Assessing access for prospective adoptive parents living with HIV: an environmental scan of Ontario’s adoption agencies

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ABSTRACT

Work has been underway to increase the availability of parenting options for people living with and affected by HIV. One option, adoption, has not yet been explored in the literature. The study aimed to gain a better understanding of the potential of adoption for individuals/couples living with HIV in Ontario, and to assess potential structural barriers or facilitators that may impact their experience navigating the adoption system by conducting an environmental scan of adoption service providers in Ontario. A list of adoption service providers was compiled using the Ontario government’s website. Information relevant to the study’s measures was collected using service providers’ websites. Service providers without websites, or with websites that did not address all of the research measures, were contacted via telephone to complete a structured interview. Online data extraction was possible for 2 and telephone surveys were completed with 75 adoption service providers (total n = 77). Most service providers reported that HIV status is not an exclusion criterion for prospective parents (64%). However, more than one-fifth of the participants acknowledged they were not sure if people with HIV were eligible to adopt. Domestic service providers were the only providers who did not report knowledge of restrictions due to HIV status. Private domestic adoption presented social barriers as birth parent(s) of a child can access health records of a prospective parent and base their selection of an adoptive parent based on health status. Adoption practitioners and licensees involved in international adoptions reported the most structural barriers for prospective parent(s) living with HIV, attributed to the regulations established by the host country of the child(ren) eligible for adoption. Although international adoptions may present insurmountable barriers for individuals living with HIV, public and private domestic adoption appears to be a viable option.

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Introduction

With the transition of HIV from a life-threatening disease to a manageable chronic illness with improved quality of life, intentional planning of families has increased among people living with HIV (PLHIV) (Loutfy et al., 2009; Ogilvie, Palepu, Remple, & Mann, 2007; Paiva, Filipe, Santos, Lima, & Segurado, 2003). While pregnancy is most common, there are a variety of reasons why PLHIV may desire to adopt children. However, a review of more than 350 documents regarding the reproductive rights of PLHIV noted that adoption is rarely addressed (de Bruyn, 2006).

In Canada, there are three options for adopting a child who is not a family member: (1) public domestic adoption, (2) private domestic adoption, and (3) international adoption (Adoption Council of Canada, n.d.). According to the Ontario Ministry of Child and Youth Services (OMCYS, 2010/2015), public adoptions involve local child welfare agencies and minors who are Crown Wards in foster care; private adoptions involve children placed for adoption by the birth parent(s); and international adoptions involve children from a foreign state. Each adoption involves an application process including a health assessment, homestudy, and approval from the appropriate governing body (Adoption Council of Canada, n.d.). Each adoption may involve an adoption practitioner, responsible for conducting homestudies and supervising adoption placements, and/or an adoption licensee, responsible for managing the placement of children and the legal process involved in adoptions (OMCYS, 2010/2015).

Given the lack of literature regarding eligibility of PLHIV as prospective adoptive parent(s), we conducted an environmental scan of the adoption system in Ontario, Canada, to assess facilitators and structural barriers that may impact PLHIV who intend to adopt.
Methods

Study design and participants

We used an environmental scan, a method used to gather knowledge in order to identify opportunities for change (Graham, Evitts, & Thomas-MacLean, 2008), as our methodology. A list of adoption service providers was obtained from the OMCYS (2010/2015) website, consisting of public domestic agencies \( (n = 46) \), adoption licensees \( (n = 37) \), and adoption practitioners \( (n = 98) \). Participants were required to be: licensed, operating, and reachable by a website or telephone. Duplicates identified during data collection were only included once in the final count.

Data were collected between May and September 2014 and consisted of two parts: (1) reviewing service providers’ websites \( (n = 71) \) and (2) conducting structured telephone interviews with service providers without websites and those whose websites yielded incomplete data collection. Three phone calls were made (and voice-mail messages left), if necessary, over a period of three weeks. Ethics approval was obtained from Women’s College Research Institute Research Ethics Board.

Measures

Adapted from a previous study (Ross, Epstein, Goldfinger, & Yager, 2009) participants were categorized based on the type of adoption facilitated (public or private, domestic or international) and the participant’s role in facilitating adoptions. The eligibility of single parents, same-sex couples, and PLHIV were documented. Marital status, previous divorces, and health status were also examined with respect to eligibility. Lastly, participants of the telephone survey were asked if they knew of any PLHIV who had adopted through their services. Summary statistics were determined using SPSS.

