ADOPTION EDUCATION LLC

SPECIAL REGIONAL CONSIDERATIONS

INDIA

1. History of International Adoption
2. Logistics
3. General Health Issues of the Population
4. Special Considerations for Children Adopted from India

TO ACCESS THE QUIZ:
After reading this course, please sign back on to www.adopteducation.com. Go to the table of contents and click on the last page (#4) for the region you wish to take the quiz for. Click the NEXT arrow at the bottom of the page to begin question 1 of the quiz.

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INDIA

History of International Adoption

Historically, adoption was not a popular or traditional concept in India, and the few adoptions that were permitted were limited to a child within the extended family. These adoptions were governed by the Hindu Adoptions and Maintenance Act of 1956. The Act prohibited non-Hindus (including foreigners) from adopting Indian children within India. While foreign nationals are not permitted to adopt Indian children in India, in the late 1970's the Government of India introduced a provision for legal guardianship. A foreign national is now permitted to apply for and obtain legal guardianship of a child who is declared by the courts to be destitute and abandoned. The child may then be taken out of India to be adopted, and must be adopted within two years. [1]

The official national agency that oversees the intercountry adoptions in India is the Central Adoption Resource Authority. The Central Adoption Resource Authority (CARA) is an Autonomous Body under the Ministry of Women & Child Development, Government of India. Its mandate is to find a loving and caring family for every orphan/destitute/surrendered child in the country. CARA was initially set up in 1990 under the aegis of the Ministry of Welfare in pursuance of Cabinet decision dated 5-9-1990. Pursuant to a decision of the Union Cabinet dated 7-2-1998, the then Ministry of Social Justice & Empowerment conferred the autonomous status on CARA on 3-18-1999 by registering it as a Society under the Societies Registration Act, 1860. It was designated as Central Authority by the Ministry of Social Justice & Empowerment on 7-17-2003 for the implementation of the Hague Convention on Protection of Children & Cooperation in respect of Inter-country Adoption (1993). The Ministry of Women & Child Development has been mandated to look after the subject matters ‘Adoption’ and ‘Juvenile Justice (Care & Protection of Children) Act, 2000’ pursuant to the 2-16-2006 notification of the Government of India regarding reallocation of the Business. [2]

Indian law has no provisions for foreigners to adopt Indian children, but under the Guardian and Wards Act of 1890, foreigners may petition an Indian District Court for legal custody of a child to be taken abroad for adoption. Following a 1984 Indian Supreme Court decision, non-Indians are required to work through an adoption agency in their home country that is licensed in accordance with local law and appears on a list of agencies approved by the Indian government. Only an Indian agency recognized and listed by the Indian Government may make children available for adoption by foreigners. [3]

The Government of India, in pursuance of its constitutional mandate, has evolved a National Policy for the Welfare of Children. The thrust of this policy is summed up in the following words:

> "The nation's children are a supremely important asset. Their nurture and solicitude are our responsibility. Children's programs should find a prominent part in our national plans for the development of human resources, so that our children grow up to become robust citizens, physically fit, mentally alert and morally healthy, endowed with the skills and motivations needed by society. Equal opportunities for development to all children during the period of growth should be our aim, for this would serve our large purpose of reducing inequality and ensuring social justice." [3]

NUMBER OF IMMIGRANT VISAS ISSUED TO ORPHANS COMING TO THE U.S. FROM INDIA

FY 2007	416
FY 2006	320
FY 2005	323
FY 2004	406
FY 2003	472
FY 2002	464
FY 2001	543
FY 2000	503
FY 1999	499
FY 1998	478
FY 1997	349
FY 1996	380
FY 1995	371
FY 1994	412
FY 1993	331
FY 1992	352
FY 1991	445
FY 1990	348

SOURCE – US Department of State, http://travel.state.gov/family/adoption/stats/stats_451.html

Logistics

India is a party to the *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* (the Convention) and with which the Convention is in force for the United States. Because India is a Convention country, adoption services must be provided by an 'accredited agency', 'temporarily accredited agency', 'approved person', 'supervised provider', or 'exempted provider' as those terms are defined by the Convention. In addition, all recognized adoption agencies (or, as they are referred to in India, placement agencies) in India are local and must be registered with their Indian state Voluntary Coordinating Agency (VCA). No placement agencies provide national coverage, so prospective adoptive parents must determine the Indian state from which they propose to adopt. CARA licenses all the VCAs and all Indian placement agencies. [4]

Most relinquished children in India are from unwed mothers or from families too poor to care for them. As a result of gender discrimination, the majority of children adopted by Americans are girls.

