

THE HEALTH STATUS OF  
CHILDREN FROM INDIA ADOPTED  
IN OREGON

by

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A Thesis

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of

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November 4, 1926 to November 12, 1985  
He taught me to love learning,  
to always ask "why?"  
and not to believe everything I read.

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Who came home from India and  
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## TABLE OF CONTENTS

<u>Chapter</u>		<u>Page</u>
I	Introduction.....	1
	Review of the Literature.....	2
	Social and Political Background of Intercountry Adoptions.....	2
	Unavailability of Domestic Adoptions.....	3
	Availability of Foreign Children for Adoption.....	8
	Health Problems and Intercountry Adoption.....	14
	Adoptions from India.....	17
	The Health of Children Adopted from India.....	22
	Statement of the Problem.....	25
II	METHOD.....	28
	Subjects and Setting.....	28
	Design and Procedure.....	30
	Data Gathering Instrument.....	30
	Chart Review.....	31
	Questionnaire.....	31

<u>Chapter</u>	<u>Page</u>
III RESULTS AND DISCUSSION.....	34
Description of the Sample.....	34
Characteristics of Respondents and Families.....	34
Characteristics of Adopted Children.....	41
The Representativeness of the Sample.....	41
Health Status of Adopted Children...	48
What Parents Knew Prior to their Child's Arrival.....	48
Health on Arrival in Oregon....	55
Illnesses and Conditions Newly Diagnosed or Confirmed After "Coming Home".....	61
Are these Children Carriers of Diseases Endemic to India?.....	65
Tuberculosis.....	68
Hepatitis B.....	69
Salmonella.....	71
Problems Diagnosed After the Child "Came Home".....	74
Developmental Delays.....	74



<u>Chapter</u>	<u>Page</u>
What Unknowns Were the Most Frightening?.....	75
Worries About Future Problems..	76
Health Problems Becoming Evident as the Child Grows Older.....	77
Life Threatening Illnesses.....	77
Planning for the Arrival of a Child from India.....	79
Planning in Relation to Hepatitis B.....	79
Planning in Relation to Salmonella.....	81
Planning for Health Care.....	81
How Parents Have Dealt With These Problems.....	82
Case Examples of Sample Children....	84
Case #1.....	84
Case #2.....	85
Case #3.....	85
Case #4.....	86
Case #5.....	87
Case #6.....	88
Case #7.....	88

<u>Chapter</u>	<u>Page</u>
IV	
SUMMARY, CONCLUSIONS,	
RECOMMENDATIONS AND IMPLICATIONS	
FOR NURSING.....	91
Recommendations.....	105
Implications for Nursing.....	110
REFERENCES.....	112
APPENDICES	
A - Cover Letter.....	118
B - Chart Review Data Sheet.....	120
C - Questionnaire.....	122
D - Questionnaire Item Justification....	133
E - Raw Data for Questionnaire Items	
#5, 6, 7, 8, 13 and 15 .....	136
ABSTRACT.....	141

LIST OF TABLES

<u>Table</u>	<u>Page</u>
1 Immigrant Orphans Admitted to the United States from all Countries; Asia, the Caribbean, and Latin America..	11
2 Immigrant Orphans From India Admitted to the United States Since the Origin of IMH Calcutta.....	21
3 Characteristics of Respondents.....	36
4 Number of Children in Study Families....	37
5 Number of Adoptions by Families in Study	39
6 Children Adopted from Other Countries by Families in Study.....	40
7 When the Sample Children "Came Home" to Oregon.....	42
8 Characteristics of Children in Study....	43
9 Adoptive Patterns of Oregon Families Adopting Children From IMH India Through PLAN, Inc.....	45
10 Health Problems Children Experienced in India as Reported by their Parents.	53
11 Treatments Children Received in India as Reported by their Parents.....	54

<u>Table</u>	<u>Page</u>
12 Health Problems and Illnesses of Sample Children as Reported "After Coming Home".....	64
13 Children Reported by their Parents as Arriving in Oregon With Infections Native to India.....	66
14 Infections and Illnesses Sample Children Were Tested for Within One Year of "Coming Home".....	67
15 Use of Existing Groups for Information and Support.....	80

LIST OF FIGURES

<u>Figure</u>		<u>Page</u>
1	Intercountry Adoptions in the United States 1973 through 1983.....	10
2	Boys: Arrival Weight by Age.....	57
3	Girls: Arrival Weight by Age.....	58
4	Boys: Arrival Length by Age.....	59
5	Girls: Arrival Length by Age.....	60

## CHAPTER I

### INTRODUCTION

The phenomenon of intercountry adoptions is recent, occurring on a large scale only since World War II. During the late 1940s, most foreign children who were adopted came from Europe. In the 1950s and 1960s, the source of adoptable children shifted from Europe to Asia. In the 1970s and until the present, most intercountry adoptions have been from the less developed countries of Asia and Latin America. Such adoptions entail issues somewhat different from those evidenced in domestic adoptions. Thus, many authors have discussed the cultural adjustment of these children, their bonding, and the effects of transracial adoption on the family and child. Few have discussed the health condition of these children on arrival, or dormant disorders emerging at a later date. Therefore, little information is available to parents by which they might anticipate, circumvent, or cope with these health problems.

In that specific diseases may be endemic to certain regions, but not to others, the medical needs of children from different lands may differ. Hence, a separate determination is needed of the types of

disorders encountered in children from each country. The present study was undertaken to expand our knowledge regarding the health condition of one group of adopted children, namely, children adopted from India. This study will also document the ways in which the adopting parents have attempted to cope with these health problems.

### Review of the Literature

This review of the literature will be organized around three topics. First, the social, political, demographic and other factors responsible for the rise of intercountry adoptions will be considered. Second, the literature on health problems attending intercountry adoptions will be surveyed. Third, the history of the adoption by Americans of children from India will be presented, together with such information as exists on their health status.

### Social and Political Background of Intercountry

#### Adoptions

The rise in intercountry adoptions in the United States over the past forty years may be attributed to social, political, and demographic changes in the United States, and to conditions and changes in the countries from which children are adopted. One very

important domestic factor has been the decline in the number of American babies available and suitable for adoption. Correspondingly, an important factor in the developing countries from which these children come is the large number of children who are orphaned, abandoned, or otherwise lacking family ties. The following review provides a sketch of historical events and conditions leading to the availability of these children for adoption by Americans. Also considered are the legal and political policies of the United States and of the various developing countries regarding emigration, immigration and adoption which determine the possibility and frequency of intercountry adoptions.

#### Unavailability of Domestic Adoptions.

Historically, in the United States children became free for adoption as a result of parental death or an illegitimate birth. However, circumstances in this country have changed. With a decrease in the mortality rate of adults in the United States, few children are orphaned by the death of both parents (Statistical Abstract of the United States, 1985). Today, children are more likely to become available for adoption through termination of parental rights either voluntarily or by court order (Kadushin, 1974).



The number of illegitimate children released for adoption has also declined markedly since the early 1970s. This decline is the result of widespread sex education, easy access to contraceptives, and legalized abortion (Pilotti, 1985). It is also attributable to a change in societal norms. Until the 1970s many illegitimate infants were given up for adoption by their birth mothers because of the stigma attached to single parenthood in our society. Raising and providing for a child as a single parent was a difficult, and almost insurmountable task. Since the advent of the "liberated female" it has been socially more acceptable and financially more feasible for single mothers to keep their illegitimate babies. Consequently the number of white infants available for adoption in this country has declined (Bonham, 1977).

How many children are currently available for adoption in the United States? Accurate statistics are virtually nonexistent since there is no uniform method for documenting adoption status. The best estimate is 100,000, according to Costin (1979). These children are wards of the individual states and are "adrift" (Emlen, 1976) in the foster care system of this country. Many enter the system at an early

age, and remain in foster homes for many years, awaiting legal termination of their parents' rights to them. When these children finally become free for adoption, often their age is a handicap. In America, most prospective parents prefer infants. Additionally, they may fear that these older children have become emotionally disturbed because of their destabilizing experiences in foster care. The physically handicapped child or child of mixed race is considered to be especially at risk (Kadushin, 1974). It is this prejudice against older children that accounts for the rapidly growing number of the so called "hard to place" children among American children available for adoption (Kadushin, 1974).

Because of these circumstances, the number of white American infants available for adoption has declined, and the rise in adoptions noted in the 1950s and 1960s was reversed in the 1970s. But as the number of white adoptions steadily dropped, other adoptions continued to rise (Bonham, 1977). Transracial adoptions tripled between 1968 and 1971 (Kadushin 1974). At their peak in 1971, transracial adoptions numbered 2,574, most of which were domestic. In 1972 such adoptions declined 40% and

between 1972 and 1973 they decreased 30% (Simon, 1984). This reversal in the trend for white American couples to adopt domestically born non-white children may be traced to events at the 1972 Conference of the National Association of Black Social Workers. It was the consensus of that Conference that the practice of placing black babies in white adoptive homes constituted racial genocide.

As a result of the Association's pressures, adoption placement practice in the United States changed. The 1973 Standards for Adoption of the Child Welfare League of America (CWLA) indicated "a preference" for placing a child with parents of its own racial background whenever possible (Gill & Jackson, 1983).

With this in mind, Simon and Alstein (1977) predicted that transracial adoption as a practice would cease. In 1975, out of 104,888 adoptions only 830, or 0.8%, were transracial (Simon & Alstein 1981). However, by 1978 the CWLA had relaxed this rule, stating that if all other resources had been exhausted, a child might be placed with a family of different race. By 1984, adoption trends again changed, with several hundred transracial adoptions

being completed every year (Simon, 1984). Despite ongoing controversy over transracial and intercountry adoptions, it would seem that a transracial adoption is preferable to placement in a foster home (McRoy, & Zurcher, 1983; Kadushin, 1974), or in no home, as in the case of children available for intercountry adoptions.

In summary, since 1975 it has been estimated that there has been a significant drop in domestic adoptions in America (Bonham, 1977). This has not been because of a decrease in the demand but rather because of a decline in the number of American children available for adoption. A decrease in the number of unwanted births because of the legalization of abortion, widespread birth control, and more relaxed social values in Western Europe and the United States resulted in a short supply of domestic babies available for adoption since the start of the 1970s (International Concerns Committee, 1986; Pilotti, 1985; Sherwen, Smith & Cueman, 1984). Concomitantly the demand for adoptable babies has reached peak levels (Pilotti, 1985). Pilotti is of the opinion that the demand will probably continue to increase through the 1980s since that will be the time for the

"baby boom" generation to start or add to their families of procreation. Because of the scarcity of infants available for adoption domestically some Americans are looking to foreign countries for adoptions.

Availability of Foreign Children for Adoption. In the aftermath of World War II, large numbers of orphaned and abandoned children were placed in permanent adoptive homes in various European countries and in the United States. By 1950 European adoptions slowed, and after 1955 Asian countries became the main source of intercountry adoptions. Thus, in the wake of the Korean War the main source of children for intercountry adoptions were the orphaned, racially mixed, or unwanted children of Korea. "In that region, as in others of the so-called Third World, the combination of poverty, overpopulation, and in some cases, war, has yielded scores of abandoned children who cannot be adequately protected in their home lands" (Pilotti, 1985, p.26). With the cooperation of the Korean government, and following the Refugee Relief Act of 1953 various religious organizations, such as the Holt International Children's Services brought hundreds of immigrant children to the United

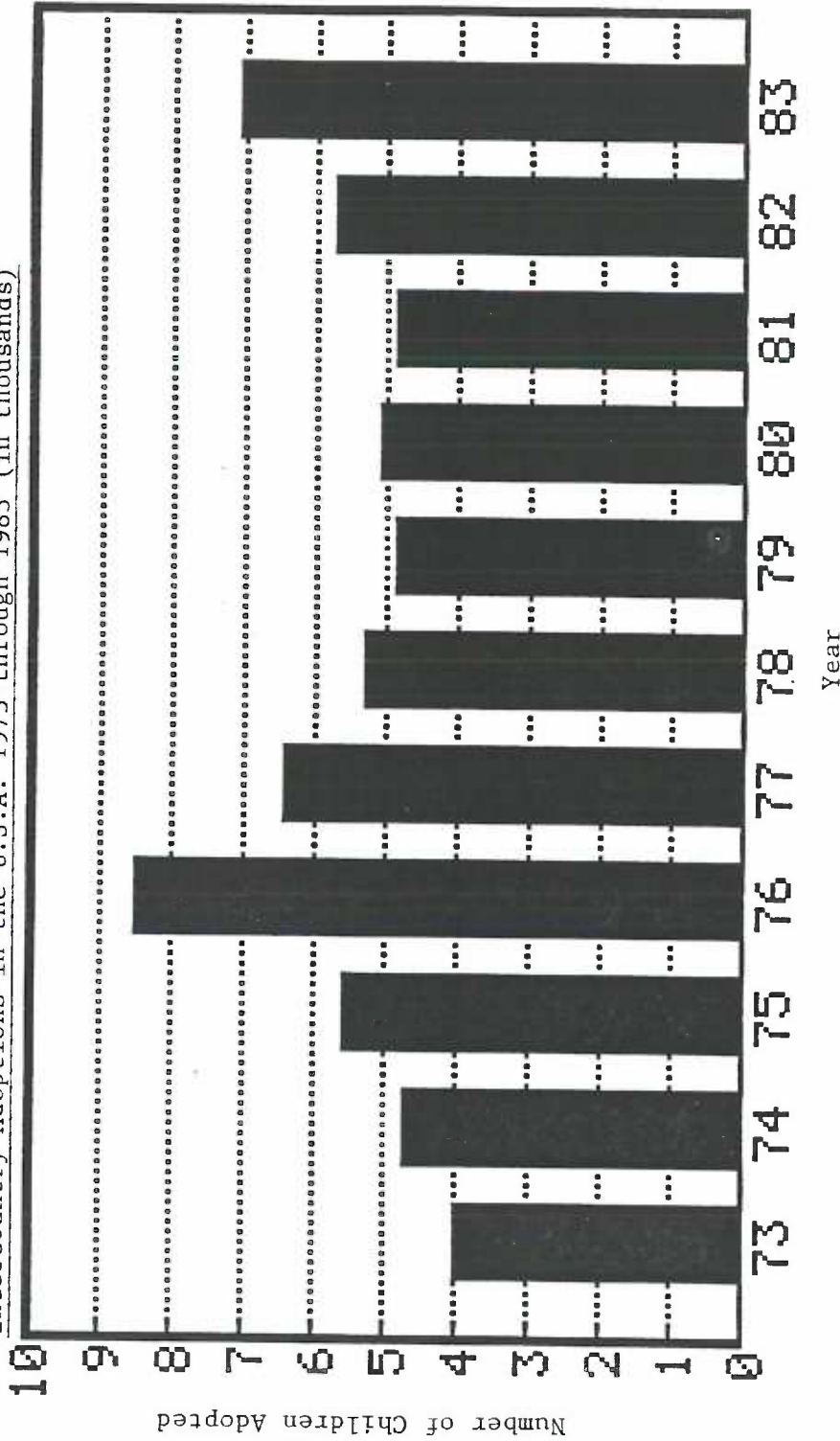
States for adoption. Adoption of Korean children by Americans has continued steadily since the Korean conflict until the present.