Results

Study population

Of the 181 potential participants, 10 were no longer operational and four were duplicates \( (n = 167) \). Eighteen declined to participate with the most common reason being lack of time. Three participants declined due to the study topic. Sixty-nine were unreachable after three phone calls. In total, 22 public domestic agencies, 17 adoption licensees, and 38 adoption practitioners participated \( (n = 77) \) with data extracted solely from online resources for two \( (2/77) \), yielding a 46% response rate. Table 1 summarizes basic participant information.

| Attributes of participating adoption service providers | \( n \) (%)
|--------------------------------------------------------|---------|
| Adoption service provider                              |         |
| Private agency/licensee – domestic                     | 7 (9%)  |
| Private agency/licensee – international                | 6 (8%)  |
| Private agency/licensee – domestic and international   | 4 (5%)  |
| Public agency (domestic)                               | 22 (29%)|
| Adoption practitioner                                  | 38 (49%)|
| Type of adoption                                       |         |
| International adoptions                               | 6 (7.8%)|
| Domestic adoptions                                     | 30 (39%)|
| Both                                                   | 41 (53%)|

Note: Totals not adding to 100% are due to missing data.

Eligibility requirements

Forty-nine respondents (64%) reported that living with HIV is not an exclusion criterion for pursuing adoption. However, three (4%) of the service providers stated that HIV is an exclusion criterion for the adoptions they are involved in, seven (9%) described some restrictions associated with HIV status, and eighteen (23%) reported that they did not know if HIV was an exclusion criterion. Many service providers volunteered that restrictions depended on the laws of the host country of the child, with some countries allowing PLHIV to adopt (i.e., Canada) and others prohibiting PLHIV from adopting. Table 2 presents the eligibility of PLHIV based on the type of adoption. Six service providers confirmed that they were aware of successful adoptions where at least one adoptive parent was living with HIV.2

General eligibility criteria for prospective parents are summarized in Table 3. Seven private adoption service providers (licensees and/or practitioners) noted that the health status of potential adoptive parent(s) is disclosed to birth parents upon request.

Discussion

Most of the participating adoption service providers did not have policies prohibiting PLHIV from adopting. However, more than one-fifth of the participants reported being unsure if PLHIV were eligible to adopt. Domestic service providers were the only providers who did not report knowledge of restrictions due to HIV status. However, a social barrier was evident for private domestic adoption as the birth parent(s) have access to all application documents from a prospective parent, including their health documents, and they ultimately select the adoptive parent(s). Adoption practitioners and licensees involved in international adoptions reported the most structural barriers for prospective parent(s) living with HIV, attributed to the regulations established by the host country of the child(ren).
Domestic adoption

According to the Ontario Human Rights Commission (OHRC), individuals may not be discriminated against based on any of the protected grounds outlined in the Human Rights Code (1962/2015), one of which is "disability." Since HIV is formally recognized as a disability in Canada (Canadian Human Rights Commission, 2013), people cannot legally be discriminated against on the basis of HIV status during the Canadian adoption process. Despite this, many service providers were unclear if PLHIV were eligible to adopt. While some indicated they would consult a governing body, this initial lack of awareness, in the context of HIV stigma (Lawson, Bayly, & Cey, 2013; Mahajan et al., 2008; World Health Organization, UNAIDS, & UNICEF, 2008), may cause individuals to withdraw from the adoption process. Service providers should receive education regarding HIV-related reproductive rights and advances in medicine to ensure adoptive applicants are not discriminated against and/or deterred.

PLHIV considering adoption should be counseled that domestic adoption is the most viable route, and they should be prepared to disclose and discuss their HIV status. While providing service providers with specialized training is an important first step, this does not address the potential barrier due to disclosing health records to birth parents. Since the health of prospective adoptive parents is evaluated by medical professionals and the governing body prior to the parent(s) being considered for placement, releasing specific health information to birth parents seems unnecessary and may potentiate discrimination. Policy makers should consider keeping health records of potential applicants confidential from anyone who is not formally educated regarding guiding regulations and health conditions. Until this occurs, PLHIV should be counseled on the information that can be released to birth parents prior to pursuing private domestic adoption to ensure they are making an informed decision regarding disclosure and potential discrimination. Adoption service providers should also ensure that birth parents receive only factual information regarding health conditions of potential applicants.

International adoption

Similar to findings for sexual minority groups (Ross et al., 2009), we found international adoptions to be structurally prohibitive due to host country policies.

