emergency post

exposure prophylaxis to prevent transmission. Other blood borne infection should also be considered (e.g. hepatitis C/B) and additional tests arranged depending on the individual circumstances.

New infections with HIV in childhood that are not from the mother are very rare. As with adults, it takes 3/4 months for the antibody test to become positive, but a special test can pick up the infection at an earlier stage than this. Such children need to be closely followed up in the family HIV clinic.

Where the child, parent or workers have raised HIV as an issue, it is important to access specialist advice to consider whether there has been a real risk of infection and whether there is anything to gain from testing.

Testing should only be carried out where there is substantive evidence of exposure to HIV, and not purely on the grounds of the sexuality or life-style of a child or parent.

Where the child’s HIV status is not known, testing should never be carried out solely at the request of the foster carers or as a routine examination or assessment. However it is important that parents, foster carers or adopted parents should know the child’s status, as HIV is a treatable condition, and the treatment is important for the child's long-term health and well-being. Where appropriate to the child’s age and developmental stage, the child should be informed of his/her diagnosis, (normally very young children are not informed about their diagnosis).

Where an HIV test is being considered, staff must organise a referral to a family HIV clinic or an experienced doctor where expert advice can be given to the child and family about the test and treatment available. This must address the needs of each individual child/family arising from race, gender, spirituality, language and disability.

4. Consent to HIV Testing - all Children

The informed consent of a child aged 16 or over must be given before testing.

If a child under 16 has sufficient age and understanding, his or her permission must be given before testing. The issues are: should one test without the parents’ knowledge, how will positive test be dealt with, and what agreement is made with the child about informing his/her parent/s. It is recommended that advice is sought from a specialist Paediatrician in HIV.

In order for children and parents to be able to participate in decision-making in an informed way, they must be provided with adequate information and given appropriate support in the event of a positive diagnosis

Wherever possible, the consent of the parents should be obtained.

Where parental consent is not forthcoming but there is a clear medical recommendation that testing is in the child’s best interests, legal advice should be obtained as to whether and in what circumstances the test can proceed.

5. Consent to HIV Testing of Looked After Children

As well as the consents of the child and the parent, all requests for HIV testing of **Looked After** children should be referred to the **Designated Manager (HIV and AIDS)** who will discuss the case with the HIV/AIDS Lead Officer for the Children's Services Department. The decision should be taken with the appropriate medical advice.

Testing can only proceed on a Looked After Child if the written consent of the **Designated Manager (HIV and AIDS)** with the advice of the team manager of the child's social worker.

If the Local Authority does not have **Parental Responsibility** the parent/s must give consent. If the consent is not given, then legal advice must be sought.

6. The Test Itself

Arrangements for the test must be made by the social worker, in consultation with the child an experienced Paediatrician, who will make suitable arrangements for the child to visit a Genito-Urinary Clinic.

The test involves the taking of a blood sample and arrangements should be made to take the sample at the most appropriate place and time for the individual child, in keeping with the opening times of the Genito-Urinary Clinic.

7. The Test Result

There is a need for discussion before any test takes place, clarifying who will be told the test results and how, and who will have access to them. If a child is of sufficient age and understanding to give informed consent, then the result will be given to the child directly, unless they choose otherwise.

In other situations, the results will usually be given to whoever gave the consent for the test to take place. Even if workers have been involved in the initial discussions, they do not have any automatic access to the test results.

The child should be accompanied by an adult of their choice if old enough, when the test results are given, so that he/she can be given support at the time and after returning home. It is important that the child knows where he/she can go to get information and expert advice about the test and the treatment available

Whatever the outcome of the test, the child concerned should receive the same level of service. The only difference in treatment should be where it is necessary to protect the child.

A child infected or affected by HIV is a **Child in Need** who may require a service.

8. Confidentiality and the Disclosure of HIV Status

Confidentiality is extremely important in relation to HIV, both legally and ethically.

Where a child is Looked After, the immediate carers of the child must be informed if it is known that the child is infected with HIV. Wherever possible, the parent's consent to this will be obtained before the placement.

Foster carers should not to tell their children about the Looked After child's status without the authority of the relevant social worker. It is unlikely that children have the level of understanding to deal with all the issues.

Where a child is placed in a Children's Home, only those members of staff who have a special involvement with the child and where their knowledge would enhance their work with the child need be informed of the child's HIV status.

The only other professionals who should be told of the child's HIV status are the child's GP and Health Visitor.

Before disclosing information about HIV to any other agency or individual, for example a nursery or playgroup, the following criteria must be satisfied

a. Written consent to the disclosure must have been given by the parents and the child (where appropriate)

b. The disclosure is considered to be in the best interests of the child

c. Those receiving the information are aware of its confidential nature

A completed form of written consent is essential, and should clearly specify to whom and why the information would be given.

It is anticipated that only in exceptional circumstances would information that a child is infected with HIV be shared at a **Child Protection Conference**. Child protection conferences may be called because of important factors of neglect which are directly related to the child's diagnosis, so revealing the diagnosis must be decided on a case-by-case basis.

9. Looked After Children

Home's managers must ensure that Looked After Children have access to relevant, up to date, information about the risks associated with Sexually Transmitted Infections and blood-borne virus transmission. Children should also be provided with information and guidance on suitable hygienic measures they can take to reduce the risk of transmissions.

The primary issue to be considered prior to placement is that children under 8 are more prone to general infection, and therefore may pose more of a risk to a child infected by HIV.

If a Looked After Child is at risk or known to be affected by HIV, the home's manager and social worker should seek medical advice as to the risks to the child and other children in the placement, and should incorporate any advice given into the child's **Placement Plan**.