In 1970, there were 1428 immigrant orphans, comprising 0.9% of all American adoptions, and in 1975, over 4,000, comprising 2.7% (Bonham 1977). Most of these orphans were from Asia. According to the Immigration and Naturalization Service (INS), Asian adoptions rose steadily during the early 1970s (see Figure 1). The sudden increase in intercountry adoptions in 1975 (up to 4221 from 2976 in 1973) may be attributed to the rise in the number of Asian adoptions, with the 1975 "Operation Baby Lift" from Viet Nam to the United States. The Saigon Government reacted by developing a new policy ending the emigration of these children. Subsequently, the number of immigrant orphans in the United States declined sharply.

With Viet Nam cut off as a supplier of adoptable children, prospective parents from developed nations turned to other developing countries of Asia, including India, and to Latin American and Caribbean countries (Resnick, 1984). After 1978, intercountry adoptions again increased (see Table 1). Of the

Figure 1

Intercountry Adoptions in the U.S.A. 1973 through 1983 (in thousands)



Note: Data obtained from the United States Immigration and Naturalization Service (INS) Annual Reports 1973 through 1983. Total numbers for 1976 include an additional 1998 orphans from the transition quarter of 1976 when INS changed their fiscal year.

Table 1  
Immigrant Orphans Admitted to the United States from all Countries;  
Asia, the Caribbean, and Latin America

Region/Country of Origin	1978	1979	1980	1981	1982	1983
All countries	5315	4864	5139	4868	5749	7127
Asia	3759	3139	3434	3216	4189	5334
Korea	3045	2406	2683	2444	3254	4412
Viet Nam	61	1	1	2	6	3
India	149	231	299	314	409	409
Other	504	501	451	456	520	510
Caribbean	--	56	89	82	103	86
Latin America	--	1298	1256	1290	1260	1472

Note: Data were obtained from the 1982 and 1983 U.S. Immigration and Naturalization Service (INS) Annual Reports. Data are not available for 1978 for Caribbean and Latin American Countries.



immigrant orphans from Asia, the majority continued to arrive from Korea, and a small but increasing number derived from India (see Table 1). Statistics from the INS (1982) indicate a total of 1850 immigrant orphans from India were adopted in the United States between 1978 and 1983. The INS also reports that 5,323 orphans were adopted from abroad from 1978 through 1982, and an additional 20,849 immigration orphans were admitted to the United States for adoption. Most were from Third World countries.

It should be noted that these children had usually been released for adoption because of parental poverty, or they had been abandoned because they were illegitimate. It was probably not because of lack of love that these parents gave up their children, but because poverty and social values often made it difficult to keep and care for their children (Bolles, 1984). These developing countries have not experienced the changes in social norms that we have experienced in the United States over the past fifteen years. Birth control is not widely approved there, and illegitimacy is stigmatized. These societal differences help to explain the rise in incidence of intercountry adoption (Bolles, 1984; Pilotti, 1985; ICC, 1986).

The advantage of intercountry adoptions over domestic adoptions lies mainly in the large supply of infants available. Then too, older children from other countries may not be as "hard to place" as older American children because of the presumption that they may be freer of emotional disturbances (Sherwen et al., 1984; ICC, 1986) since they have not experienced the deleterious effects of our foster care system (Bolles, 1984). Finally, despite the paper work foreign adoptions entail, they are often completed in less time than are domestic adoptions. Most intercountry adoptions take less than two years (Bolles, 1984) from start to finish.

However, foreign adoptions are not without problems. There are health risks inherent in this type of adoption. For example, there are diseases endemic to the areas these children come from. In addition, these children may suffer from the effects of poor nutrition, prenatally, postnatally and as growing children. It should also be noted that poverty, poor nutrition, and illegitimacy have grave effects on prenatal growth and often result in premature birth, which has its own health risks and adverse effects on development (Chandrasekhar, 1972).

### Health Problems and Intercountry Adoption

Little has been published related to the health status of children adopted from other countries, or more specifically, Third World countries. Since the 1980's a number of "How to adopt" publications and guides have included chapters or sections on intercountry or foreign adoptions (Martin, 1980; Nelson-Erichsen and Erichsen, 1981; Plumez, 1982; Bolles, 1984). These publications, along with others dealing exclusively with intercountry adoption (Winick, Meyer & Harris, 1975; ICC, 1986) have dealt mainly with legal aspects, and adoption red tape. In discussing government health documents, they allude to the health risk inherent in these adoptions and the differences in health care delivery between the United States and these other countries. However, health problems are not described in detail, nor their extent estimated.

Nelson-Erichsen and Erichsen (1981) devote a section of their book to "medical emergencies and problems" in which they describe the three medical classes identified by the U.S. consular service. Each child must be examined by the U.S. Embassy doctor before an immigrant orphan's visa can be approved. "Class A" orphans may be excluded from obtaining a

visa because of "severe handicaps", "class B" orphans may also be denied a visa if a handicapping condition may threaten their ever becoming self supporting or if they give evidence of a disease such as "inactive tuberculosis". Potential adoptive parents may apply for a "waiver" to allow such a child to enter the country as an immigrant orphan, but not all waivers applied for are granted. A "class C" orphan is healthy and will be granted a visa without a waiver.

Plumez (1982) mentions that INS requires a check for "mental retardation and major medical problems" before an immigration visa is granted. She reminds the reader that this does not guarantee a problem free baby. She adds that some people seek intercountry adoptions from private parties on the assumption that such children will have fewer health problems than children from orphanages. Contrariwise, Martin (1980) claims that an adoption agency is more likely to provide information regarding known medical problems than is a private party. Martin acknowledges the possibility of poor prenatal and postnatal nutrition and encourages parents to assume that any medical care received has been minimal.

"The Penguin Adoption Handbook" by Bolles (1984) also provides a chapter on intercountry adoptions. This author recommends that all children adopted from another country be seen by a pediatrician "within eight days of their arrival in the United States" (Bolles, 1984, p.123). Bolles warns that physicians may be alarmed by the health of the child in that what is normal for the child's country of origin may not be usual by U.S. standards. He cites low birth weight and parasitic infections as two examples.

In 1975, Winick et al. published a retrospective study on the effects of "malnutrition and environment enrichment by early adoption". It is one of the very few studies which concern the health status of children adopted from other countries, and is well known to adoptive parents of foreign children and to the agencies placing these children. Winick et al. studied a group of children adopted from Korea between 1958 and 1967 through Holt International Children's Services. All the children in this sample were placed in adoptive homes in the United States before the age of three, with the mean age at adoption being 18 months. The study reported that even the most severely malnourished children surpassed Korean norms

after nurturing in the American homes. The authors noted that the study did not include older malnourished children adopted in the United States from Korea. The long term effects of malnutrition on these children remain to be studied.

#### Adoptions from India

In 1978 Cherie Clark-Prakash traveled to India to work with Mother Theresa. It was here that she founded the International Mission of Hope Center (IMH) to begin caring for the many abandoned infants and young children in need of health care, food and homes. The infants are mostly products of pregnancies terminated during the third trimester via elective induction of labor with oxytocin. After delivery these infants are frequently left to die in alleys and gutters, without warmth or nutrition. The IMH Center rescues and cares for these children, along with term babies abandoned at hospitals soon after birth. The latter have been fed and kept warm in the hospitals, so they come to the IMH Center in better health than the oxytocin children. If these children were not cared for by the Center, and should they survive infancy, they would be placed in government run orphanages or prisons.

The IMH is a child welfare organization, and not an adoption agency. The Center began in a small apartment sized building where all but the sickest children were cared for. The latter were cared for in a nearby hospital where, unfortunately, the mortality rate was reported as almost 100% (Johnson, letter to physicians, no date, available at PLAN). By November, 1981, IMH had secured the funds to begin an intermediate level newborn intensive care nursery. With the implementation of this new level of care, staffing needs increased. The Center is now staffed by one full time pediatrician and four part time pediatricians from a nearby hospital. There are seven formally trained Indian nurses, and a ratio of at least one caregiver per two infants. These caregivers are specially trained by the Center. Infant feeding is accomplished by bottle or gavage. Intravenous fluids are available and given, if needed, via peripheral intravenous infusions. Antibiotics are available for infections either intramuscularly or intravenously. Whole blood transfusions as well as phototherapy can be used if needed. Mechanical ventilation is not an option, so apneic spells are treated with short term positive pressure with an Ambu

bag and mask. Supplemental oxygen is given for those with poor oxygenation. With these improvements, infant survival has increased from 37.9% in 1981 to 70.5% in 1982 (Johnson, letter to physicians).

By 1985, IMH had secured adoptive homes for 1300 Indian children in the United States (Clark-Prakash, 1985). These children were infants, toddlers, and older children. Many fell into the "special needs" category. Prior to 1985 the older children came to the IMH Center from West Bengal jails and government orphanages. Today, they also come to their adoptive homes from a Boys' Home in Bangalor (D. Lauber, personal communication, January 8, 1986).

American adoptions from India are greatly affected by the constantly changing political climate in India. Approval for adoptions seems to follow seemingly sporadic "quotas", that is, the number of children allowed to leave the country for adoption is never known ahead of time. Adoption approval relies greatly upon the personal philosophy of the presiding Indian judge. Despite the political unrest in India, increasing numbers of children arrived in the United States for adoption from 1978 through 1983. Then in 1984, according to PLAN, Inc. adoptions to the United



States nearly ceased because of government problems. Table 2 indicates the number of orphans admitted over this period.

On May 8, 1985, IMH was granted the newly required intercountry adoption license by the Government of India (Clark-Prakash, 1985). About that same time the Supreme Court of India ruled that any orphan held by any organization working with foreign adoptions must be kept in India for three months before being released for adoption in another country. This was an attempt to secure an adoptive home in India as a first choice. However, up to now Indian families have not shown much interest in adopting these children. At present, in the average month, the IMH works with approximately two Indian families interested in adopting available children (Clark-Prakash, 1985).

These changes in Indian law come at a time when the intake of orphaned and abandoned children at IMH is on the increase (Clark-Prakash 1985). These changes may significantly affect the number and nature of Indian adoption in the United States. The number of children emigrating from India will probably increase, after an initial lag time. The children adopted in the future will be older and will present different health problems.

Table 2

Immigrant Orphans From India Admitted to the United States Since the Origin of IMH Calcutta

Year	Number of Orphans Admitted for Adoption
1978	142
1979	214
1980	296
1981	299
1982	384
1983	388
1984	--
1985	--
1986	--
<b>Total</b>	<b>1723</b>

Note: Table adapted from the 1982 and 1983 U.S. Immigration and Naturalization (INS) Annual Reports.

No figures are available for 1984, 1985, 1986.

The Health of Children Adopted from India. The literature does not provide an accurate description of the health status of these children. What can American parents expect? How can they plan for the arrival of their child from another country? Would more information and preplanning ease the transition into family? Clearly there is a need for information sharing through publications such as the "Annual Report on Foreign Adoption" by the International Concerns Committee for Childrens (ICC) and "Today's Child-The Health Needs of IMH Infants" (vanGulden Wicker & Walker-Haavig, 1981). These publications provide a review of the medical problems that might be encountered by adopters of children from the International Mission of Hope in Calcutta, India. Within the adoption agencies parents who have adopted should share with families waiting to adopt, information on topics such as malnutrition, cerebral palsy, hepatitis B, and salmonella. Parents need access to more information than is available to them at present.

A few reports from physicians are available. The 1986 "Report on Foreign Adoption" (ICC, 1986) summarizes a presentation by Dr. Robert Bilenker on

"medical and developmental inconveniences of adopted foreign children" (p.20). Here potential inconveniences, and both short term and long term health problems are reviewed. "Inconveniences" listed are "undernutrition", differences in growth and development, and the lack of medical records. Short term health problems include: parasitic infections; hepatitis B; positive tine test (tuberculosis skin test), possibly related to Bacille bilie de Calmette-Guerin (BCG) treatment; virulent strains of measles, possibly leading to whooping cough or pneumonia; venereal diseases contracted at birth; and lice, scabies and fungal infections. Long term problems mentioned include rickets, polio and familial history of leprosy. Dr. Bilenker encourages prospective parents to select a physician carefully before their child arrives. The physician should have familiarity, if not experience in treating children with these kinds of problems.

