

THE PLACE OF CHILD HEALTH IN THE ADOPTION PROCESS

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PREAMBLE

Although the health of adopted children is a central and legitimate issue in all adoptions, it is nevertheless not often dealt with in specialised literature and research. Based on this observation, the International Adoption Service (SAI - *Service de l'Adoption Internationale*) of the French Ministry of Foreign and European Affairs suggested to the ISS/IRC¹ that they carry out a joint study on this theme.

It is first of all important to specify that the objective of the study is not to make a list of the different pathologies that may affect adopted children, nor is it to study the way in which children receive medical follow-up after their adoption. Instead, it concerns examining the place given in the adoption process to issues related to child health and to study how healthcare is organised. For example, what information do adoption applicants receive concerning the health of the child that is proposed to them? How is the child's check-up carried out? What support do families receive before adoption, in the country of origin, on the child's arrival and afterwards?

In order to do so and to paint as complete a picture as possible of the health aspects of adoption, we have both collected information from the practice itself and analysed the different systems in place throughout the world. As the subject is extremely vast, the study focused on the measures taken by the receiving countries, as they have particular responsibility in this field. The viewpoint of the countries of origin is nevertheless also included, thanks to the contributions that we have received from many of them.

As regards methodology, a questionnaire was sent out in January 2010 to a large range of persons and authorities that were likely to contribute to the research. In total, 32 replies were received from 22 countries, of which 13 were receiving countries, 7 were countries of origin and 2 were "mixed" (both receiving countries and countries of origin at the same time). Among these replies, 20 came from Central Authorities, 4 from Adoption Accredited Bodies (AABs) and 8 from professionals, mainly doctors. Given that some replies were compilations of replies from several intervening parties within the country, the diversity is greater in reality than what it seems.

In order to facilitate the reading and use of the results obtained, we have decided to process the information received by following the classic pattern of an adoption process. The first part addresses the issue of the child's health during the pre-adoption phase. At this stage, we focused mainly on the way in which adoption applicants are informed and prepared when they launch the procedure. The second part deals with support for applicants during the procedure, when they have been matched to a child and are present in the country of origin, as well as the conditions and the quality of the child's health check-up. The last part focuses on the child's healthcare on arrival in the receiving country and afterwards, especially post-adoption follow-up phase. Each part is dealt with by following the same pattern and first of all provides a summary of results, the main observations and finally the proposals made in order to consolidate or improve the situation.

We wish to thank very sincerely all the persons and institutions who replied to this questionnaire². The quality of the replies received has allowed us to draft a study that we hope will be constructive and useful for all the players involved.

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¹ International Reference Centre for the Rights of Children Deprived of Their Family/International Social Service: www.iss-ssi.org/2009/index.php?id=131

² Countries represented: Armenia, Australia, Belgium, Brazil, Cyprus, Czech Republic, Denmark, Dominican Republic, Ecuador, France, Germany, Ireland, Italy, Lithuania, Monaco, New Zealand, Philippines, Portugal, Spain, Sweden, Switzerland and Turkey. For further details, see the list of persons/institutions who replied to the questionnaire in Annex 1.

1. INTRODUCTION

Insofar as this study addresses the issue of health in the adoption process at an international level, it is first of all necessary to recall that 'adoption systems' vary considerably from one country of origin to another, and that the health specificities of adoptable children can be linked to these systems.

For example, the countries of origin that have implemented complete programmes of alternative measures for children deprived of their family, mainly propose special needs children for intercountry adoption. From a purely medical viewpoint, these special needs cover a large range of physical and/or mental pathologies that are more or less reversible, requiring long-term care or specific treatment that is still relatively inaccessible in several countries. This first group of children can be distinguished from the others insofar as by definition, the children have a very specific medical background. This group also includes children who are older and/or with siblings.

Conversely, for 'standard' intercountry adoptions, the children may suffer from different pathologies such as deficiencies, infections, etc., which are linked to their environment of origin and to their background. In simple terms, the problems they may have can generally be easily treated and should not cause any particular medium- and long-term concerns, on condition, of course, that the medical examinations have been carried out in a complete and thorough manner.

This distinction is important for this study as the adoption process for a child with special needs, if identified as such, is not prepared or managed in the same way as that of a 'normal' adoption. For example, the applicants' approach and their preparation are different, the intervening parties, whether institutional or private (belonging to an AAB) are specialised, the medical information in relation to the child is more thoroughly examined and explained, etc.