While CARA is engaged in clearing inter-country adoption of Indian children, its principal aim is to promote in-country adoption. In fact, CARA ensures that no Indian child is given for inter-country adoption without him/her having been considered by Indian families residing in India. CARA also provides financial assistance to various Non-Governmental Organizations (NGOs) and Government run Homes to promote quality child care to such children and place them in domestic adoption. [2]

Criteria for Foreign Prospective Adoptive Parent/s (FPAP): [2]

- Married couple with 5 years of a stable relationship, age, financial and health status with reasonable income to support the child should be evident in the Home Study Report.
- Prospective adoptive parents having composite age of 90 years or less can adopt infants and young children. These provisions may be suitably relaxed in exceptional cases, such as older children and children with special needs, for reasons clearly stated in the Home Study Report. However, in no case should the age of any one of the prospective adoptive parents exceed 55 years.
- Single persons (never married, widowed, divorced) up to 45 years can also adopt.
- Age difference of the single adoptive parent and child should be 21 years or more.
- A FPAP in no case should be less than 30 years and more than 55 years.
- A second adoption from India will be considered only when the legal adoption of the first child is completed.
- Same sex couples are not eligible to adopt.

Criteria for eligible children: [2]

- The child must be legally free for adoption.
- Clearance from ACA/State Government is mandatory for all children except wherever exempted under the Guidelines.
- Siblings/twins/triplets cannot be separated except in exceptional cases.
- Two unrelated children cannot be proposed to a foreign family at a time.
- A child may as far as possible be placed in adoption before it reaches the age of 12.
- The consent of the child has to be obtained wherever applicable.

When a recognized Indian agency receives a child its first responsibility is to trace the biological parents and restore the child to them failing which, as far as possible to place the child in adoption with Indian families. It would be desirable that an Indian recognized placement agency should place annually more than 50 percent of the total number of children given in adoption with Indian families. However, the handicapped children, children above six years of age and siblings will be excluded from this calculation. [3]

India makes an effort to place all abandoned or relinquished children with an Indian family in India first. If that is not possible, then they prefer that an Indian family abroad be found. Finally, if no Indian family can be found, then the child can be placed with a non-NRI (Non Resident Indian) family. Typically NRI couples adopting from India will find the process goes much more quickly and smoothly than for a non-NRI couple. And there may be more options for the NRI couple as well. An NRI couple may adopt a young healthy infant, whereas a non-NRI couple may find it difficult to locate an agency with such a program. [4] The final decision on the suitability of the family is made by the agency in India.

General Health Issues of the Population

Despite impressive gains in economic investment and output, India faces pressing problems such as significant overpopulation (population: 1,147,995,898 based on a July 2008 estimate), environmental degradation, extensive poverty, and ethnic and religious strife. [5]

India grows by 16 million people every year (or 43,836 a day), just 2 million less than the entire population of Australia. Forty percent of the world's poor live in India, with 28 percent living below the poverty line. More than a third live on less than a dollar a day, and 80 percent live on less than two dollars a day. [6]

Common to India are natural hazards which include droughts; flash floods, as well as widespread and destructive flooding from monsoonal rains; severe thunderstorms; and earthquakes. [5] The extremely high poverty level makes it difficult to recover quickly from disasters.