In a letter to other physicians and parents of children adopted from the IMH Center of Calcutta, India, Dr. Dana Johnson of the Department of Pediatrics, University of Minnesota, describes the health problem they might expect to encounter. For

infants, the problems include travel diarrhea, compromised growth, feeding problems, retrolental fibroplasia, salmonella, cytomegalovirus infection, parasitic infection, hepatitis B, scabies, pneumonia, and sudden infant death syndrome (SIDS). In addition to these (excluding SIDS), older children should be screened for diseases associated with tropical urban poverty such as parasites, malaria, tuberculosis and malnutrition.

The effects of changes in the health care available to infants cared for at the IMH center in Calcutta, India have been reviewed in an unpublished paper by Subramanian, Johnson, Clark-Prakash, Dadina & Ferrara (University of Minnesota Hospitals, no date). The study cited evidence that the infant mortality rate had decreased significantly because of the higher standard of care implemented in 1981. However, the authors allude to potential "chronic medical and educational" needs post adoption of children who could not have survived the newborn state previously, but who are now surviving and immigrating to the United states for adoption. Their subsequent quality of life has not been documented.

In the early 1980s the IMH office in Denver, Colorado, asked parents to respond to a questionnaire about the health status of their children upon arrival from India, and the subsequent growth and development of their children from India. Parents reported conditions such as developmental delays, salmonella, diarrhea, scabies, malnutrition, dehydration, pneumonia, and malaria. Although the study was not completed or published the preliminary data have circulated among parents who have adopted and those planning to adopt.

#### Statement of the Problem

Two surveys by Walker (1978) and Sherwen et al. (1984) confirm the desire and the need of adoptive parents for more information. Walker (1978) explored the "informational needs" of 167 parents who had adopted white children or children of different racial background. Eight percent of these adopted children were either mentally or physically handicapped. Seventy-two per cent of these parents agreed that they needed more information on how to prepare for the arrival of the child, 57% needed more knowledge on the normal growth and development patterns of children, 54% wanted information on how to deal with illnesses

of children, 50% on how to care for children, and 48% on how to keep a child healthy. From these data Walker (1978) concluded that as a group adoptive mothers would be responsive to the offer of informational assistance by health professionals.

Sherwen et al. (1984) conducted informal and nonrandom interviews with 117 Caucasian middle class mothers of 193 adoptive children of Caucasian or of mixed ethnic background. Of these children, 57 experienced either emotional, physical or intellectual difficulties. Sherwen et al. (1984) found nine concerns common to these adoptive mothers. These were a range of fears and difficulties including "underestimation of the impact of cultural differences".

To meet these needs and concerns of adoptive parents, more must be learned about the health problems likely to be encountered upon adopting a child from another country. The available information is not exhaustive and does not indicate the incidence or magnitude of the problems. The present investigation is an attempt to expand knowledge in this area, with relation to children adopted from India. Specifically, answers will be sought to the

questions: What is the health status of these children upon arrival in this country? Are they carriers of diseases endemic to India? What health problems develop later? Which of these problems are anticipated and planned for, and which are unexpected? How do parents at present deal with these health problems, and what resources are available to them? Answers to these questions, by providing a more accurate picture of the extent and severity of existing health problems, should enable agencies placing these children to better prepare parents awaiting the arrival of their children from India. Answers to these questions may also be useful for parents dealing with delayed problems, by documenting existing resources of support and information.



## CHAPTER II

### METHOD

#### Subjects and Setting

Of the 27 licensed adoption agencies placing children from IMH in the United States one is located in McMinnville, Oregon. The agency is PLAN (Plan Loving Adoptions Now, Inc.) and deals with a wide variety of adoptions, including intercountry adoptions. PLAN made its first IMH placement from Calcutta in 1978, and has placed a total of 258 children in Oregon since that time.

Prior to approval for adoption from India, PLAN requires the potential adopter to be a resident of Oregon, attend preadopt classes, and submit to a "home study." Periodically, group meetings are held to introduce parents who are waiting for a child to parents who have already adopted from India. An attempt is made to expose potential parents to varying degrees of success and disappointment experienced by those who have children from India. It is hoped that prospective parents then have a better idea of what to expect of their child from India.

Agencies are unable to provide these prospective parents with accurate statistics describing the actual occurrence of problems for which these children are at high risk. However, parents are warned of the risk of cerebral palsy, various enteric infections, developmental delays and emotional difficulties. Waiting parents are provided with a recommended reading list and special handouts on feeding, cerebral palsy, and salmonella.

The 258 Indian children adopted from IMH by families in Oregon are the subjects of this descriptive study. The children represent both sexes. The present ages of the children vary from under one year to 17 years. At the time of immigration to this country, their ages ranged from a few months to 15 years. They have lived in the United States from less than one month to 8 years.

Of the 210 Oregon families that adopted these children, 168 have adopted one child, 38 have adopted two children, two have adopted three children and two families have adopted four children, three of whom were siblings. At the present time, 253 of the 258 adopted children are living.

### Design and Procedure

This research is descriptive in nature. Data were gathered by review of charts kept at PLAN adoption agency, and by questionnaires mailed to all 210 adopting families. Inasmuch as each questionnaire collected data concerning the health of one specific Indian child, families that had adopted more than one child were provided with more than one questionnaire to complete.

To preserve anonymity, families were identified on the questionnaire only by a preassigned number. The number was needed to link questionnaire and chart data for analysis.

A letter accompanied the questionnaire, describing the purpose of the study, the groups involved, and provisions for confidentiality and anonymity (see Appendix A). Pre-addressed, stamped envelopes were included in the questionnaire packets. Return of the completed questionnaire was interpreted as consent to participate in the study.

### Data Gathering Instrument

Data were gathered both from the questionnaires, and from the review of records maintained by PLAN, Inc.

### Chart Review

Selected descriptive and epidemiological information about each child and family was transcribed from PLAN records by the investigator with the aid of Delores Lauber, intercountry adoption coordinator for PLAN, onto a separate Chart Review Data Sheet (see Appendix B). On this sheet, each family is identified only by number, and each child within the family identified by the order of adoption.

Eight items of information are included on this Data Sheet. These items refer to the child's sex, age at adoption, dates of the home study, assignment of child and arrival of child in the United States. Also included is information regarding the source from which the IMH obtained the child in India, because the health status of the child is intimately affected by the care or neglect experienced under the different circumstances represented by these sources.

These items also permit confirmation of data provided by parents and serve as a validity check.

### Questionnaire

The purpose of the questionnaire was to obtain descriptive information about the health of these adopted children at the time of arrival in America from the IMH Center in Calcutta, and the health

problems manifested later on. It was also the intent of this questionnaire to determine the extent to which these children were tested by health professionals for reportable communicable diseases. Finally, information was gathered about the resources these families used to deal with the health problems their adopted children presented on arrival or encountered shortly thereafter. The development of this instrument was guided by review of the literature on the health problems of intercountry adoptions, literature on tropical diseases endemic to India, the provisions of immigration law and infectious disease statutes, and child assessment tools. In addition, unpublished health status studies (Boncheau, no date) and a needs assessment conducted earlier by the present investigator were used as sources for questionnaire items.

The 10 page questionnaire consisted of 69 items (see Appendix C). Both open- and closed-ended questions were included, and additional comments were encouraged to enrich and explain the data gathered.

There are three parts to the questionnaire. Parts I and III expanded on the information obtained by the chart review, by exploring adoption behavior and

family status. In addition, questions 69 and 70 inquired into the health insurance coverage or lack of coverage for the adopted child, because Oregon State insurance laws do not mandate coverage of an adopted child as they would a biological child. Part II asked the parents what they knew about their child's health prior to leaving India, what they discovered after the child's arrival in the United States, and any discrepancies between what was believed originally and what was subsequently discovered. Questions about the screening or testing for various communicable diseases were included, as were inquiries about the utilization and perceived value of resources for coping with the health problems presented by these adopted children (see Appendix D for justification of specific items).

## CHAPTER III

## RESULTS AND DISCUSSION

In this chapter, selected characteristics of the respondents and of their adopted children will be presented first. Then the health status of the adopted children on arrival from India in Oregon will be discussed. The extent to which parents were aware of their child's preexisting health problems will be noted, as will the extent to which they were aware of problems which might develop later on. Finally, the ways in which these adopting parents coped with the health problems of their adopted children, and the resources available to them in that process will be considered.

Description of the SampleCharacteristics of Respondents and Families

Questionnaires were sent to all families who had adopted children from IMH India through PLAN, Inc., from the first placement made in 1978 through arrivals in September of 1986. There were 258 questionnaires sent to 210 families. The initial return was 50% after six weeks. Duplicate questionnaires sent all nonrespondents

increased the response rate to 78%. Followup postcards brought no further returns. Thus, information was obtained from 166 families regarding the 200 children they had adopted.

Although all families lived in Oregon when Plan, through its "home study", approved their application to adopt, by the time of the present investigation 16 families had moved out of state, two out of country. Questionnaires were returned with postmarks from Australia and Africa.

In 87.3% of the cases, questionnaires were completed by the mother of the adopted child. The majority of the India placements by PLAN were to married couples (77.6%) and the rest to single or divorced persons. Marital status from the time of first placement to the time of this study changed little (see Table 3). If problems resulted from the adoptions, they apparently did not lead to marital dissolutions to any significant extent.

The majority of the responding families have from one to four children, including biological and adopted (see Table 4). In only 43 families was the child adopted from India the only child



Table 3

Characteristics of Respondents

Characteristics	Number	Percent
<b>Respondent</b>		
mother	144	86.7%
father	10	6.0
both	12	7.2
<b>Marital status<sup>a</sup></b>		
single	34	20.5
married	129	77.7
divorced	2	1.2
widowed	1	.6
<b>Present marital status</b>		
single	30	18.1
married	128	77.1
divorced	6	3.6
widowed	2	1.2
<b>Total</b>	<b>166</b>	<b>100.0%</b>

<sup>a</sup>At the time of the first placement from IMH India

Table 4

Number of Children in Study Families

---

Number of Children (Biological and Adopted)	Number of Families	Percent
One	43	25.9%
Two	44	26.5
Three	31	18.7
Four	25	15.1
Five	11	6.6
Six to eleven	10	6.0
No information	2	1.2
Total families	166	100.0%

---

in the family. Additionally, half of the families have adopted more than one child, as shown in Table 5. Most of these children were adopted from India, although 47 children were adopted from other countries by 38 of the families (see Table 6). The fact that parents adopted more than once suggests a basic satisfaction with their situation and their adopted children.

For the responding families, the wait from the "home study" by PLAN until assignment of a child averaged 8.6 months, and ranged from less than one day to a maximum of three years. Sometimes assignment was made prior to the "home study" under special circumstances involving "special needs" children. The time elapsing from assignment to arrival of the child "home" averaged 2 months, and ranged from 2 days to 13 months. Thus, 10.6 months was the mean time for the adoption process. This is a relatively short time for the process to take place and supports the claim of Bolles (1984) that foreign adoptions are frequently speedier than domestic adoptions.

Table 5

Number of Adoptions by Families in Study<sup>a</sup>

Number of Children adopted by family	Number of Families	Percent of Families (N=166)
One	83	50.0%
Two	63	38.0
Three	14	8.4
Four	2	1.2
Five	2	1.2
Six	2	1.2
Total	166	100%

<sup>a</sup>Total number of children adopted by 166 families  
was 281

Table 6

Children Adopted from Other Countries by Families  
in Study

Number of Children per Family	Number of Families	Percent
Children adopted from India through PLAN and other sources		
One	130	78.3%
Two	33	19.9
Three	1	0.6
Four	2	1.2
Total adopted from India: 207 <sup>a</sup>		
Adopted children from other countries <sup>b</sup>		
One	31	18.7
Two	6	3.6
Four	1	.6
Total adopted from other countries: 47		

<sup>a</sup> There were 200 children adopted from PLAN, and 7  
from other sources.

<sup>b</sup> Based on 38 families

### Characteristics of Adopted Children

Of the 200 children adopted from India by the respondents, 128 were female and 72 were male. Most children placed were infants from the IMH Nursing Home in Calcutta India, and arrived in Oregon at less than six months of age. The majority of the children arrived in Oregon between 1980 and 1984 (see Table 7). At the close of the study these children ranged in age from 8 months to 20 years (see Table 8).

The children coming from the IMH Nursing Home are younger than those coming from prisons and government orphanages in India. Their history from birth until arrival in Oregon is also better known. Therefore, the "younger" children (who are more numerous in this study) are the ones for whom parents are better able to provide a more detailed health history.