Given the current-day evolution of intercountry adoption, which has seen an increase in the proportion of adoptions of special needs children, it is obvious that the health element in the adoption process will occupy a greater place. However, one cannot fail to notice that although the cases clearly identified as being 'special needs' well and truly benefit from adequate support in the countries of origin and in the receiving countries, the importance given to health issues is not yet sufficient for the greater majority of intercountry adoptions. In this context, it would be useful to draw inspiration from the efforts made in the placement of special needs children in order to better manage all intercountry adoptions. Such a move is all the more important as children who are officially declared as being 'healthy' or as having curable illnesses can later develop all sorts of physical and/or psychological pathologies that are not identified at the time of matching, but which could create major problems for their adoptive family. In other terms, a 'normal' adoption could in fact turn out to be an 'adoption of a special needs child' and may lead to serious complications.

2. THE STATE OF HEALTH OF ADOPTED CHILDREN: AN OVERVIEW

A. Results

Although it is difficult to establish a precise overview of the state of health of adopted children (as quantitative data are extremely scarce on this subject), the replies received nevertheless indicate that adopted children have often complex health problems, among which the most common ones enumerated are digestive and cutaneous parasitosis, infectious diseases (hepatitides B and C, tuberculosis, etc.), problems linked to malnutrition, growth retardation, attachment disorders, etc. More atypical pathologies such as asthma or various allergies are also often referred to. In addition, when the countries of origin implement specific programmes for special needs children, the pathologies are of course different. This is the case for example in Lithuania, where 80% of children proposed are part of this category.

B. Analysis

Observation 1: In general, we have observed that the main health problems of adopted children can be effectively taken care of in the receiving country, barring cases where the pathologies appear later. In fact, the health problems encountered by professionals (see above) remain, on the whole, relatively easy to treat in a Western health system.

This first observation must nevertheless be put into perspective: at the current time, children with more serious pathologies more often than not remain in institutions in the countries of origin, either because their biological family is not in a position to pay for their care, or because they have not found any alternative family solution, precisely because of their handicap. We have also observed that for cultural reasons, these same children are only rarely proposed for intercountry adoption, as their country of origin declares them as unadoptable.

ISS/IRC missions in several countries of origin³ have clearly shown that the 'non-adoptability' of these children depended more on structural factors than on reasons purely related to their individual characteristics. Several scenarios have thus been identified:

- If the administrative organisation of a country decides that a child with a mild handicap (i.e. loss of an eye, developmental retardation, etc.) is referred to a medical organisation rather than an institution such as an orphanage, the fact that the authorities who will take care of him or her (a health ministry for example) are not competent in the field of adoption will mean that this measure is not considered, even if it could totally fulfil the child's needs.
- If the decision relative to the psycho-social adoptability of the child (as opposed to the legal adoptability) lies with nursery personnel, we observe that the appraisal of adoptability is often distorted by cultural prejudice, meaning that only children who are apparently healthy are proposed to foreign applicants.
- Lastly, certain legislative frameworks explicitly exclude the adoption of children with certain types of pathology, thus preventing any individual assessment of the relevance of an adoption.

Proposal 1: Healthcare systems still need to be developed and improved in several countries of origin by including all alternative care measures in order to avoid children remaining institutionalised for the simple reason that they are ill and that their family does not have the means to look after them. If the States of origin do not have the necessary resources to take charge of these developments alone, exchanges of experience and of good practices between countries of

³ For example: in 2007: Kazakhstan, Kyrgyzstan, Azerbaijan; in 2009: Vietnam; in 2010: Côte d'Ivoire, Guatemala.

origin should be encouraged⁴ and, if necessary, the intervention of external specialists should also be supported.

⁴ Such exchanges have taken place in Latin America for example between Guatemala and Peru, Chile and Colombia.

3. PRE-ADOPTION SUPPORT

In the pre-adoptive phase, adoption applicants can be informed and/or prepared as regards health issues linked to adoption in two ways: as part of collective information sessions and/or with individual consultations.

A. Results for *collective* information sessions on medical subjects before the adoption

Brief overview

Number of replies	Availability of information sessions	IF YES		
		Conditions of the information session (compulsory nature or not, price, duration, frequency, framework)	Providers (who, training, etc.)	Session content
32 replies for 22 countries	Yes: 18 No: 10 Varies in relation to the region and/or the body in charge: 3	- compulsory in 15 cases - free in 13 cases, -- charged in 5 cases, - variable price in 2 cases - variable frequency - variable duration but 1 hour minimum - public or private framework	All sessions are always provided by professionals specialised in adoption	Variable but the information provided is usually general

Detailed summary

As the above table indicates, the majority of receiving countries provide adoption applicants with information sessions in one form or another, and more often than not in a compulsory manner (15 out of 22, i.e. 68%). The form, conditions (duration, frequency, etc.) and the content of these sessions nonetheless varies a lot from one country to another. Thus, in some cases, these sessions are like real courses or pre-adoption preparation classes. In other cases, the structure is less rigid. Certain countries such as Portugal, Sweden or French-speaking Belgium provide very structured content, with a precise programme and number of hours. In other States, such as in Australia or Switzerland, session content is more variable and adjustable in relation to the region and/or the body in charge of the information session⁵.