Current issues impacting the environment include deforestation; soil erosion; overgrazing; desertification; air pollution from industrial effluents and vehicle emissions; water pollution from raw sewage and runoff of agricultural pesticides; tap water which is not portable throughout the country; huge and growing population which is overstraining natural resources.[5] The environment has deteriorated significantly due to unplanned urbanization, industrialization and indiscriminate use of pesticides in agriculture. Until recently, medical wastes were also deposited and mixed with municipal waste collection. Most of the country's water resources are polluted due to discharge of untreated / partially treated wastes from industry, domestic sewage and fertilizers / pesticide run off from agricultural fields. Agricultural activities including widespread use of fertilizers, pesticides and weedicides killers also alter the environment and create health hazards. Water stagnation and the consequent multiplication of vectors have increased the risk of vector-borne diseases. The high level of air pollution is resulting in increased respiratory diseases in cities. [7]

The main constraints with regard to water supply are inadequate maintenance of water systems, lack of finances and poor community involvement. Most Municipalities/Panchayats do not have any system for monitoring the quality of water, while water contamination causes water-borne diseases even in metro cities like Delhi and Kolkata. Most of the people in rural areas are not aware of the health and environmental benefits of improved sanitation. [7]

According to the World Bank (2001), premature death and illness due to major environmental health risks account for nearly 20 percent of the total burden of disease in India. India has environmental health risks of both categories: traditional hazards related to poverty and lack of development, such as lack of safe water, inadequate sanitation and waste disposal, indoor air pollution and vector borne diseases; and modern hazards caused by development that lacks environmental safeguards, such as urban air pollution and exposure to agro-industrial chemicals and waste. [7]

India is the world's largest producer of licit opium for the pharmaceutical trade, but an undetermined quantity of opium is diverted to illicit international drug markets. The country is the transit point for illicit narcotics produced in neighboring countries and the illicit producer of methaqualone *(a sedative and hypnotic nonbarbiturate drug that is habit-forming*). India is vulnerable to narcotics money laundering through the hawala system and licit ketamine (*anesthetic medication used illicitly usually by being inhaled in powdered form especially for the dreamlike or hallucinogenic state it produces*) and precursor production. [5]

*Note - **Hawala** (also known as **hundi**) is an informal value transfer system based on performance and honor of a huge network of money brokers which are primarily located in the Middle East, Africa and Asia. – from Wikipedia, http://en.wikipedia.org/wiki/Hawala*

India has been on the Tier 2 Watch List since 2004 for its failure to show evidence of increasing efforts to address trafficking in persons. As defined by the Trafficking Victims Reauthorization Act of 2003, Tier 2 are those countries whose governments do not fully comply with the act's minimum standards but are making significant progress to bring themselves into compliance with those standards.

At the present time, India is a source, destination, and transit country for men, women, and children trafficked for the purposes of forced or bonded labor and commercial sexual exploitation. The large population of men, women, and children - numbering in the millions - in debt bondage face involuntary servitude in brick kilns, rice mills, and embroidery factories, while some children endure involuntary servitude as domestic servants. There is internal trafficking of women and girls for the purposes of commercial sexual exploitation and forced marriage also occurs. The government estimates that 90 percent of India's sex trafficking is internal. India is also a destination for women and girls from Nepal and Bangladesh trafficked for the purpose of commercial sexual exploitation. Boys from Afghanistan, Pakistan, and Bangladesh are trafficked through India to the Gulf States for involuntary servitude as child camel jockeys. Indian men and women migrate willingly to the Persian Gulf region for work as domestic servants and low-skilled laborers, but some later find themselves in situations of involuntary servitude including extended working hours, nonpayment of wages, restrictions on their movement by withholding of their passports or confinement to the home, and physical or sexual abuse. [5]

In India, though health education has been a low priority, it has been an integral part of all national programs. Lack of information is the major barrier to the effective access to services.