### The Representativeness of the Sample

A limited chart review was conducted in order to compare the families and children of respondents with those of nonrespondents. There were 166 responding families representing 200 children, whereas there were 44 nonresponding

Table 7

When the Sample Children "Came Home" to Oregon

---

Arrival year	Number of Children Adopted	Percent
1978	1	0.5%
1979	15	7.5
1980	26	13.0
1981	21	10.5
1982	32	16.0
1983	36	18.0
1984	35	17.5
1985	18	9.0
1986	16	8.0
Total	200	100.0%

---

Table 8  
Characteristics of Children in Study

Characteristic	Number	Percent
Sex		
Male	72	36.0%
Female	128	64.0
Source of child in India		
Prison	13	6.5
Bangalor	2	1.0
Nursing Home	162	81.0
Abandoned or unknown	3	1.5
Government orphanage	9	4.5
Other	11	5.5
Age when came to Oregon		
< 1 month	7	3.5
1 month < 6 months	152	76.0
6 months < 1 year	5	2.5
1 year < 5 years	9	4.5
5 years < 16 years	27	13.5
Present Age (12-15-86)		
8 months to 1 year	12	6.0
1 year < 5 years	104	52.0
5 years < 10 years	60	30.0
10 years < 18 years	20	10.0
18 years < 21 years	4	2.0



families representing 59 children. Of the nonresponding families, 32 adopted one child through PLAN, 10 adopted 2 children, one adopted 3, and one adopted 4. Thus, in respect to adoption patterns, nonresponding families appear to differ little from responding families (see Table 9).

There is also little reason to suspect that the children of the nonrespondents were less healthy than those of the respondents. The proportion of children in the "special needs" category (i.e., at high risk due to prematurity) was almost identical in the two groups. Thus, of the 31 children considered "high risk", 7 were assigned to nonrespondents (comprising 11.7% of their 59 adopted children from IMH, through PLAN), and 24 were assigned to the respondents (comprising 12.0% of their 200 Indian children from PLAN). Inasmuch as only five children placed in Oregon by PLAN have died to date (two among children of respondents, and three among nonrespondents), this differential in mortality cannot be considered a major factor in accounting for refusal to participate in this study.

Table 9

Adoptive Patterns of Oregon Families Adopting Children  
From IMH India Through PLAN, Inc.

Number of Children adopted from IMH India through PLAN, Inc.	Number of Families	Percent of Specific Group	Percent of Total Group
In respondents' families			
One	136	81.9%	64.8%
Two	28	16.9	13.3
Three	1	.1	0.5
Four	1	.1	0.5
Total children = 200			
In Nonrespondents' families			
One	32	73.0	15.0
Two	10	23.0	4.0
Three	1	2.0	0.5
Four	1	2.0	0.5
Total children = 59			
Total PLAN, Inc. families			
One	168	--	80.0
Two	38	--	18.0
Three	2	--	1.0
Four	2	--	1.0
Total children adopted = 258			

It may be noted that many children die in India after assignment to an adoptive family and prior to arrival in Oregon. The death of an assigned child seems to affect a family almost as profoundly as a child's death after "coming home". To the personal knowledge of the investigator, some of these children that died prior to "coming home" belonged to the nonrespondent group. However, it is not known whether nonrespondents experienced such losses to a greater extent than respondents. Although these children were never included in the sample, their deaths may have affected their "parents'" willingness to participate in this study about their other adopted children who did "come home" from India.

Another phenomenon unique to this population is that of "replacement". This occurs after an adoptive child "comes home" to Oregon. If the child and the family are not compatible, an attempt is made to find a suitable child-family match. A total of eight children arriving from IMH India in Oregon since 1978 have been "replaced" in a second adoptive home. Three of

these children are in the responding group; the remaining five are in the nonrespondent group. All of these "replacement" children are now considered to have "special needs" because of mental or physical handicaps, and/or behavior problems. Only two of these "replaced" children were identified as "special needs" placements prior to "coming home" to Oregon. Both of these are in the nonrespondent families.

It is possible then, that the nonrespondent group included a somewhat greater proportion of "replaced" and "special needs" children than the respondent group. And it is possible that families with such children are more reluctant to be surveyed. However, such circumstances by their rarity can account for only a few of the refusals to participate.

Possibly some parents chose not to participate in this study because of its university sponsorship. PLAN received several calls from parents expressing either anger or feelings of harassment or hesitancy to participate because they had had negative interactions with health care providers at the

University's hospital. Several parents later returned questionnaires apologizing for lateness and explaining their hesitancy. Apparently they feared, from their experience, that the university professionals would like to see an end to foreign adoption because of the seemingly large numbers of very sick children they see from other countries. There is no way of knowing which of the parents inquiring at PLAN decided to return their questionnaires or chose not to participate.

From the above information, available from records, it would seem then, that there are few differences between respondents and nonrespondents. Hence, the findings of this study may be generalized to the total population of children adopted through PLAN from IMH India in Oregon.

#### Health Status of Adopted Children

##### What Parents Knew Prior to their Child's Arrival

The birth weights and lengths are known for 135 of the 200 children in this study. The mean birth weight for the 48 males was 1.82 kg, 3 to 4 standard deviations below the median weight of

3.3 kg computed by the World Health Organization (WHO, 1978). The lowest birth weight for the males was 0.9 kg, which is more than 4 standard deviations below the WHO median and the highest birth weight was 2.95 kg which is still below the 50th percentile weight.

The mean birth weight for the 87 females was 1.79 kg, falling between the 1st and 3rd percentiles, by WHO (1978) standards. As with the males, all birth weights for the females fall below the WHO mean, from 0.79 kg (more than 4 standard deviations below the median) to 2.73 kg (somewhere between the 3rd and 50th percentiles).

Birth lengths are known for only 94 of the 200 sample children. The mean birth length for 34 males in the study was 44.35 cm. WHO (1978) estimates 50.5 cm to be the 50th percentile value. Hence this sample mean falls between the 1st and 3rd percentile value. The range was from 35.6 cm (which is 4 standard deviations below the WHO median) to 53.1 cm (which is slightly above the WHO 50th percentile).

Birth lengths were known for 60 females. The mean length was 42.66 cm, a value which is almost 3 standard deviations below the median. The range in birth lengths for the females was from 27.94 cm (4 standard deviations below the WHO median) to 50 cm (just above the WHO 50th percentile mark). It may be concluded that the birth weights and birth lengths of the children in the sample (or at least those for whom information is available) were far below the average for developing countries.

Questionnaire Item #9 asked parents to check the health problems, if any, about which they were informed prior to assignment of their child. Of the parents who responded to this item, 36 indicated they were informed of medical problems, 29 of physical, 5 of emotional, one of mental and 14 of developmental problems. Inasmuch as a response to one item did not preclude a response to any other, parents may have been warned that their child had problems in more than one, or in all categories. The terms (i.e. physical, emotional, etc.) may have been interpreted in a variety of ways, in that several

parents wrote in "premature" when circling "developmental", "medical", or "physical". When a child is known to be premature, it is PLAN's policy to inform the prospective parent(s) of the risks inherent in that state; hence these types of interpretations. Unfortunately, based on this questionnaire item alone, it is difficult to report with any certainty how many families were warned of and were prepared for any one or all of these problems.

To further explore what parents knew about the health of these children while they were in India, parents were queried regarding specific health problems and illnesses (see Questionnaire Item #13, Appendix C). They may have known about a condition prior to the child's "coming home", or they may have discovered a previous diagnosis in the medical record which sometimes accompanied the child. In either case, if the parent knew the condition existed "in India" it was to be so indicated. Appendix E provides the number of cases reported for each of the 40 conditions listed in Item #13. Only six conditions were reported with a frequency of 10 cases or greater,



(see Table 10). None of these conditions is surprising or unusual for this population. What is surprising is the presumably good health of the majority of these children while in India. Prematurity was reported for 25% of the population. Inasmuch as 164 of the 200 children were infants when they were assigned and "came home" to their adoptive parents, many parents must have coped with the risks of prematurity.

Questionnaire Item #10 asked parents about the medical treatments their child had received "in India". It can be assumed that most children receiving these treatments were infants cared for and treated in the Nursing Home associated with IMH where these treatments are available. In that agency, records are kept and may be sent to the United States with the child. The most frequent treatments reported were "intravenous feedings" and "gavage feedings", treatments given premature and/or very sick children. The frequency of these treatments (see Table 11) approximated the number of premature infants in the group.

Table 10

Health Problems Children Experienced in India  
as Reported by Their Parents

Health Problem <sup>a</sup>	Number of Children With Condition	Percent of all Children With Condition
Anemia	12	6.0%
Compromised growth	16	8.0
Feeding problems	12	6.0
Malnutrition	28	14.0
Pneumonia	11	5.5
Prematurity	50	25.0
Other	13	6.5

<sup>a</sup>Conditions and illnesses with a response of  $\geq 10$  cases.

Table 11

Treatments Children Received in India as Reported  
by their Parents

Treatment/Intervention	Frequency of Occurrence	Percent of All Children Receiving TX (N=200)
Blood transfusions	25	12.5%
Phototherapy	12	6.0
Intravenous feedings	53	26.5
Gavage feedings	55	27.5
Supplemental oxygen	24	12.0
Other	17	8.5

Health on Arrival in Oregon

Typically children from IMH, India, arrive in Oregon through the Portland International Airport via trans-Atlantic or Pacific flights. It is a long trip, with each child having an escort, and with infants traveling one to two in a basket as carry-on luggage. Questionnaire Item #10 asked parents their subjective impressions of their child's appearance upon arrival at the airport. According to the parents' reports, 69 children appeared subdued and quiet, 65 malnourished, 47 had "travel diarrhea", 32 appeared dehydrated. Only 10 were "withdrawn", and 11 "unusually irritable". An "other" category was indicated in 38 instances. The response choices provided for Item #10 have a rather negative tone. Interestingly, despite this built-in response bias, many parents wrote "happy", "smiling", "normal baby", as their "other" response.

Arrival weights and lengths/heights were not known for all 200 sample children. From the data which are available, however, it is clear that the growth of these adopted children, both males and females, between the ages of two weeks and five years, was far below the "normal" level for

American children. It may be argued that American standards are not applicable to this population. However, their weights and heights are clearly below the average for the world's children, as estimated by WHO's 50th percentile values, and below the standards for Indian children as determined by values in a growth chart published by Food Specialities Limited, New Delhi, with the support of the Nestle Company. (See Figures 2, 3, 4, and 5).

The Indian growth chart does not differentiate between males and females, nor does it indicate whether it is applicable to urban or rural populations in India. The WHO growth charts were developed from preexisting charts in developing countries and some industrial countries. Therefore one might question the reliability and validity of those norms. However, those growth statistics would appear to provide the best normative data available at this time for use in assessing the health and developmental status of the children in this sample.

Figure 2

Boys: Arrival Weight by Age (N=57)

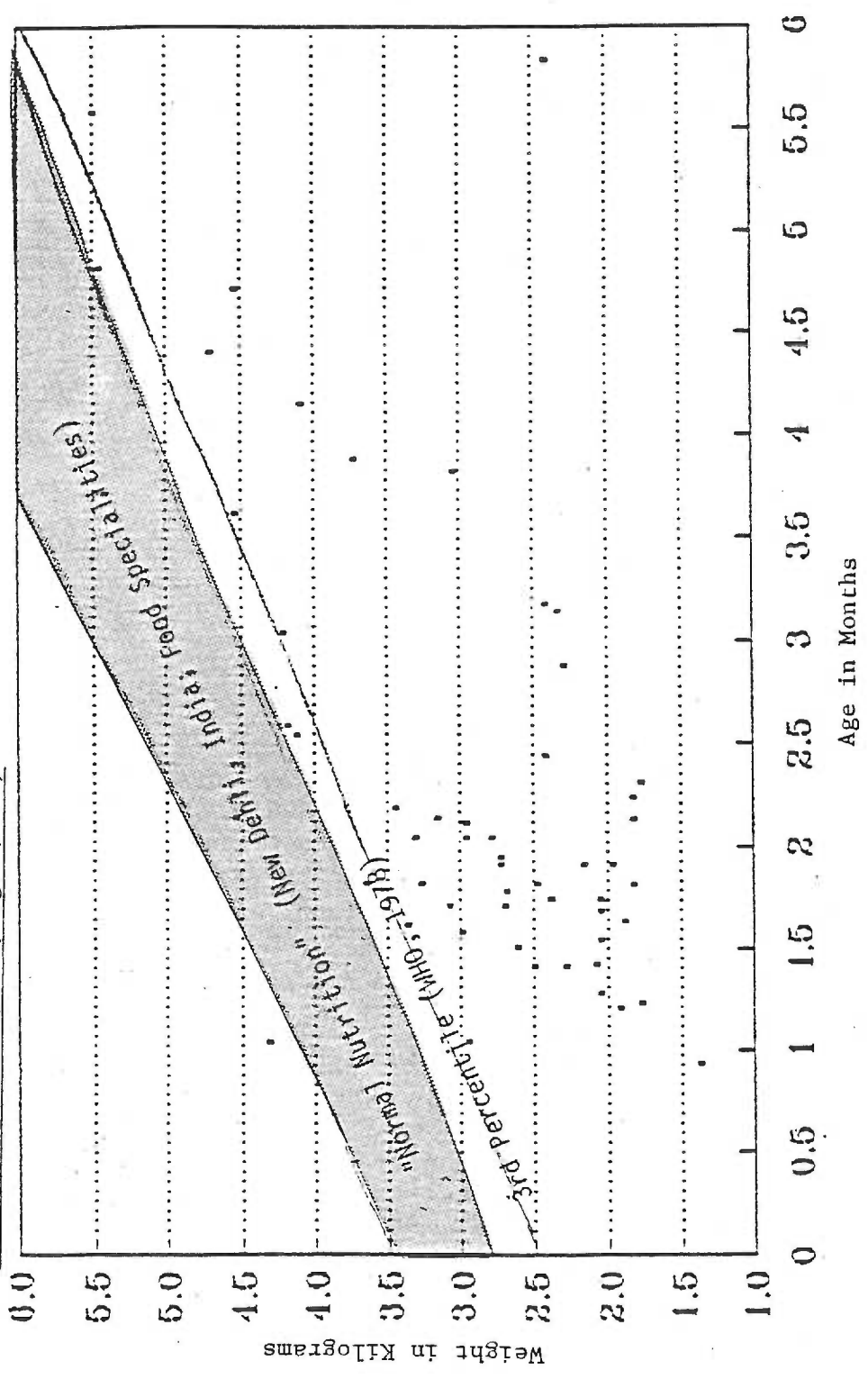


Figure 3

Girls: Arrival Weight by Age (N=99)