Collective information sessions often take place at the very beginning of the adoption process, or even before applicants have really begun the process. They do not usually focus on medical problems, but deal with these issues as part of more global information. At this stage, these sessions usually provide a form of introduction to adoption and aim to explain to applicants the current adoption situation, the profile of adoptable children, what such a process implies, etc. Sometimes, more specific country information is already given at this stage, as in Australia for example, to applicants who have already chosen the country of origin of their future child. But in any case, medical issues are addressed in general terms, especially during discussions on special needs children, or on the most common medical problems encountered among adopted children.

⁵ In this regard, in federal States the organisation of these sessions often varies in relation to the jurisdiction.

B. Results for *individual* pre-adoption consultations

Brief overview

IF YES				
Number of replies	Availability of individual pre-adoption sessions	Conditions (organisation, duration, frequency, price, funding, compulsory nature, etc.)	Providers (who, training, etc.)	Content
32 replies for 20 countries	Yes: 24 No: 5 Varies in relation to the jurisdiction and/or the body in charge: 3	- compulsory in 9 cases - charged in 7 countries by this information must be interpreted in relation to the type of funding of the healthcare system in place in the country (see below) - variable frequency - lasts 1 to 2 hours	Generally paediatricians, sometimes accompanied by a nurse and/or with the participation of a psychologist or a psychiatrist.	Very varied content

Detailed summary

Individual pre-adoption consultations are available in most countries. These are only compulsory in 9 countries that replied to our questionnaire, but they are strongly recommended in almost all the others.

These consultations are organised in two ways:

- Consultations that are similar to medical consultations and are part of the standard healthcare system;
- Information sessions based on the collective session model, but which are individualised. In this case, the sessions are often funded by the State or a public organisation.

Sometimes the two models coexist, as in France, where adoption-related medical consultations are very specific and can take place at various stages of the procedure.

Financial coverage of these consultations depends on the funding structure of the healthcare system in place in the country. In this regard, we can distinguish countries known as 'Beveridgian' with tax-based funding (i.e. Great Britain and Spain) and countries known as 'Bismarckian' with a social insurance-based structure (i.e. France and Germany)⁶. In the case of an individual medical consultation, its payment comes under the same rules as a practitioner's other consultations. Concerning collective consultations on the other hand, their cost is borne either by the applicants or by a public or private organisation.

The content of individual consultations or sessions is however extremely varied and covers one, several or all of the following subjects:

⁶ Social welfare systems in Europe are of two different origins. In 'Beveridgian' systems (from the name of Lord Beveridge, founder of the British model), rights to basic social welfare protection are given to all citizens and are funded by taxes. 'Bismarckian' systems (from the model of the German system, founded by Chancellor Bismarck) are based on social insurance and funded by employee contributions, with an extension to those who are eligible. This health insurance cover is extended to other persons irrespective of their professional status.

- General information on the country of adoption chosen by the applicants as well as its health environment. Often, this is a repeat of the information given during the collective pre-adoption sessions while at the same time it is individualised.
- Preparation of and psychological support for the parents in welcoming the child, including in looking after its medical care. In this respect, the practice of the Swiss Adoption Accredited Body *Terre des Hommes* is interesting: the session leaders deal with the profile of the child with the help of fact sheets presenting the real situation of children with their photograph (which is not that of the child being described), a description of the health and developmental problems, necessary treatment, prospects, etc. The applicants therefore come face to face with the reality of adoptable children and can tackle the issue of their openness in relation to a health problem with the session leader.
- Information such as travel advice (vaccinations, hygiene tips, etc.)
- Help in deciphering the child's medical records after matching.

This information is generally given by a paediatrician, sometimes accompanied by a nurse and/or with the participation of a psychologist and/or a psychiatrist. In three cases, these consultations are carried out by persons with mainly psychosocial training, with the possibility of applicants being referred to a specialised health service for the medical understanding of the child's file, if necessary.

In all cases, these consultations are generally considered as a complement to the first collective information sessions. The two phases form a progressive and coherent approach.