Maternal Health

Each year in India, roughly 30 million women experience pregnancy and 26 million have a live birth. With an estimated 77,000 deaths per annum, India contributes to a majority of maternal mortality burden in the region. The main causes of high MMR being socioeconomic status of women, inadequate antenatal care, the low proportion of institutional deliveries, and the non-availability of skilled birth attendants in two-thirds of cases. Maternal mortality ratio, an important indicator of maternal health in India is estimated to be 301/100,000 live births. Major causes of maternal mortality in India remain hemorrhage (38%), sepsis (11%), abortions (8%), hypertensive disorders (5%), obstructed labor (5%) and other conditions including anemia, medical disorders during pregnancy contributing to 34% of all maternal deaths. [8]

Regional disparities in maternal and neonatal mortality are wide with states like Kerala having a maternal mortality ratio of 110/100,000 live births and others like Uttar Pradesh with 517/100,000. It is also recognized that delays in accessing specialized maternal care happen at all levels leading to maternal mortality and severe morbidity. The healthcare indicator used to monitor the process of reducing maternal mortality is the proportion of deliveries attended by a skilled birth attendant. [8]

In 1951, India was the first country in the world to launch a family planning program. Since then approaches aimed at reducing population growth have taken a variety of forms. According to performance statistics of family welfare program in India (Ministry of Health and Family Welfare, Government of India), the couples effectively protected by various methods of family planning increased from 22.8 percent in 1980-81 to 44.1 percent in 1990-91 and further increased to 56.3 in 2005-06.

India is faced with an unparalleled child survival and health challenge. The country contributes 2.38 million of the global burden of 10.8 million under-five child deaths, which is the highest for any nation in the world. Nearly 26 million infants are born each year, of whom 1.2 million die before completion of the first four weeks of life and 1.7 million die before reaching their first birthday. [9]

Infant and Child Heath

The Infant Morality Rate (IMR) in India has declined from 114/1000 live births in 1980 to 58/1000 in 2004. There are however wide variations amongst and within the states in infant and child mortality. In 2004, while Kerala recorded an IMR to 12/1000 live births, in the same year the IMR in Madhya Pradesh were 79/1000. The other states with an IMR significantly above the national average of 58/1000 live birth are Orissa (77), UP (72), Rajasthan (67) and Assam (66) (SRS 2004). [9]

The major killers of children are – acute respiratory infections, dehydration due to diarrhea, measles and neonatal tetanus and in some areas malaria. The high prevalence of malnutrition contributes to over 50% of child deaths. In India, a significant proportion of child deaths (over 40% of under-five Mortality and 64% of infant mortality) take place in the neonatal period. Apart from infections, other causes like asphyxia, hypothermia and pre-maturity are responsible for neonatal mortality. About one-third of the newborns have a birth weight less than 2500 gram (low-birth weight). A significant proportion of mortality occurs in low-birth weight babies. It has been recognized that further reduction of IMR will require focused attention on Neonatal mortality. [9]

The Universal Immunization Program against six preventable diseases, namely, diphtheria, pertussis, childhood tuberculosis, poliomyelitis, measles and neonatal tetanus was introduced in the country in a phased manner in 1985, which covered the whole of India by 1990. Significant progress was made under the Program in the initial period when more than 90% coverage for all the six antigens was achieved. Immunization programs in India have been successful to certain extent.

Adolescent Health

Adolescents (10-19 years) form a large section of population – about 22.5 percent, that is, about 225 million. They are living in diverse circumstances and have diverse health needs. The total population of young people (10 – 24 Years) is approximately 331 million comprising nearly 30 percent of the total population of India (Census 2001). [10]

Adolescents are full of energy, have significant drive and new ideas. They are a positive force for a Nation and are responsible for its future productivity provided they develop in a healthy manner. Since mortality in this age group is relatively low the adolescents are considered to be healthy. However, mortality is a misleading measure of adolescent health. In fact, the adolescents do have a range of health problems that cause a lot of morbidity as well as definite mortality. [10]

In spite of definite health problems they may have, it is a common observation that adolescents do not access the existing services. In India there have not been any designated services for this age group so far, leading to substantial unmet service needs. Absence of friendly staff, working hours that are inconvenient to adolescents and lack of privacy and confidentiality have been identified as important barriers in accessing health services by adolescents and young people. [10]