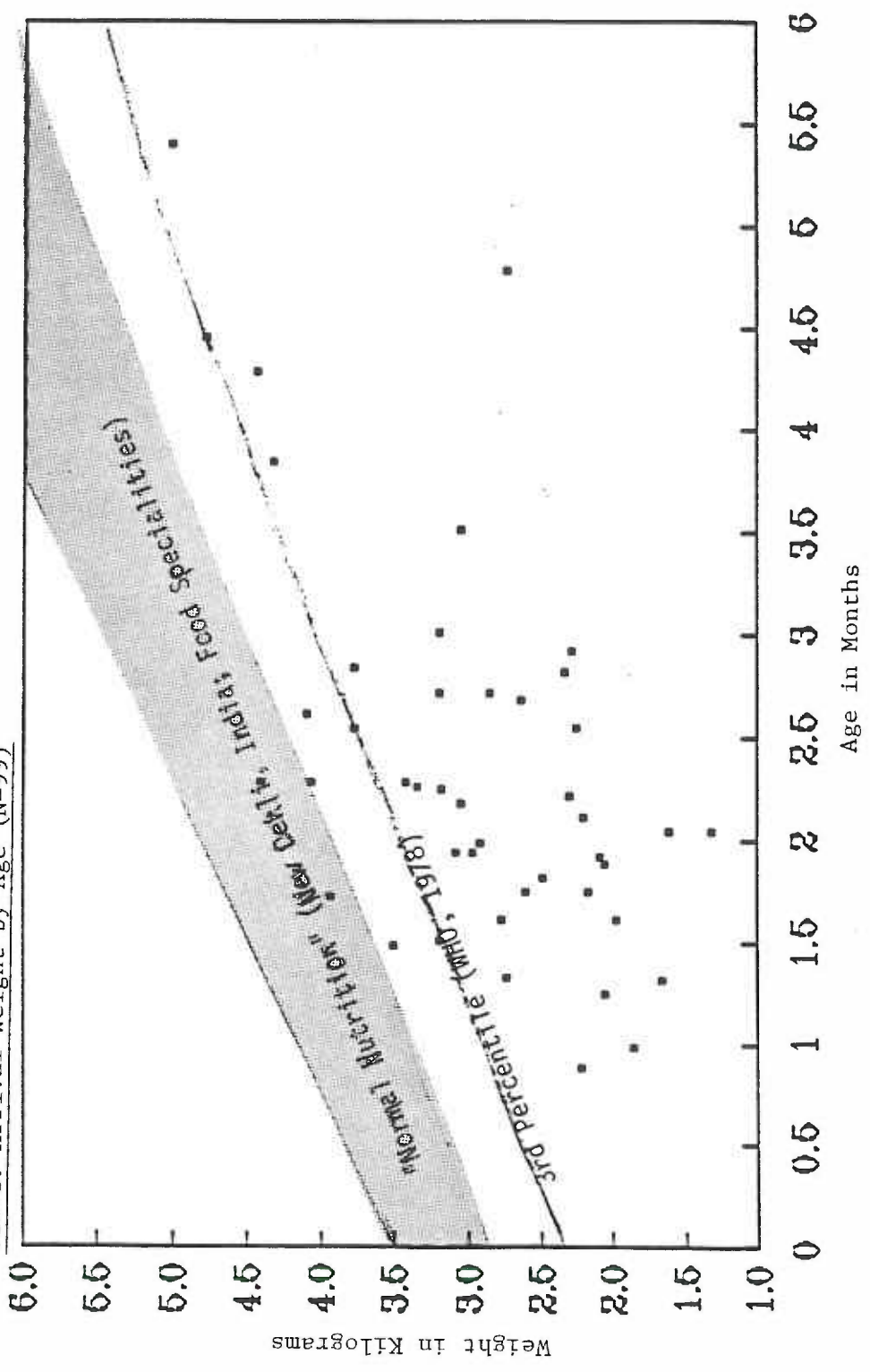


Figure 4

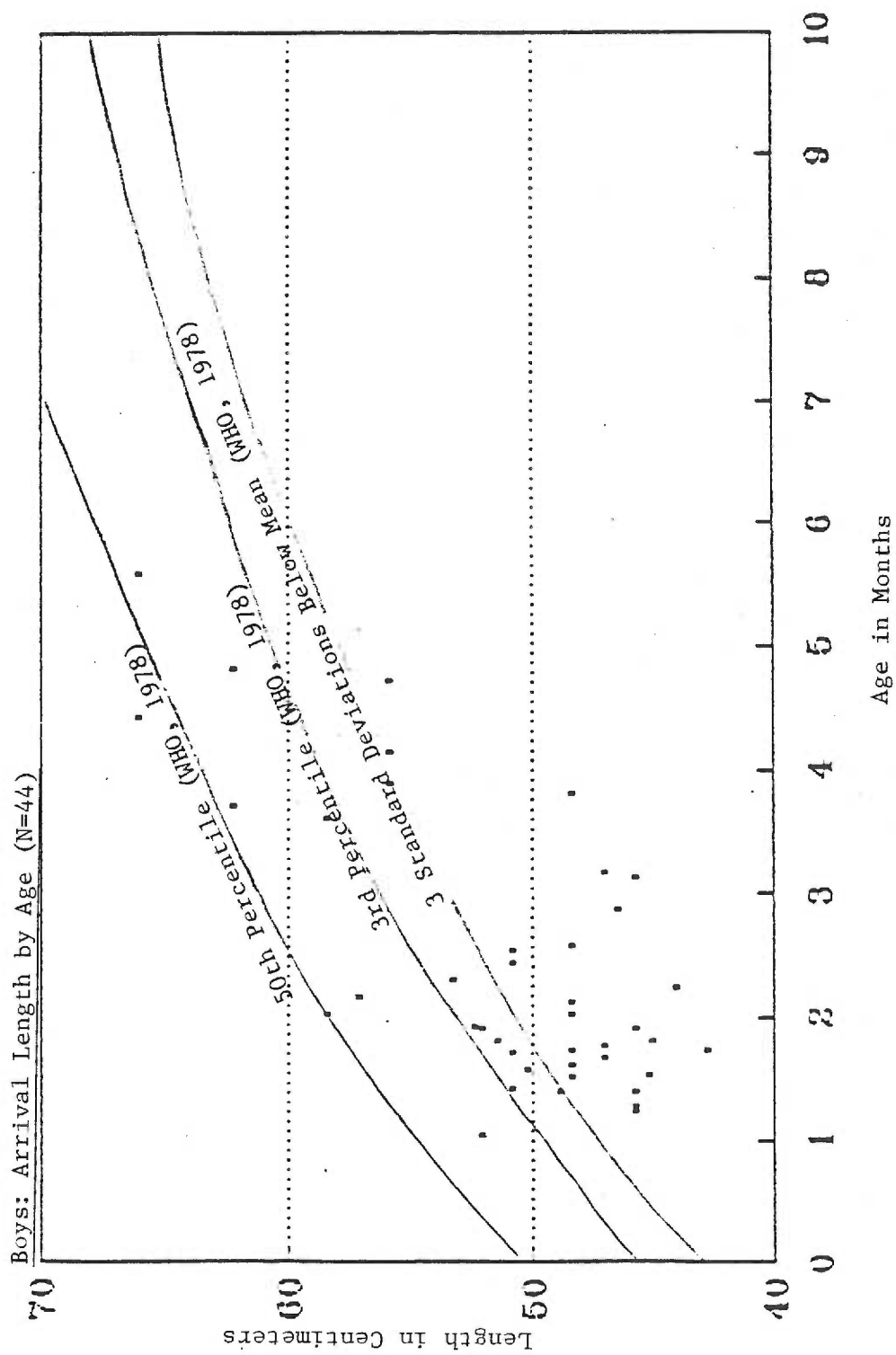
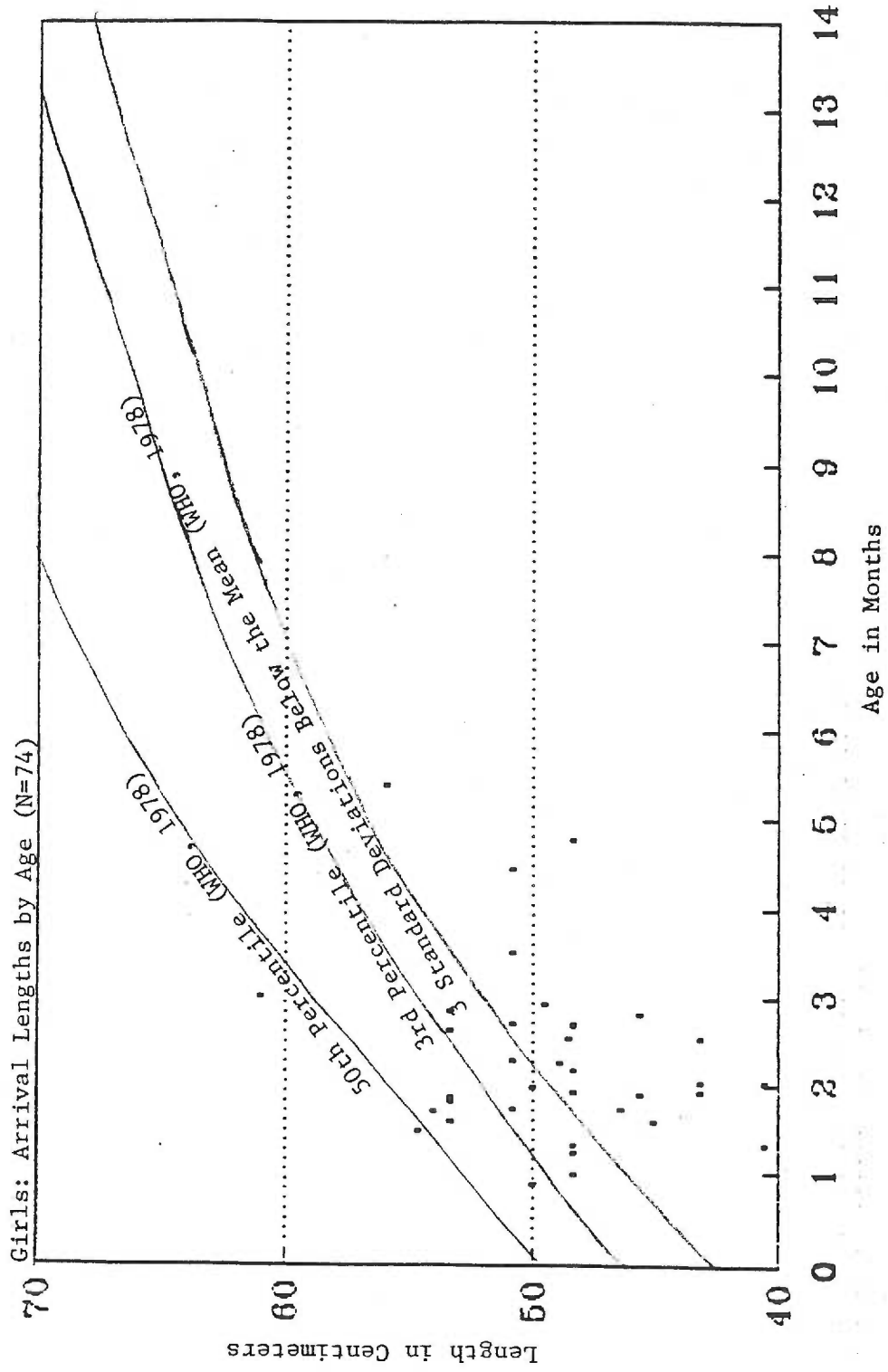




Figure 5



Despite such indications of developmental delays and health problems, it is apparent from a review of the literature given to prospective parents and from personal conversations with the parents of these children that there is a widely held belief that these children "have a strong will to live" and "are born with a survival instinct and can often adapt to their situation, though it be grim" (Bisen, 1986). This "survival instinct" is also mentioned in the unpublished study by Subramanian et al. and in Johnson's "Letter to Physicians."

The weights and heights of children over five years of age upon arrival are listed in Appendix E. No normative data exist to which the growth of these children may be compared.

Illnesses and Conditions Newly Diagnosed or Confirmed after "Coming Home"

Questionnaire Item #13 explored the health of the child after "coming home" to their parents in Oregon, as well as while still in India. For most illnesses and conditions the numbers reported for the category of "after coming home" were greater than those reported for the category

"in India" (see Appendix E). An exception was noted with conditions of prematurity, which decreased "after coming home" from 50 to 30 cases, and apnea (often associated with prematurity) which decreased from 6 cases to 3. These decreases may reflect the fact that as premature infants age they eventually "catch up" to their counterparts of normal gestational age.

Fewer cases of pneumonia and malnutrition also were reported as diagnosed "after coming home", with 9 and 22 cases, respectively, than diagnosed "in India" with 11 and 28 respectively. Perhaps the decrease, in malnutrition at least, may reflect successful treatment and intervention at the Calcutta Nursing Home. It should be noted that the cases reported "in India" and those reported "after coming home" may or may not represent the same children.

The lesser number of cases of club feet reported "after coming home" may be attributed to a strategy employed by IMH to circumvent Indian government policy. In 1984 the government of India would allow only children with health

problems and handicaps to be adopted out of India. Consequently IMH may have documented handicapping conditions such as "club feet" so that children might be released for adoption to American parents. They then arrived in Oregon miraculously cured.