C. Analysis of results for pre-adoption support as a whole

Observation 1: General information sessions exist in several countries, but their form is quite varied. Health and medical information is generally touched upon in a global context and there are no collective sessions specifically dedicated to this single subject.

Proposal 1: This first stage should be compulsory for anyone wishing to undergo the adoption process. Sessions should remain quite general and should, for the medical aspect, deal with issues such as the most common health problems among adopted children, special needs children, the health reality in the countries of origin, etc. At this stage, it concerns presenting the realities of adoption to applicants and breaking away from existing myths, dreams, stereotypes or even fantasies, so that the adoption project becomes feasible and realistic.

Observation 2: Individual sessions also exist in numerous countries. They are either organised as individual information sessions, or in the form of medical consultations. Sometimes the two models coexist, as in France. In any case, this individualised stage constitutes an extension of the first general informative phase by proposing more targeted and personalised information.

Proposal 2: Whatever form is chosen, this stage should also be compulsory as it allows further support for and preparation of the adoption applicants. It also means that they receive personalised attention and are given the opportunity to express their possible fears and concerns in relation to certain types of medical problems, and to receive answers on this subject, especially concerning the treatment possibilities, the type of care, the prospects, etc. These sessions or consultations also allow session leaders to work with the adoption applicants in order to clarify or if necessary adapt their adoption project.

Observation 3: Deciphering of the medical records is often proposed at the time of matching proposal.

Proposal 3: Strict ethics must be respected to ensure that this practice is not perceived as help in selecting the 'best child possible'. This point is all the more important since, in principle, if the procedure is correctly carried out, the profile of the child that the applicants are ready to adopt is referred to beforehand, including their 'openness' concerning the health problems that the child may have. The child proposed should therefore correspond to their expectations, thus reducing

refusal rates⁷. Under these conditions, the deciphering of the medical records should only ensure that the child corresponds well to what the applicants have been prepared for. The records should allow the future parents to clearly understand the medical background of the child being proposed to them, his or her prospects and possible treatments to be expected.

This is a crucial moment in the adoption process, which must imperatively be managed and accompanied by professionals to allow parents to measure up the situation and to determine if they are capable of looking after this child with all the therapeutic constraints (among others) that will then arise. Proposing a child for adoption is a very emotional moment, particularly if it has been preceded by a long wait. The applicants find themselves in a situation where contradictory feelings can emerge: the desire to welcome the child can become very strong and even obscure future difficulties, while at the same time, stress can lead to a certain panic, for the same reasons. It is therefore essential that the applicants benefit from appropriate support and that there is cooperation between the country of origin and the receiving country. The time taken to become aware of the complexity of the situation and to anticipate practical logistic aspects is time saved for the child's integration and this investment also helps to limit risks of failure. One can thus easily imagine that conversely, in the case of an individual adoption in a country outside the Hague Convention, the lack of such support could subsequently create significant problems.

Observation 4: Assessments of these pre-adoption sessions are extremely rare or even non-existent.

Proposal 4: Assessment of this pre-adoption support should be implemented by an independent body in order to ensure that the sessions respond to people's needs.

⁷ This issue nevertheless remains extremely sensitive and very few figures are available. Among the responses that we received, only one German AAB announced a refusal rate of approximately 20%.

4. MEDICAL SUPPORT FOR ADOPTION APPLICANTS AND THE CHILD IN THE COUNTRY OF ORIGIN

A. Results

Brief overview

Number of replies	Do applicants benefit from medical support in the country of origin?	IF YES		
		Methods used to carry out the child's medical check-up	Providers	Content of the medical records
24 replies for 16 countries	Yes: 4 No: 9 Variable: 11	Extremely variable	Orphanage doctor: 4 AAB doctor: 4 Local doctor: 1 Remote assistance: 3 Other (Central Authority, embassy, etc.): 3 Sometimes several of these solutions are proposed in relation to the AAB, the region, etc.	Sufficient: 5 Insufficient: 4 Variable: 7

Detailed summary

Medical support of adoption applicants and of the child in the country of origin is comprised of two main elements: the compilation of the child's health records, then support and advice to adoption applicants concerning the child's health when they are in the country of origin, if the medical records are incomplete or if parents require clarifications or in-depth medical advice.

The above table shows to what extent medical follow-up remains doubtful and incomplete. On the one hand, several replies indicate that the child's medical records are, in general, insufficient to allow adoption applicants to make a decision with full knowledge of the facts. Numerous authorities also highlight the fact that the quality of the file varies greatly above all in relation to the child's country of origin or the circumstances in which he or she entered the alternative care system. For example, if the child is born of unknown parents and was abandoned, his or her medical background is obviously much more difficult to define than if the child had been given up for adoption by the original mother. Certain discussion partners, mainly AABs, consider however that the medical files that they receive are sufficiently documented to allow applicants to make an enlightened choice.