Infectious Diseases

Kala-azar is a slow progressing indigenous disease caused by a protozoan parasite of genus *Leishmania.* The parasite primarily infects reticuloendothelial system and may be found in abundance in bone marrow, spleen and liver. The Sandfly of genus *Phlebotomus argentipes* are the only known vectors of kala-azar in India. Indian Kala-azar has a unique epidemiological feature of being Anthroponotic; human is the only known reservoir of infection. Kala-azar is endemic in 33 districts of Bihar, 11 districts of West Bengal and three districts in Jharkhand and sporadic cases have been reported in Uttar Pradesh. After a reported increase in the number of cases and deaths due to kala-azar during 1989-1991, an intensive program for containment of kala-azar was launched in 1992. The strategy for control of infection included interruption of transmission through insecticidal spraying with DDT and early diagnosis and treatment of kala-azar cases. [11]

One of the most important resurgent tropical infectious diseases in India is dengue. Dengue is a viral disease that is transmitted by the infective bite of *Aedes Aegypti* mosquito. Dengue Fever and Dengue Hemorrhagic Fever (DHF) are acute fevers caused by four antigenically related but distinct dengue virus serotypes (DEN 1,2,3 and 4) transmitted by the infected mosquitoes, *Aedes aegypti*. Dengue is a disease of the tropics and is one of the most important emerging diseases affecting nearly half of the world's population. Periodic dengue outbreaks occur in many parts of India, in both rural and urban areas. Mortality is usually low but may be high in case of dengue shock syndrome and DHF. Diagnostic tests for dengue are not readily available in most parts of the country and no drug or vaccine is available for the treatment of Dengue/DHF. [11]

Filariasis is caused by several round, coiled and thread-like parasitic worms belonging to the family *filaridea*. These parasites after getting deposited on skin penetrate on their own or through the opening created by mosquito bites to reach the lymphatic system. The disease manifests often in bizarre swelling of legs, and hydrocele and is the cause of a great deal of social stigma. Filariasis has been a major public health problem in India next only to malaria. Filariasis is endemic in 19 States/union territories in India. Estimates based on surveys by Filariasis Survey Units suggested that: about 454 million people (120 million in urban areas) are living in known endemic areas; there are 29 million filariasis cases in the country and 22 million micro-filaria carriers. [11]

Malaria is a potentially life threatening parasitic disease caused by parasites known as *Plasmodium viviax (P.vivax), Plasmodium falciparum (P.falciparum), Plasmodium malariae (P.malariae)* and *Plasmodium ovale (P.ovale).* Malaria has been a major public health problem in India. In 2003, there were 1.87 million cases of malaria (including 0.86 million *P.falciparum* cases) and 1006 deaths reported. Provisional data for the year 2004 reveals that the largest numbers of cases in the country were reported by Orissa, followed by Gujarat, Chhattisgarh, West Bengal, Jharkhand, Karnataka, Uttar Pradesh and Rajasthan and the largest numbers of deaths were reported by Orissa, followed by West Bengal, Mizoram, Jharkhand, Meghalaya, Karnataka, Tripura and Assam. [11]

Japanese Encephalitis (JE) is a viral disease and is transmitted by infective bites of female mosquitoes mainly belonging to *Culex tritaeniorhynchus, Culex vishnui and Culex pseudovishnui* group. However, some other mosquito species also play a role in transmission under specific conditions. JE virus is primarily zoonotic in its natural cycle and man is an accidental host. Man is a dead end in transmission cycle due to low and short-lived viraemia. Mosquitoes do not get infection from JE patient. JE virus is neurotorpic and arbovirus and primarily affects central nervous system. JE viral activity has been widespread in India. Outbreaks have been reported from different parts of the country. During recent past (1998-2004), 15 states and Union Territories have reported JE incidence. Annual incidence ranged between 1765 and 3428 and deaths between 466 and 707. [11]

Tuberculosis (TB) is an infectious disease caused by a bacterium, *Mycobacterium tuberculosis*. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year. TB is a major public health problem in India. India accounts for one-fifth of the global TB incident cases. Each year over 1.9 million people in India develop TB, of which around 0.87 million are infectious cases. It is estimated that annually around 325,000 Indians die due to TB. [12] Organized TB control activities have existed in India for 40 years; however, the quality of diagnosis and treatment of TB in the public and private sectors has been variable, and TB incidence and prevalence trends have not changed substantially over this time.