### Table 2. Eligibility based on HIV status.

|                  | Private agency/licensee | Public domestic agency | Practitioner | Total |
|------------------|-------------------------|------------------------|--------------|-------|
|                  | Domestic $n = 7 \%$ | International $n = 6$ | Both $n = 4$ | $n = 22$ | $n = 38$ | $n = 77 \%$ |
| Eligible         | 3                       | 3                      | 17           | 26    | 49 (64\%) |
| Ineligible       | –                       | –                      | –            | 1     | 3 (4\%)   |
| Restrictions     | –                       | 3                      | 1            | –     | 3 (9\%)   |
| Do not know      | 4                       | 1                      | 5            | –     | 8 (18\%)  |

Note: Majority of restrictions and ineligibility were voluntarily reported as being due to the host country of the child.

### Table 3. General eligibility criteria for prospective adoptive parents.

|                  | Private agency/licensee | Public domestic agency $n = 22$ | Practitioner $n = 38$ | Total $n = 77 \%$ |
|------------------|-------------------------|-------------------------------|------------------------|-------------------|
|                  | Domestic $n = 7 \%$ | International $n = 6$ | Both $n = 4$ | $n = 22$ | $n = 38$ | $n = 77 \%$ |
| Single parent    |                         |                              |                        |                   |                   |
| Eligible         | 7 (100\%)               | 1 (17\%)                     | 3 (75\%)              | 22 (100\%)        | 31 (82\%)         | 64 (83\%)         |
| Ineligible       | –                       | 2 (33\%)                     | –                      | –                 | 2 (3\%)           |                   |
| Restrictions     | –                       | 3 (50\%)                     | 1 (25\%)              | –                 | 7 (18\%)          | 11 (14\%)         |
| Unmarried        |                         |                              |                        |                   |                   |
| Eligible         | 7 (100\%)               | –                             | 3 (75\%)              | 21 (95\%)         | 22 (58\%)         | 53 (69\%)         |
| Ineligible       | –                       | 4 (67\%)                     | –                      | –                 | 1 (3\%)           | 5 (6\%)           |
| Restrictions     | –                       | 2 (33\%)                     | 1 (25\%)              | 1\* (5\%)         | 14 (37\%)         | 18 (23\%)         |
| Same-sex couples |                         |                              |                        |                   |                   |
| Eligible         | 7 (100\%)               | –                             | 3 (75\%)              | 21 (95\%)         | 23 (61\%)         | 54 (70\%)         |
| Ineligible       | –                       | 6 (100\%)                    | –                      | –                 | 6 (8\%)           |                   |
| Restrictions     | –                       | –                             | 1 (25\%)              | 1\* (5\%)         | 15\* (39\%)       | 17 (22\%)         |
| Previously divorced |                   |                              |                        |                   |                   |
| Eligible         | 7 (100\%)               | 3 (50\%)                     | 3 (75\%)              | 20 (91\%)         | 30 (79\%)         | 63 (82\%)         |
| Ineligible       | –                       | –                             | –                      | –                 | –                 |                   |
| Restrictions     | –                       | 1 (17\%)                     | 1 (25\%)              | 1\* (5\%)         | 6 (16\%)          | 9 (12\%)          |

Note: Majority of the restrictions and ineligibility were voluntarily reported as being due to the host country of the child. Data not adding to 100\% are missing.

\*Two service providers (total) reported eligibility but indicated they would refer to someone else and thus they were included under restrictions.

\#Reported to be due to Canadian laws.
We concur with recommendations that the Ministry of Children and Youth Services and international adoption agencies challenge international policies that reproduce stigma (Ross et al., 2009).

**Strengths and limitations**

Inclusion of adoption agencies, practitioners, and licensees representing both domestic and international adoption is an important strength of this study. Potential recall bias and social desirability bias inherent in the self-report survey design are important limitations. Further, surveys queried whether or not individuals were eligible for adoption, not whether or not the respondents were personally willing to work with PLHIV. This study, therefore, does not address the potential impact of personal biases on the adoption process. The response rate for this survey was low but comparable to another study that similarly found many potential participants to be unreachable (Ross et al., 2009).

**Conclusions**

The current study demonstrates that PLHIV have been able to successfully adopt through public domestic adoption in Canada, supporting this as a viable option for PLHIV if social barriers are minimized. We encourage other countries to explore their adoption policies and to challenge potential barriers to adoption for PLHIV. The exploration of the adoption process from a structural level is only the first step in assessing access to adoption for PLHIV. Interviews with prospective and successful adoptive parents living with HIV have commenced to provide an understanding of the actual adoption experiences of PLHIV.

**Notes**

1. A homestudy is the assessment and evaluation of prospective parent(s) by an adoption practitioner to determine suitable placement options (Adoption Council of Ontario, n.d.).
2. It is unclear if these adoption service providers were referring to unique adoptions, as service providers can contribute to the facilitation of adoptions in multiple private and/or public contexts

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**Disclosure statement**

No potential conflict of interest was reported by the authors.

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