On the other hand, concerning support and advice for adoption applicants when they are in the country of origin, a form of follow-up by a doctor present in this country is regularly proposed in 4 out of 16 countries. More than one third do not propose any follow-up of this kind, and in almost half of cases, this support varies especially in relation to the country of origin and the body looking after the applicants.

Furthermore, when this support is organised, it is extremely varied and the future parents generally assume the costs. In some cases, the child is brought to a private local paediatrician. In other cases, the applicants are followed by a doctor from the AAB, as proposed for example by *Eltern für Africa*, in Germany, which has a medical correspondent in the country of origin. Such follow-up is not proposed by all AABs however. Sometimes the applicants and the child can be referred to a local authority correspondent.

B. Analysis of results

Observation 1: This stage is the weak point in many countries, even when the adoption is carried out through an AAB. In the country of origin, adoption applicants are often left to their own devices regarding medical aspects, even though more often than not the child's medical records are incomplete or vague and additional examinations need to be carried out.

Proposal 1: In order to improve this support of applicants and of children during the adoption procedure, it would be appropriate to avoid individual adoptions that are badly (or not at all) monitored, insofar as is possible. If individual adoptions nonetheless remain authorised, applicants should have access to a list of doctors that they can turn to if necessary. This list could be made available by the Central Authority or embassies. For their part, AABs should systematically identify one or several trustworthy local medical partners. Remote medical assistance should be avoided as much as possible to favour direct on-the-spot support.

Here once again, support and advice for applicants, as well as the possible additional examinations of the child should not be carried out with the objective of helping applicants to select a child. The acceptance or refusal of a proposed child comes beforehand, before the actual meeting. This follow-up should however meet any concerns that the future parents might have when they are in the country and actually faced with the reality of the adoption. Lastly, it should help to ensure the best care possible for the child, to avoid overlooking a serious problem and to anticipate the organisation of more complex care if necessary.

Observation 2: The issue of medical charges and their payment remains hazy and relatively unclear. What do these medical costs actually cover? What do the costs relative to the compilation of the child's medical records actually pertain to? How are these costs presented/detailed in the total invoice submitted to adoption applicants? Although this study has not dealt with these issues, experience acquired during ISS/IRC missions in the countries of origin nevertheless indicate huge differences between the country of origin and intermediaries in the way of invoicing and justifying different costs that are more or less linked to the health aspects of the adoption. Whether it concerns medical tests, various treatments, remuneration of medical personnel or nannies, or even categories that are vaguer such as massages given to the child, the imagination of some providers is boundless when it comes to increasing the bill. In any case, these costs are borne by the adoptive parents either through the fixed rate set by the AAB, or by directly paying the fees of local health professionals. If no official rate is set, rough financial estimations will maintain an unregulated market, thus leading to misuse.

Proposal 2: It is essential that a quality framework help applicants (and the receiving countries) to determine what is justified from what is not. Ideally, the country of origin should establish a list of acceptable costs and set official rates. Medical costs and what they include should also be detailed in the invoice submitted to adoption applicants. It would also be appropriate that the international community agree on what exactly is covered in the costs borne by the adoption applicants. The draft Guide to Good Practice no. 2 on Accreditation and Adoption Accredited Bodies by the Hague Convention could for example, include a section on medical costs in the breakdown of costs required of adoption applicants. Health monitoring should also ensure the quality of these different services.

Observation 3: The content of medical reports is heterogeneous and depends on the 'medical culture' of the country and of the practice of carers. Even though the WHO International Classification of Diseases harmonises medical terminology, its interpretation differs from one country to another. This situation is delicate as the medical assessment of the child's health file, and then the way this is communicated to the adoptive parents is based on this very file. Misunderstandings and ambiguities can appear, jeopardising the very process of adoption. In addition, particular attention must be paid to the veracity of the medical records, particularly when a system limits international adoption to special needs children. ISS/IRC missions have shown that in

several countries of origin, some children were declared to be sick or handicapped in an abusive manner, in order to facilitate their adoption abroad.

Proposal 3: In order to limit these risks and make the work of practitioners concerning these medical records more harmonious, access to reliable health data that are understandable by all is necessary. Exchange of good practices between health professionals in the country of origin and the receiving country could be developed by taking as a base the medical report recommended by the Hague Convention guide. Guidelines could be drafted to supervise the medical care of children adopted through AABs, from the moment of their matching until their arrival in the receiving country.