In the category of conditions newly diagnosed or confirmed "after coming home", the frequency of occurrence of 22 illnesses and conditions exceeded their frequency "in India". Obviously, parents were often "surprised" by these health problems. Table 12 lists 15 of these conditions and illnesses, with an incidence of 10 or more cases. Other conditions and illnesses that increased with an incidence less than ten are nevertheless of public health concern. These were cytomegalovirus, malaria, polio, and tuberculosis. These numbers reflect only the known cases. The responses to Item #13 in no way differentiate those that have and those that have not been tested for the condition. Many conditions and illnesses may be asymptomatic, misdiagnosed, or simply not tested for. Therefore, we do not know the true incidence of

Table 12

Health Problems and Illnesses of Sample Children as  
Reported After "Coming Home"

Condition	Number of Cases	Percent	Change in Number of cases from "In India"
Anemia	33	16.5%	21
Cerebral palsy	11	5.5	9
Compromised growth	33	16.5	17
Developmental delays	23	11.5	15
Feeding problem	28	14.0	16
Hearing problems	19	9.5	14
Hepatitis B	10	5.0	5
Lice	16	8.0	7
Malnutrition	22	11.0	-6
Parasites	19	9.5	15
Prematurity	30	15.0	-20
Rashes	30	15.0	21
Salmonella	59	29.5	43
Scabies	22	11.0	14
Other	26	13.0	13

these conditions and illnesses, and are left with only a general impression.

Are these Children Carriers of Diseases Endemic to India?

In Item #11, only two diseases endemic to India were reported with an incidence greater than 10. These were worms and fungal infections (see Table 13), conditions that do not carry a huge threat to the public health. However, these results are only as accurate as the parents' awareness of testing and treatment. To know if a child did or did not have a disease a parent must first know if he or she was indeed tested, and, if treated, for what condition he or she was treated.

Questionnaire Item #15 was intended to ascertain patterns of testing infections and diseases common to poor populations in Third World countries. Table 14 summarizes the extent of testing for the reportable communicable diseases these children may bring to this country. Salmonella, tuberculosis and parasites were the only diseases for which more than half the children were tested. Failure to test may be

Table 13

Children Reported by Parents as Arriving in Oregon  
With Infections Native to India

Infections	Number of Cases	Percent of All Children (N=200)
Amebiasis	4	2.0%
"Oriental Sore"	1	0.5
Tape worm	5	2.5
Hook worm	14	7.0
Other worms	14	7.0
Dysentery or shigellosis	6	3.0
Typhoid	1	0.5
Kyasanur Forest Fever	2	1.0
Yeast	29	14.5
Tinea	1	0.5
Other	31	15.5

Table 14

Infections and Illnesses Sample Children Were Tested  
for Within One Year of "Coming Home"

Infection or Illness	Number of Children Tested	Percent of Children Tested (N=200)
Salmonella	121	60.5%
Hepatitis B	76	38.0
Tuberculosis	115	57.5
Malaria	11	5.5
Leprosy	3	1.5
Parasites	105	52.5
Cytomegalovirus	9	4.5
Other	11	5.5



related to lack of understanding by the health care provider and by the parent. The extent of testing of these children may be underestimated in that they may have been tested, with negative results, without the knowledge of their parents. Further information on the testing for salmonella, tuberculosis and hepatitis B was obtained by other specific questionnaire items. This information is presented below.

Tuberculosis. Item #13 gathered information about known disease "in India" and "after coming home". No cases of tuberculosis (TB) were reported "in India" whereas 5 cases were reported "after coming home". Responses to Questionnaire Item #15 indicated 115 children had been tested for TB within one year of "coming home".

Presumably other children were tested later. Thus, Item #16 inquiring whether the child had had a positive TB skin test, received 25 "yes" and 146 "no" responses. Only 2 of these positive skin tests were reported as diagnosed with active TB, 15 parents "didn't know", and the rest were diagnosed as free from TB.

Antituberculosis medicine, BCG, is commonly given in countries other than the United States and results in a positive TB skin test. Six of the sample children were reported to have been given BCG; 32 children were not. Parents of 134 children did not know. The cases in which children were known to have received BCG do not account for the 23 who had positive TB skin tests and who were not diagnosed with active tuberculosis. The 23 may or may not have received BCG, but were very likely exposed to tuberculosis in India.

The information provided indicates that at least 57.5% of the children had been tested for TB. However, all 200 children should have been tested either by skin test, or by chest x-ray if the child had a history of a positive skin test, BCG treatment, or active TB.

Hepatitis B. Items #13, 20, 22, and 23 were intended to identify the extent of diagnosis and testing of this disease among the adopted children. Five children were known to have had hepatitis B in India, and 10 cases were reported "after coming home". Within one year of arrival

in Oregon 76 children had been tested for hepatitis B and more children were tested in later years. Sixty-five children (32.5%) were apparently never tested; 56 said they hadn't been tested, and the other 9 gave no answer. In all, 13 had positive tests and 122 negative tests for hepatitis. Five of the 13 children with positive hepatitis B tests were reported as carriers of the disease. Five of the responding families reported having been vaccinated for hepatitis B. However, these were not all the same families as those in which children were identified as carriers.

Children given blood transfusions in India were checked against those tested for hepatitis B, in recognition of their high risk for the disease. Of the 25 children receiving blood transfusions in India only 8 were tested for hepatitis B within the first year of arriving "home", and of these 5 had positive tests. Of the 13 children with positive hepatitis B tests, as reported in Item #20, 5 had received blood transfusions "in India". It becomes evident that testing for hepatitis B is not as complete as it

should be. Clearly the children who received blood transfusions, and who came to IMH from a government orphanage or a prison are at highest risk for hepatitis B and without exception should be tested. And all other Indian children simply because of their birth place incur a much higher risk of hepatitis B than children born in the United States. Hepatitis B is a communicable disease that easily passes from person to person, and even from mother to fetus. Only 38% of this population was tested within the first year of "coming home". Eventually, 67.5% (135 children in all) were tested, whereas 100% should have been tested upon arrival.

Salmonella. Of the 65 children with salmonella, 6 were diagnosed while "in India", 55 "after coming home", and 4 diagnosed both before and after placement. Parents reported that 121 children were tested and 49 were not tested for salmonella within the first year after coming home. Thirty parents did not respond. When questioned further (see Questionnaire Items #25 through #34), 123 (62.4%) parents reported their children had been tested for salmonella

(the additional two may have been tested after the first year home). Most of these children (75.2%) were tested by their physicians or other health care providers. Sixty of the children tested for salmonella (48.8%) had a positive test. Salmonella follow-up was provided by the county health department for 37 children, by private health care providers for 12 children, and by both physician and county health department for 7 children. Three children were not followed.

Children with positive salmonella tests were repeatedly tested in 85.5% of the cases, until a negative stool was documented. The mean time of "shedding" was 7 months, and many (45.8%) had diarrhea. Only 5% were carriers. Child care arrangements were affected for 27.1% of children with the diagnosis of salmonella.

Salmonella is a reportable communicable disease, one that all children should be tested for. Families with a little information and preparation can easily cope with it. Like many illnesses, especially communicable diseases, salmonella can be quite problematic for the

single parent or for the family in which both parents work outside the home and rely upon day care centers for child care. However, with a bit of forewarning, alternative arrangements can be made.

Followup by county health departments is often "spotty" and seemingly incomplete, in part because of inadequate funding. In many situations a child's stools are not tested simply because the child poses no risk to the community. Such is the situation where a child is of preschool age, with no siblings in school, and with a "stay at home" parent.

Tuberculosis, hepatitis B, and salmonella are three diseases that are required by law to be reported and followed. They are diseases that may complicate life slightly but do not preclude normal family life. Parents simply need information and education to deal with these illnesses. However, testing should be done since these children are at high risk and possible vectors of the disease to others in their family and community. Preventative measures can only be undertaken if the condition is known to exist, therefore 100% testing must be the goal.

Problems Diagnosed After Child "Come Home"

Responses to Questionnaire Item #13 permit a determination of the extent to which parents were faced with an unanticipated health problem in their children after "coming home". For seven health conditions the number of instances diagnosed in this country was considerably greater than the number diagnosed in India. There were 27 "surprise" diagnoses of anemia, 11 of cerebral palsy, 23 of compromised growth, 19 of developmental delays, 25 of skin rashes, 17 of parasitic infections, and 55 of salmonella. Anemia, skin rashes, parasitic infections, and salmonella are inconvenient but treatable conditions, with no long term effects. However, cerebral palsy, compromised growth, and developmental delays are not always easily diagnosed or treated and do have long term effects on the lives of the child and other family members.

Developmental Delays. Parents became aware of developmental delays in 23 (66% of the 35 reported cases) after the child arrived in this country. In 11 of these instances, the delay was

attributable to cerebral palsy, newly detected after "coming home" to Oregon. Cerebral palsy often can go undetected for the first six months of life, in that small premature infants may exhibit increased muscle tone not unlike children with cerebral palsy. It is not unheard of to have some forms of C.P. go undiagnosed for the first two years of life or longer.

Although no surprise cases were noted in Item #13 related to feeding problems, many of the "life threatening" complications listed in Questionnaire Item #58 concerned the inability to take oral nourishment due to developmental delays and/or cerebral palsy. Perhaps the developmental delays and cerebral palsy were diagnosed as "feeding problems" prior to "coming home", when further diagnostic work uncovered these serious conditions. Thus parents perhaps were prepared for the feeding problems, but not the developmental delays and cerebral palsy.

What Unknowns Were the Most Frightening?

An open ended question (Item #57) inquired as to "fears of the unknown". Many of the replies referred to fears experienced prior to their



child's arrival in Oregon. Parents worried about low birth weight, small size and possible difficulty in bonding between parent and child. Some concern was expressed about lack of health records and health history, and the possibility of a "surprise" diagnosis such as cerebral palsy. Most concerns about low birth weight and size were stated in terms of possible cerebral palsy and developmental delays. These potential problems are now discussed by PLAN and by the preadopt courses. Many of the "concerns" or "worries" about the unknown can not be considered unique to this population but can easily be generalized to any parent population. Concerns such as: "What will he or she look like?", "Will my child ever really arrive?", "Will my child be healthy?" are normal for prospective parents be they biological, or adoptive of domestic or intercountry children.

#### Worries About Future Problems

Many parents commented either they had "no worries" or "normal worries of any parent for their child". Several cited concerns over the child's future acceptance by his or her peers, because of difference in size and/or race. Many

parents of children with developmental delays, cerebral palsy or hearing loss feared their children might have severe learning problems or be unable to lead an independent life. However, several parents with severely handicapped children acknowledged that their children would always have to be dependent on someone.

In addition to developmental problems and independence issues the parents cited concerns over problems, diagnosed or still in the diagnostic phase, and their possible sequelae, both physiological and psychological.

#### Health Problems Becoming Evident as the Child Grows Older

Previously undetected health problems were reported to become evident as the child grew older by 45 families (23.4%). These health problems included cerebral palsy, asthma or other allergies, hearing impairment/loss, bone and/or growth disorders, psychological and/or behavioral problems, blindness, seizure disorders, learning disorders and motor problems.

#### Life Threatening Illnesses

Of the sample families, 46 responded to the open ended question (Item #58) regarding life

threatening illnesses. Most responses were prefaced by the comment that these illnesses were severe and at one time "life threatening", but had been resolved with treatment in all but one case. In that case, the child became ill just prior to arrival "home", and died within days. His illness was not diagnosed until a post mortem was performed. Cause of death proved to be massive "brain tumor" as well as many other severe complications.

Other life threatening illnesses mentioned which required ongoing treatment were: malabsorption, vitamin K deficiency, multiple seizure disorders, chronic respiratory problems, asthma, ventricular septal heart defect (VSD), and suicidal tendencies. Life threatening situations that have been successfully treated or have been resolved include: severe diarrhea leading to dehydration, pneumonia, malnutrition, allergic reactions to medications, anemia and meningitis. Salmonella and hepatitis B were life threatening for some children, due to the general poor health of the child, but were noted to have been resolved with good outcome.

### Planning for the Arrival of a Child from India

Resources for planning for the arrival of a child from India were utilized for 184 children. The resources (reported in Questionnaire Item #65) are listed in Table 15. The overwhelming majority felt the PLAN agency and newsletter, and IMH personnel and "The Heart Connection" were very useful. Sharing the experiences of other parents with children from India was also very useful preparation. Other organizations considered useful by the parents were P.I.C. (Parents of Indian Children), and O.U.R.S.. Parents also mentioned as useful the advice secured from physicians, preadopt classes, and the experience of those who had lived in India.

### Planning in Relation to Hepatitis B.

Parents of 71 of the children reported using or feeling that any available information about Hepatitis B was useful. Parents of 27 children said nothing was useful, and one parent simply said that she "did not want" to know. No comment was made by 102 parents. Resources utilized were: PLAN, physicians, brochures, O.U.R.S.,

Table 15

Use of Existing Groups for Information and Support

Group or Organization Utilized	Percent Using for Support	Percent Using for Information
O.U.R.S.	18.5%	38.5%
PLAN, Inc.	54.0	78.5
Informal gatherings of "preadopt" class	31.5	46.5
Other parents of children from India	57.5	67.5
Indian Cultural Association	2.0	9.0
Other	14.0	15.5

IMH, preadopt classes, and personal experience either from own professional knowledge or from previous intercountry adoptions.

Planning in Relation to Salmonella.