At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV or AIDS. HIV emerged later in India than it did in many other countries. Infection rates soared throughout the 1990s, and today the epidemic affects *all* sectors of Indian society, not just the groups – such as sex workers and truck drivers – with which it was originally associated. Overall, around 0.36% of India's population is living with HIV. While this may seem a low rate, India's population is vast, so the actual number of people living with HIV is remarkably high. There are so many people living in India that a mere 0.1% increase in HIV prevalence would increase the estimated number of people living with HIV by over half a million. In India, as elsewhere, AIDS is often seen as *"someone else's problem"* – as something that affects people living on the margins of society, whose lifestyles are considered immoral. Even as it moves into the general population, the HIV epidemic is misunderstood and stigmatized among the Indian public. People living with HIV have faced violent attacks; been rejected by families, spouses and communities; been refused medical treatment; and even, in some reported cases, denied the last rites before they die. [13]

Mortality

A World Health Report (1999) gives the main causes of mortality in India as non-communicable diseases (48 percent), communicable diseases (42 percent) and injuries (10 percent). The dominant communicable diseases are infectious and parasitic diseases, respiratory diseases, maternal conditions, perinatal conditions and nutritional deficiencies. Non-communicable diseases are malignant neoplasm, diabetes mellitus, neuropsychiatric disorders, sense organ disorders, cardiovascular diseases, respiratory diseases, digestive diseases, musculo-skeletal diseases, congenital anomalies, oral diseases and other non-communicable diseases.

Special Considerations for Children Adopted from India

Before the Adoption

In India, extreme poverty and the stigma of unwed motherhood often force young women to abandon their children at birth. Many of the babies and children in Indian orphanages are abandoned by parents who are unable to provide for them. There are many older children in desperate need of adoption as well as infants. Many children who grow up in orphanages would face a life on the streets without job skills, family, or status in Indian society. International adoption, when no family within India is found, is their best hope.

Abandoned or relinquished children in India are most often cared for in an orphanage. They are rarely placed in foster care. Typically, little is known about birth parents, birth history, or health history prior to admission to an orphanage. Although material goods may be sparse, it is the personal interaction between caregiver and child that sets India apart as a country from which children are typically well-adjusted and emotionally healthy. Children are held in very high esteem in the Indian culture and this carries over to the care they receive. Orphanage health records are very reliable and the health care provided by the orphanage and local hospitals is excellent. Although many children enter the orphanage in less than optimum health, they tend to do well in the orphanage and thrive once they are home with their families.

After the Adoption

The actual adoption of the child will take place in the U.S., according to the laws of the state in which you reside. Each state has its own laws governing adoption of children. Your adoption agency or local child welfare bureau can help you with this final step.

Resources

1 U.S. Consulate General, Mumbai, India, http://mumbai.usconsulate.gov/adoption.html
2 Central Adoption Resource Agency, http://www.adoptionindia.nic.in/
3 Nrilinks.com, One Stop Portal for Non Resident Indians, http://www.nrilinks.com/india/adoption/default.htm
4 U.S. Department of State, http://travel.state.gov/family/adoption/country/country_398.html
5 Central Intelligence Agency, The World Factbook, https://www.cia.gov/library/publications/the-world-factbook/geos/in.html
6 PBS, Frontline World Rough Cut: India: Calcutta Calling
http://www.pbs.org/frontlineworld/rough/2006/01/india_calcuttalinks.html
7 World Health Organization (WHO), Regional Office for South-East Asia,
http://www.searo.who.int/EN/Section313/Section1519_10851.htm
8 World Health Organization (WHO), Country Office for India,
http://www.whoindia.org/EN/Section6/Section297_1301.htm
9 World Health Organization (WHO), Country Office for India, http://www.whoindia.org/EN/Section6/Section415.htm
10 World Health Organization (WHO), Country Office for India, http://www.whoindia.org/EN/Section6/Section425.htm
11 World Health Organization (WHO), Country Office for India,
http://www.searo.who.int/EN/Section313/Section1519_10854.htm
12 World Health Organization (WHO), Country Office for India, http://www.whoindia.org/EN/Section3/Section123.htm
13 AVERT, http://www.avert.org/aidsindia.htm

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