5. POST-ADOPTION SUPPORT

A. Results for consultations on the child's arrival

Brief overview

Number of replies	Are there medical consultations available on the child's arrival?	IF YES		
		Conditions (compulsory nature, funding, price, duration, frequency, etc.)	Providers (who, training, link with the attending physician, etc.)	Assessment
27 replies for 15 countries	Yes: 20 No: 7	- Compulsory only for certain Belgian and Australian jurisdictions - Price and funding according to the healthcare system in place in the country - Generally lasts one hour - Variable frequency	Paediatrician: 4 Paediatrician in conjunction with a psychologist: 6 Various medical personnel: 3	No assessment except in Belgium

Detailed summary

A large majority of receiving countries provide medical consultations in the weeks following the child's arrival, but this is neither systematic nor compulsory. Only some jurisdictions in Australia and in Belgium impose this.

In addition, few countries seem to provide specialised medical consultations in the field of adoption. According to information that we received, only certain French, Australian, Belgian and Czech authorities have implemented them, even though the replies received are sometimes too vague to confirm this last point. In any case, if this specialisation exists, it is developed by the practice and in an empirical manner. To our knowledge, there is no recognised academic training given in the field of adoption, but interesting initiatives have been tried in order to improve the training of medical personnel. Thus, in Australia, a system allows specialists to transmit relevant adoption information to general practitioners and general paediatricians. In Spain, a guide has been published for paediatricians and health professionals to help them in their daily practice when they have to care for adopted children.

From a practical point of view, these consultations generally take place during the first weeks, or even the first months following the child's arrival in the receiving country. They last for one hour on average, are of variable frequency, take place in a hospital environment or in a private practice and are given by medical personnel, generally a paediatrician. This paediatrician often works in conjunction with a psychologist. This is the case, for example, with *Consultations d'Orientation et de Conseil en Adoption* (COCA – Intercountry Adoption Counselling and Guidance Services), which have been created in several French regions and which provide paediatric, paedopsychiatry or parasitology consultations specialised in adoption. Following the example of other countries, these consultations are funded like any other medical consultation, according to the social welfare system in place in the country, and on the whole do not benefit from any specific resources.

Unfortunately, assessments of these consultations are extremely rare. It is therefore difficult to give them a qualitative appraisal. Only a few replies mentioned a form of assessment: French-speaking Belgium for consultations that are co-funded by the Central Authority, Dutch-speaking Belgium for consultations organised by certain AABs and the *Agence Française d'Adoption* (French Adoption

Agency) through a coordinated study by the Intercountry Adoption Counselling and Guidance Services (COCA) for the 2007-2008 period.

B. Results for post-adoption consultations

Brief overview:

IF YES				
Number of replies	Are there post-adoption medical consultations available?	Conditions (compulsory nature, funding, price, duration, frequency, etc.)	Providers (who, training, link with the attending physician, etc.)	Assessment
28 replies for 16 countries	Yes: 21 No: 7	- Compulsory: 1 - Price and funding according to the healthcare system in place in the country - Generally lasts about 1 hour - Variable frequency	Paediatrician: 8 Paediatrician in conjunction with a psychologist: 10 Various medical personnel: 3	No assessment except in Belgium

Detailed summary

Given that post-adoption medical follow-up constitutes an extension or development of health care provision for the duration of consultations established on the child's arrival, the replies obtained for the two stages are logically very similar. Some form of post-adoption follow-up is organised in 21 countries out of 28. This support is however, almost never compulsory, even if though it is strongly recommended in all cases.

As the providers are generally the same as those on the child's arrival, i.e. a paediatrician working in conjunction with a psychologist, the consultations are, once again, rarely specialised in the field of adoption.

The follow-up is generally in the form of consultations lasting between thirty minutes and one hour and a half, and are as frequent as is necessary. They take place either at the hospital or in a private practice and their content concerns aspects that are both clinical and psychological.

Sometimes, just as in Switzerland⁸, a form of follow-up of the medical evolution and/or the health of the child is provided during post-adoption follow-up visits at home that the Central Authority must

⁸ Federal law relative to the Hague Adoption Convention and the Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption:

Art. 17 Guardianship in the case of adoption before the transfer.

¹ If the child was adopted before his/her transfer to Switzerland and if the adoption can be recognised there, the juvenile court immediately appoints a Guardian Ad Litem (GAL).

² The GAL helps the adoptive parents by giving advice and support in looking after the child. When the adoption in the State of origin has not broken the pre-existing link of filiation with the biological parents, he helps the adoptive parents so wishing to seek adoption under Swiss law.