Questionnaire Item #35 was intended to obtain information on the utilization and usefulness of available resources. Responses regarding 162 children revealed that the health care provider was seen as most useful for 58 children (35.6%), County Health Departments for 41 (25.2%) "friends, family and literature" for 70 (42.9%) and "nothing" for 34 children (20.9%). Some respondents checked more than one category.

Planning for Health Care.

The majority of the parents selected a health care provider (HCP) prior to the arrival of their child. Pediatricians or general practitioners were selected by parents of 197 of the children. Selection was on the basis of the parents' personal knowledge of the provider in 105 of the cases. The provider had previous experience in the health care of people from India or Asia in 116 instances. Ninety percent of the parents

were "satisfied" to "very satisfied" with their health care provider. The disillusionment of the 7.1% who were "dissatisfied" to "very dissatisfied" was related to the provider's lack of understanding of children from India and "vagueness" about what was "wrong" with the child.

One mother commented that she was satisfied with the health care provider until she received her questionnaire and realized how many tests her child should have received but did not. Others felt that they were not well enough informed by the agency in 1979 and the early 1980's.

#### How Parents Have Dealt With These Problems

For the most part parents have dealt with ongoing illnesses and undiagnosed conditions with what can only be described as a determination to get the best diagnosis with testing, and best outcome through followup and interventions. These parents like any other parents, also are willing to "go with the flow" as circumstances change and different diagnoses are made necessitating a variety of interventions.

Many parents turned to religion for help. They coped with illnesses, with adjustments to adoption, and with health insurance problems by "trusting in the Lord", "prayer", "it is in the hands of the Lord". Prayer was a predominant coping response for this population, as might be expected in that PLAN, Inc. is a Christian organization. PLAN does not require prospective parents to be Christian, but it does attract many of its clients from the community of Christian believers.

Because Questionnaire Items #60 and #63 elicited responses only from parents with ill or handicapped children, there is a built in negative bias. It is evident when examining parental responses in relation to the years in which specific children "came home" that parents have become increasingly more "prepared" for and "fearful" of the worst case scenario, in which the child assigned and thought to be free of handicaps turns out to have severe mental and physical handicaps that were previously undetected. The reader must understand that many parents preselect a "special



needs" child, a child they know has a major health problem. However, there are also situations where parents did not know they were adopting a handicapped child. Some of these parents adjusted to the situation and have since sought to adopt other "special needs" children. However, other parents "surprised" by a handicapped child when they anticipated a "normal" child have had a more difficult time, particularly with the initial adjustment to the situation. Longer lasting difficulties in family adjustment for the most part relate to the lack of services available to them in the communities in which they live.

#### Case Examples of Sample Children

Case #1. A child arriving in 1980 as an infant was reportedly tested for parasites and tuberculosis within the first year of "coming home." Five years later this child was tested for hepatitis B after the parents received a note from PLAN that all children from Asia should be so tested. The parent reports that in 1980 "no information was provided by IMH or PLAN before or after placement" and that "no advisement was made

on medical tests, ie. hepatitis B or salmonella, that should be done at the child's arrival".

This child arrived severely malnourished, with open oozing sores all over her body. At the time of the present study this child is doing well and is in good health with no learning disabilities, "so far...doing fine".

Case #2. This child "came home" in 1981 and died 18 hours after arrival in Oregon. The parents were told he "might be delayed, have possible CP, and possible hearing problems." On arrival in Oregon the child was blind, deaf, and had severe CP. The child also had "hepatitis B, tubercular meningitis, deformed hip sockets, and bronchitis. (The child) died of a massive brain tumor."

Case #3. This family, in 1982, "unknowingly" adopted a severely handicapped, developmentally delayed child, with cerebral palsy and neural hearing loss. These parents report the child is now "signing and talks constantly, (the child ) is a beautiful and sparkling child" and "is ahead of (the child's) age group intellectually".

Adopted as an infant the parents feel "we were as

prepared as we let ourselves be. PLAN and IMH went far in letting us know that these infants are high-risk. Somehow you figure it won't happen to me. So when it does, you have to deal with it head on. We took a chance, just as in giving birth. Life has no guarantees. Please pass that on to the social workers and doctors at CCD, since some were a bit negative regarding adopting these kids".

Case #4. This child came "home" in 1982 as an infant, and is now four years old. Tests were done for salmonella, tuberculosis, and venereal disease within the first year. The child had salmonella and shed the bacteria for 11 months. Child care was no problem because the mother is "a stay at home mom". No hepatitis B test has been done although intravenous feedings were given in India. These parents are delighted with their child from India. "No written description could begin to do (the child) justice. (The child's) energy level and intelligence are measured somewhere above that of most of the other children I have had experience with. (The child's) vocabulary is extensive, and never stops

using it." "She takes gymnastics and violin lessons."

Case #5. This child arrived in Oregon in 1983 from IMH. The child had been obtained from a prison. The parents were told that this child was 7 or 8 years old and of normal intelligence. Three years later "bone x-rays show that the child is at least age 13". This child appeared malnourished and hyperactive on arrival and was tested for malaria, tuberculosis and parasites. The child was found positive for parasites and tuberculosis. A test for hepatitis B performed two years after arrival was negative. After arrival this child did not develop speech, and the child's physician "insisted for a year" that it was due to different culture and language. The child has since been diagnosed with microcephaly, mild retardation and neurological problems. These parents thought they knew what to expect as they had adopted from India before. They view the child as "cute, lovable, and sweet" but feel that a placement with a family more prepared for his special needs in a larger community would have been more beneficial for the child.

Case #6. This child arrived in Oregon in 1983 and the parents were prepared for medical and physical problems, fearing cerebral palsy. This child was tested for salmonella, parasites, and tuberculosis in the first year after "coming home". A positive salmonella test was found and the shedding of salmonella lasted nine months. The mother reports difficulty in finding baby sitters. It is not known if a test for hepatitis B or malaria was done although the child had blood transfusions and malaria in India. The experience is a good one for this family; the child has no cerebral palsy and has grown out of earlier feeding problems. "I praise the Lord for this sweet child that He has given us " The child is "such a joy and worth all the hard work, expensive formulas, and worry to be able to share in helping him grow up. If I had it to do all over again I'd do it in a minute."

Case #7. This child arrived in Oregon in 1984. It was known that the child was a 900-gram premature infant, with a gestational age of 28 weeks. However, the child "had not had any major problems while in India". In actuality, the

child had received treatments in India of blood transfusions, intravenous feedings, gavage feedings, and supplemental oxygen. Prior to arrival the child had had apneic spells. In the first year after "coming home" tests were done for salmonella, hepatitis B, tuberculosis and parasitic infections. After "coming home" it was discovered that this child is totally blind (retrolental fibroplasia), has cerebral palsy, multiple seizure disorder, and asthma. There is now a possibility of a metabolic disorder and mental retardation. "In spite of (the child's) many physical problems" her parents feel the child is "a total delight and has been a great joy to our whole family; (the child) is our treasure". This family has since adopted three other multiply handicapped children.

These case reports reflect a wide range of adoption experience with children from IMH, India. No family experience is the same as another. It becomes clear that as IMH and PLAN have gained experience in placing these children, "surprises" are fewer and parents are more prepared for the child they might receive. The

organizations placing these children are becoming more aware of health risks and educating parents about tests their children will need upon arrival in this country.

CHAPTER IV  
SUMMARY, CONCLUSIONS, RECOMMENDATIONS  
AND IMPLICATIONS FOR NURSING

In recent years, the number of children available for adoption in the United States has greatly declined. Consequently, Americans wishing to adopt have had to turn more and more to foreign sources for children, mainly the less developed countries of Asia and Latin America. Such adoptions entail psychological, social and health issues somewhat different from those prevailing in domestic adoptions. These problems, particularly those involving health, have been insufficiently studied to date. Hence, little information is available by which prospective parents might anticipate, prevent, or cope with the health problems of their adopted children from other countries. The present study was undertaken to close, somewhat, this gap in our knowledge by describing the health conditions of one group of adopted children, namely, those adopted from India. This study has also sought



to document some of the ways in which the parents have attempted to cope with their children's health problems.

The sample selected for investigation consisted of all Indian children adopted from IMH, India, through the agency PLAN. The first placement by PLAN in Oregon was in 1978 and the study included placements through September 1986. During that period, 258 children were placed in 210 different Oregon families. Questionnaires were mailed to all of these families, with a return rate of 78%. Thus data were available regarding 200 children living in 166 families. From an examination of agency records, it appeared that the children of the nonrespondents did not differ substantially from those of the respondents in health status, i.e., they were not disproportionately "special needs" children or children who had died on arrival in Oregon. The findings of this study should, then, be generalizable to the larger population of Indian children adopted through PLAN.

The adopting families consisted, typically, of a married couple, and included other children, either biological or adopted. Inasmuch as marital status rarely changed after adoption, the problems associated with the adoption were apparently not so great as to break up the family. The fact that the families included other children, often also adopted, indicates a child orientation and a basic satisfaction with adoption.

Of the sample children, 128 were female, 72 were male. The largest portion of the sample arrived "home" between 1980 and 1984, and were infants when they came to Oregon. These children now range in age from 8 months to 20 years. Because the older children came to the IMH center from a variety of places, such as prisons and government orphanages, their medical histories are unknown, and they are therefore underrepresented in the data of this study.

The specific questions posed in this research were: 1) What is the health status of these children upon arrival in this country? 2) Are they carriers of diseases endemic to India? 3) What health problems develop later? 4) Which of these problems are anticipated and planned for and which are unexpected? and 5) How do parents at present deal with these health problems, and what resources are available to them?

With regard to the first question, it was expected that the children in this sample would be small for their age and sex, because most children cared for by IMH in India are either the products of third trimester abortions or abandoned, malnourished infants from poverty stricken backgrounds. The findings confirm that expectation. Thus, for those children for whom data are available, the mean birth weights and birth lengths, for both males and females, were 3 to 4 standard deviations below the WHO (1978) mean for children of the world. It must be concluded, then, that these adopted children fell

far below average birth size in comparison with children of other developing countries. It may also be concluded that the incidence of prematurity was extraordinarily high for this sample. Parents of 50 children stated they knew their children were premature. The actual figure must be considerably higher, in view of the number of treatments such as intravenous and gavage feedings, which were reported to occur in India. The facts of low birth weight, prematurity, and malnutrition all attest to the at-risk nature of these children, for short term and long term health problems.

The weights and heights of these children upon arrival in Oregon were also far below "normal nutritional" values for India as well as below WHO norms (1978). Hence, the children had not as yet overcome their initial disadvantaged state, and might be considered to be still "at risk". Parents should be aware of this fact. Because of change in diet and environment, Indian children placed in American adoptive homes before

the age of three may be expected to achieve or surpass Indian norms just as Korean children may be expected to surpass Korean norms (Winick, 1978). For those children over age three, the outcome is more problematic. There is little research either to support or refute the hypothesis of the reversibility of the effects of prolonged malnutrition.

At least a third of the parents reported their children upon arrival home appeared malnourished. Dehydration and "travel diarrhea" were also frequently mentioned conditions. Shortly after coming home many health problems surfaced, including physical problems and developmental delays, parasites, and several communicable diseases. The data provided by parents are inadequate to determine the extent to which children were tested for possible diseases. As reported, data reflect only the known cases, and cannot be used to estimate the incidence or prevalence of specific diseases or conditions, since some children might be asymptomatic and remain untested.

In short, the data indicate these children came to Oregon small for their age and often malnourished, but otherwise in acceptable health. Some problems were revealed shortly thereafter, but other dormant conditions became evident only later when the child grew older.

Since the first Oregon placement from IMH, India, in 1978, the way the children available for adoption come into this world and the status of their birth families have changed little. The infants at the Center continue to be at high risk for cerebral palsy, and for other birth defects related to low birth weight and poor prenatal care and nutrition. The health care provided to the infants and young children by IMH has changed greatly in the past nine years. The center expanded in size, and improved both its diagnostic capabilities and its treatments. Most significantly, an intermediate level newborn nursery, with full professional staff, was developed in 1981. This has meant that children who previously might not have survived can now

survive and be available for adoption; also that other children receive better care and arrive "home" in better condition than children adopted in previous years. In the present research, a random sampling of cases suggests that children have been coming home recently with fewer health "surprises" for parents.

A still more recent change, that may significantly affect future adoptions, is the establishment of a home for single pregnant women. At the home the women receive prenatal care, enjoy better nutrition and experience less emotional stress. The chances are good that these women will bear healthy term infants. Indeed, preliminary reports from IMH indicate these children have birth weights above the "normal" nutritional standards in India. The effects of this development have as yet not been experienced in Oregon adoptions.

With regard to the second research question the evidence from this study is inconclusive: Are these children carriers of diseases endemic to

India? All the children, regardless of their health status at birth, are potentially carriers of such diseases simply by virtue of place of birth. All should, therefore, be tested for the most common diseases. However, testing has been far from complete. Only 62.4% of the children were tested for salmonella, 57.5% for tuberculosis, and 67.5% for hepatitis B. Even those children who had received blood transfusions in India, and who were therefore at particularly high risk for hepatitis B, were tested in only 52% of the cases (13 of 25). The best estimates that can be made from the reported data are that 60 children (49% of those tested) were diagnosed with salmonella; 13 children (9% of those tested) had hepatitis B; and 2 (possibly 5) children had tuberculosis (1.7% of the 115 tested).

The only two diseases endemic to India which were reported as occurring frequently in these adopted children were parasites and worms. From the data obtained it is impossible to estimate



the proportions of the children in this sample who were free of these and other diseases, simply because so many were never tested.