³ The GAL drafts a report on the development of the adoption link for the juvenile court, one year after his appointment at the latest.

⁴ Guardianship automatically ends 18 months after communication of the child's arrival, at the latest, or, if there is no communication, after the placement.

Art. 18 Guardianship in the case of adoption after the transfer.

If the child is adopted only after the transfer to Switzerland, or if the foreign adoption cannot be recognised in Switzerland, the juvenile court appoints a guardian for the child for the duration of the placement.

provide to the family during a given period. For example, the social worker of the Central Authority of the Jura canton indicates that she carries out at least three visits during the first year, during which she asks questions about the health of the adopted child (general health, physical, motor and psycho-affective development, sleeping patterns, etc.) and, in case of difficulties, proposes possible resolution strategies.

Here again, no specific funding is foreseen for these post-adoption consultations and their assessment is also almost non-existent.

C. Analysis of results for post-adoption medical follow-up as a whole

Observation 1: A form of post-adoption follow-up exists in most countries, but it is extremely varied and rarely compulsory.

Proposal 1: A medical check-up should be carried out quickly and systematically after the child's arrival in order to eliminate any possible misunderstandings, respond to urgent problems and adapt care if necessary. This first medical visit should be followed by other consultations in varying frequency and in relation to needs, in order to follow the evolution and the development of the child and to support the family.

Observation 2: After his/her arrival in the adoptive family, the child is quickly integrated into the new environment. Very few specialised consultations are provided. However, the adopted child has specificities, as does the adoptive family and therefore they must be given special attention.

Proposal 2: In order to respond to the specificities of the adopted child, it is important that specialists are involved in his or her care, which should be multidisciplinary in order to provide the child and the family with global care. Such provision could be expensive, difficult and long to implement. It would therefore seem more effective to draw on the existing resources in order to organise real multidisciplinary networks of professionals specialised in adoption, i.e. psychologists, paedopsychiatrists, social workers, paediatricians and other doctors. The latter could thus serve as a point of contact that any person treating an adopted child - including general practitioners and paediatricians who are not specialised in adoption - could refer to if necessary.

This system would streamline resources while at the same time offering professional, specialised, multidisciplinary, flexible and nearby care. As this system commits the attending physician mainly, with the occasional and targeted support of specialists, it would also mean that the child could be followed-up in the long term. The implementation of such networks could also be a means to step-up the training of medical personnel in adoption issues through memoranda, conferences, seminars or even more complete training modules that would be given occasionally or regularly by specialists from the network. These training courses could also be enhanced by drafting a guide on the healthcare of adopted children aimed at supporting paediatricians and other health professionals, as is already the case in Spain.

6. CONCLUSIONS

The results of this study show that pre-adoption preparation and support for parents is quite widespread in receiving countries. Even though they are organised differently from one country to another, collective and/or individual sessions and/or consultations dealing with issues linked to the health of adopted children are provided in most countries and are compulsory in a number of cases. The medical support of children and adoption applicants after matching in the country of origin, is however more unpredictable. At this stage, the families are often left to their own devices concerning the medical aspects of adoption, even if they are supported by an AAB. Post-adoption follow-up, including on the child's arrival, is also quite limited. Although some form of medical follow-up exists in most countries, this is almost never compulsory and still not specialised enough in the field of adoption.

It is true that the care of children and the support of adoption applicants have been greatly improved these past years in most countries. Nevertheless, in a context where intercountry adoption concerns more and more children with medical problems and where pathologies are more and more serious, additional efforts need to be made in order to better integrate the issue of children's health at every level, whether before, during or after the adoption. Each country must commit at its own level by making provisions for pre- and post-adoption consultations in the law⁹. Inter-State cooperation as understood in the 1993 Hague Convention, i.e. collaboration between various intervening parties involved in adoption in order to implement the Convention, should also be improved for issues linked to the health of adoptees. This study shows that, unfortunately, at the present time, the application of this principle is often in the early stages, or even disorganised. The processes of information exchange concerning the health of the child as well as the support of families relating to these issues should especially be improved. From this perspective, the Dominican Republic for example, is making particular efforts by offering adoption applicants the possibility of having a telephone conversation with the Central Authority if they wish to obtain clarifications on the records of the child that has been proposed to them. In addition, at the time of the proposal, telephone exchanges are regularly held with the adoption applicants' doctor to discuss the diagnosis.

Adoption professionals throughout the world could also reflect on the opportunity of developing cooperation between the World Health Organization (WHO) and States on specific "child health" programmes, in order to improve health monitoring in the countries concerned. Insofar as adoption allows access to this relevant information concerning the health of children in the countries of origin, this could contribute to the adaptation of humanitarian aid programmes in the countries of origin concerned. These programmes should of course be carried out by professionals who are specialised in the issues of cooperation and be totally distinct from the adoption process.

Lastly, this study clearly highlighted the need to further structure the health/adoption relationship, by paying particular attention to the phase that begins with matching and ends with the issuance of approval, which is currently the least supervised phase from a medical point of view. It is however at this very moment that the availability of complete medical information is vital. That is why a sample good practice diagram is proposed in the annex, in order to support the various persons involved in these proceedings.

Since the Hague Convention, intercountry adoption has made amazing progress in the way in which it is managed and supervised. But this international text, fundamental though it may be, is a legal text. It is now up to the medical and social world to make the necessary efforts to ensure further progress that is in phase with the modern-day realities of such a special means of filiation.

⁹ The replies that we received indicated that sessions/consultations are almost always organised only in practice. Only Australia states that they are legally provided for in certain jurisdictions.

7. Annexes

A. The place of child health in the adoption process: a sample good practice diagram monitored by an AAB



¹⁰ Article 4 of the 1993 Hague Intercountry Adoption Convention and paragraph 324 of the Guide to Good Practice No. 1 on the Implementation and Operation of the 1993 Hague Intercountry Adoption Convention

¹¹ Annex 7-6 of the Guide to Good Practice No. 1 on the Implementation and Operation of the 1993 Hague Intercountry Adoption Convention

¹² Paragraph 357 of the Guide to Good Practice No. 1 on the Implementation and Operation of the 1993 Hague Intercountry Adoption Convention

B. List of persons or bodies who replied to the questionnaire

Armenia	Ministry of Labor and Social Affaires (CA)
Australia	Intercountry Adoption Branch (CA – compilation of replies)
Belgium	Ministère de la Communauté française de Belgique - Autorité centrale communautaire (CA French-speaking Belgium) Kind en Gezin (CA Flanders)
Brazil	CDJA – Comissão Estadual Judiciária de Adoção do Estado do Distrito Federal (CA of the Federal District)
Cyprus	Ministry of Labour and Social Insurance – Social Welfare Services (CA)
Czech Republic	Office for International Legal Protection of Children (CA)
Denmark	Department of family affairs (CA)
Dominican Republic	Central authority for intercountry adoptions
Ecuador	Consejo Nacional de la Niñez y Adolescencia (CA)
France	Agence Française de l'Adoption (French Adoption Agency) <i>Consultations d'Orientation et de Conseil en Adoption (COCA)</i> or Intercountry Adoption Counselling and Guidance Services - COCA, Pau, Dr Jean-Jacques Choulot -COCA, Marseille -COCA, Paris (Saint Vincent de Paul Hospital) Dr Frédéric Sorge Dr Fanny Cohen Herlem (consultant psychiatrist for ISS/IRC – compilation of replies)
Germany	Bundesamt für Justiz - Bundeszentralstelle für Auslandsadoptionen (CA) Zentrum für adoptionen (AAB) Eltern für Afrika (AAB) familie international frankfurt
Ireland	Child Care Directorate (ISS Correspondent)
Italy	Commissione per le adozioni internazionali (CA) Paediatric Institute of Salesi Hospital Grupo di lavoro nazionale per il bambino immigrato d'Ancona et Novara
Lithuania	Ministry of Social Security and Labour, Adoption Service (CA)
Monaco	Direction de l'Action Sanitaire et sociale (CA)

New Zealand	Ministry of Social Development, Department of Child, Youth and Family Services (CA and member of ISS as an Affiliated Bureau)
Philippines	Inter-country Adoption Board (CA)
Portugal	Departamento de Desenvolvimento Social, Unidade de Infância e Juventude, Sector da Adopção (CA)
Slovakia	Centre for the International Legal Protection of Children and Youth (CA)
Spain	Ministerio de Sanidad y Política Social, Dirección General de Política Social, de las Familias y la Infancia, Subdirección General de Infancia (CA)
Sweden	MIA – Swedish Intercountry Adoptions Authority (CA)
Switzerland	Autorité centrale d'adoption du canton de Bâle (central adoption authority of the Basel canton) Autorité centrale d'adoption du canton du Jura (central adoption authority of the Jura canton) Autorité centrale du canton de Lucerne (central authority of the Lucerne canton) Espace Adoption Fondation Terre des hommes – aide à l'enfance (AAB) Dr Isabelle Lammerant, PhD in Comparative Law, Adoption Specialist
Turkey	General Directorate of Social Services, Child Protection Agency (CA)