With respect to the third research question, the majority of health problems that emerged as the child grew older took the form of developmental delays, cerebral palsy, digestive problems and allergies. Previously undetected health problems became evident for almost one fourth of the children as time passed. The problems included cerebral palsy, asthma or other allergies, hearing impairment or loss, bone and growth disorders, and motor problems. It may be noted that cerebral palsy can often go undetected until a child is six to nine months old, and is closely associated with prematurity and birth trauma.

There is little that can be done to prevent such problems from occurring. However, from what information as has been gathered about these children we know that many of them are "at risk" for these problems by reason of their

prematurity. There is also reason to suspect that older children may be susceptible to mental retardation and developmental delays because of the poor nutrition they received over the course of their lives before "coming home".

Which of these health problems were anticipated and planned for, and which were unexpected? The earlier placements found parents unprepared, because so little was known about these children and the problems they might have. Hence, not much was anticipated and planned for. Parents in later adoptions were more aware of the risks involved. The problems most often reported as being anticipated were related to low birth weights. However, unless the parents requested a "special needs child", being aware of and anticipating potential problems are different from being prepared for and planning for the actuality of a problem. Even though parents knew the risks inherent in adopting "premature" infants, there is little evidence they were prepared for a lifelong problem. Many say they

"prayed" that the problems wouldn't happen to their child. So even if the risks were known, a diagnosis of mental retardation, cerebral palsy, or heart defect was devastating, and required a transition period during which parents could "regroup" their defenses and carry on.

Fears of the unknown most frequently reported concerned the low birth weight of the child and the consequences of prematurity. Other "unknowns" feared were lack of health records and a health history. Some parents feared that they might not bond to their child after "coming home". Most fears and concerns experienced by this parent population could be generalized to that of any new parent population. The same can be said about these parents' worries about the future, with most parents responding they worried "just like any other parent".

The "life threatening conditions and situations" reported by parents for the most part were self limiting and were treated with a good end result, but one child died 18 hours

after arrival in Oregon of a "massive brain tumor" and other complications. The child was reportedly healthy until just prior to "coming home" and the parents were unprepared for this outcome. Other "life threatening illnesses" ending in survival and ongoing treatment included neurological disorders, metabolic problems, respiratory problems, heart defects, and mental illness.

Some parents mentioned as "life threatening" conditions such diseases as salmonella and hepatitis B. These can be more easily "planned" for and anticipated. The lack of testing for most of the communicable diseases indicates that parents are either unaware of or ignore the risk that is inherent in these children, and are therefore unprepared for the likelihood of such problems.

The last research question asked: How do parents deal with these problems, and what resources are available to them? Almost all parents stated they planned for the arrival of

their child by using resources of the PLAN agency and IMH personnel. They sought information from the PLAN newsletter, and IMH's The Heart Connection, and information and support from other prospective parents in gatherings of a "preadopt class". After arrival of their child, parents continued to turn to PLAN for information and support, but also obtained information and support from other parents. Special groups such as the "Parents of Indian Children" (P.I.C.), groups for single parents, and groups for parents of handicapped children serve the unique needs of this population. Parents turned to their health care practitioners for the health problems they encountered. Over half selected a pediatrician or general practitioner with previous experience in caring for children from developing countries; and 90% of the parents were satisfied with the health care they received.

"Surprise" illnesses and conditions tested the coping capabilities of many families. Some families reacted with anger and frustration

because of difficulty in obtaining adequate resources in their community for the "special needs" of their child. Other families appeared to adjust, taking each day as it comes. Finally, many parents found their religious faith a sustaining force in the face of adversity, and resorted to prayer for help in dealing with their problems. Comments in response to open-ended questions left an impression that most parents dealt with each obstacle and new development with undaunted determination, and found great joy in their child despite any problems.

A review of case reports underlines the uniqueness of each family's experience with their adopted child. Clearly, IMH and PLAN have gained experience over the past seven years, "surprises" are fewer in number, and parents are becoming better prepared for their experience through education.

#### Recommendations

This descriptive study is modest in scope, and has barely touched upon all the problems which intercountry adoption presents. Many other studies will be needed before there is sufficient

information to develop policy or to design resources adequate to meet the needs of these adopted children and their parents. Some possible topics for research are listed below.

First, longitudinal studies are needed to explore the nature and the frequency with which psychological, social and health problems emerge in the later childhood, adolescence, and adulthood of children adopted from other countries. Longitudinal studies are also needed to assess the effect of the better nutrition and living conditions prevailing among Americans on the growth and development of these intercountry adoptions.

Second, analytical studies might relate certain characteristics and experiences of the adopted children to their health status. For example, does the subsequent health of children adopted as infants differ from that of children adopted at older ages? Are the children adopted after IMH established the intermediate level care nursery, which saved fragile infants who would have previously died, more or less healthy than the children adopted before that time? Is there

a significant difference in the health status of the children adopted before and after the period when India formulated a policy of releasing only "special needs" children for foreign adoption?

Third, analytical studies might be conducted to determine the relationships, if any, between characteristics of families (such as single-parent versus two parent, or only child versus siblings) and the health status and development of these children.

Fourth, research might be undertaken to examine the effects of children with certain characteristics ("special needs" versus healthy, male versus female, etc.) on the adjustment and well being and functioning of the families. The coping responses of families might be researched, with an aim to distinguishing effective from ineffective responses to specific conditions and problems. In the present study, the richness and abundance of the qualitative data provided by parents in response to open-ended items demonstrate their openness and generosity in communicating and sharing their trials and tribulations, their joys and rewards, and



disappointments experienced in adoption. Many also expressed an interest in learning the results of this study, in order to share the information with their health care professionals. This interest confirms the view that parents lack information. Content analysis of these responses should provide insight into various coping responses and their effectiveness, as well as insight into parental questions about the identified problems.

Fifth, research should be undertaken to evaluate the effectiveness of interventions by health care providers, as, for example, the effectiveness of educational programs to promote screening for communicable diseases, or the undertaking of preventative actions. Finally, the health status of children adopted from different countries in Asia and Latin America should be compared to this population to determine similarities and differences, and to establish generalizability of findings.

In addition to these suggestions for research, certain recommendations may be made for practice. There is a clear need for more

education and preparation of parents for these transnational adoptions. Although children in this sample were relatively healthy, a considerable number did experience developmental problems. Moreover, testing for endemic diseases was far from complete. Parents and potential parents should be educated about the possibility of such problems occurring, and encouraged to test children when they first "come home" for salmonella, hepatitis B, tuberculosis, parasites and venereal diseases. Children should also be tested for leprosy and malaria if they show any signs or symptoms, however weak.

An alternative recommendation, which might be more effective than education directed toward parents, is that PLAN and IMH adopt the policy that individuals agree, as a condition for approval as prospective parents, to have their child tested on arrival home for a number of communicable diseases. Either the agency might contract with a health care provider to assess the health of each child on arrival and screen for the appropriate health problems, or the parent's selected physician might conduct such

tests and transmit results to the agency. Such a formalized procedure should prove useful for PLAN and IMH, inasmuch as adoptions, particularly intercountry adoptions, are always subject to public scrutiny. To protect the continued legal possibility of making such adoptions, the parents and agencies involved must demonstrate responsibility with respect to maintaining the health of their communities as well as the health of their adopted children.

#### Implications for Nursing

This population offers a wonderful opportunity for nursing expertise in both research and practice, because so little is known about the health of these children, and so little is available to their parents to help them with their children's problems. Nurses might, therefore, conduct research to increase the knowledge base in this field. From this knowledge base, they might then develop valuable educational material on health problems, conditions, health risks and resources both for the parents of these adopted children and for the health care professionals involved in their care.

In their practice, nurses might establish new support groups for families in various communities where such groups are lacking, and might participate in existing groups to share their skill. Nurses might also venture into the political arena to help establish policy and procedure to protect these children, the families they come to, and the communities in which they live.

Intercountry adoption is an area which can use the services of professionals as diversified in their skills as nurses. At this point in time the needs of these adoptive families are being met, for the most part, by other adoptive families. They need our help. It is time for nursing to get involved!

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Appendix A  
Cover Letter

# THE OREGON HEALTH SCIENCES UNIVERSITY

School of Nursing  
Community Health Care Systems

3181 S.W. Sam Jackson Park Road Portland, Oregon 97201 (503) 225-7709

October 13, 1986

Dear ,

I am a Registered Nurse and a graduate student in the School of Nursing at the Oregon Health Science University. I am conducting a study under the supervision of Julia Brown, Ph.D., about the "health of children adopted in Oregon from India". In this research, I have the support of PLAN, Inc. and the approval of Cherie Clark-Prakash, director of the International Mission of Hope (IMH) in Calcutta, India. We believe that any information you can give about the health problems you have encountered will be very valuable in planning future programs and writing brochures to prepare prospective parents of children from India. We would greatly appreciate your participation in this study.

Please complete a questionnaire for each child you have adopted through PLAN, Inc. from IMH. Each questionnaire should take about 20-30 minutes to complete. If you have adopted more than one child from IMH, a questionnaire for each child will be provided. It is important that the responses on each questionnaire apply to only one child.

We wish to assure you that your responses will be kept in the strictest confidence. Neither you nor your child will be identified anywhere by name; the results will be reported only in statistical form. The questionnaire numbers will be used only for my own remaining purposes. The results will be made available to you through PLAN, Inc. and will be shared with IMH in Calcutta and Denver. The IMH office in Denver will be conducting a study in the next two years exploring the growth and development of children adopted from IMH in India.

Please return your completed questionnaire(s) in the enclosed prestamped, addressed envelope as soon as possible. If you have any questions please leave a message at (503) 225-7709, I will be happy to be of any assistance. Thank you for your time.

Sincerely,

Tara D. Smith-Garcia R.N., B.S.N.  
Graduate Student  
OHSU School of Nursing  
(206) 565-9381 (home)

Julia Brown, Ph.D.  
Professor of  
Sociology  
OHSU School of  
Nursing



Schools of Dentistry, Medicine and Nursing  
University Hospital, Doernbecher Memorial Hospital for Children, Crippled Children's Division, Dental Clinics

Appendix B  
Chart Review Form

## CHART REVIEW DATA SHEET

Family # \_\_\_\_\_  
Child \_\_\_\_\_

1. This child is the:
  - \_\_\_\_\_ 1st = A
  - \_\_\_\_\_ 2nd = B
  - \_\_\_\_\_ 3rd = C
  - \_\_\_\_\_ Sibling Group = D
  - \_\_\_\_\_ This siblings age (data sheet for each sib)
2. How many children in this family have been adopted from the International Mission of Hope, (IMH) in Calcutta, India? \_\_\_\_\_
3. Where did IMH get this child in India? From:
  - \_\_\_\_\_ 1. A Bengali Prison
  - \_\_\_\_\_ 2. The Bangalor Boys Home
  - \_\_\_\_\_ 3. a Calcutta Nursing Home
  - \_\_\_\_\_ 4. abandoned in the streets of India
  - \_\_\_\_\_ 5. unknown
  - \_\_\_\_\_ 6. a government orphanage
  - \_\_\_\_\_ 7. other: (please specify) \_\_\_\_\_
4. What is the sex of this child adopted from IMH, Calcutta, India?
  - \_\_\_\_\_ 1. Male
  - \_\_\_\_\_ 2. Female
5. On what date did PLAN, Inc. approve this family to adopt this child from India? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(month/day/year)
6. On what date was this child from IMH, Calcutta, India assigned to this family?  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(month/day/year)
7. What month, day, year did this child come home to his or her adoptive parents?  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(month/day/year)
8. What was the age of this child when he or she came home to Oregon from India? \_\_\_\_\_
9. Birth weight \_\_\_\_\_ Length at birth \_\_\_\_\_.
10. Weight on arrival in Oregon \_\_\_\_\_.  
Length/height on arrival in Oregon \_\_\_\_\_.

Appendix C  
Questionnaire

## Part I

Please answer the following questions. They will help us to describe the families that have adopted children from the International Mission of Hope (IMH) Calcutta, India.

1. How many children in all are there in your family, both adopted and biological? \_\_\_\_\_
2. How many children have you adopted? \_\_\_\_\_
3. How many children have you adopted from India? \_\_\_\_\_
4. Have you adopted children from countries other than India?  
 yes  
 no

If "yes", How many? \_\_\_\_\_

From what countries did they come? \_\_\_\_\_

When did they come? \_\_\_\_\_  
 (month/day/year)

## Part II

The following questions relate to the health of your child in India and upon arrival home to the United States, .

5. What was your child's birthweight? pounds \_\_\_\_, or kilograms \_\_\_\_,  
 don't know \_\_\_\_\_
  6. What was your child's weight on arrival in Oregon? \_\_\_\_\_  
 don't know \_\_\_\_\_
  7. What was his/her length at birth? inches \_\_\_\_, or centimeters \_\_\_\_,  
 don't know \_\_\_\_\_
  8. What was your child's height/length on arrival to Oregon?  
 feet and inches \_\_\_\_, or centimeters \_\_\_\_, don't know \_\_\_\_\_
  9. When your child was assigned to you were you informed of any  
 medical problems, and/or physical problems, and/or mental,  
 emotional or developmental problems? (circle any and all that  
 apply)
- medical      physical      emotional      mental      developmental



10. While in India did your child receive any of these treatments?  
(check all appropriate responses)
- blood transfusions
  - photo therapy (light therapy)
  - intravenous feedings (IV's)
  - gavage feedings (tube feedings)
  - supplemental oxygen
  - don't know
  - other: (please list)
11. The following is a list of fungal, bacterial, parasitic, and viral infections native (endemic) to India. Please check any your child had when he or she came home to you.

YES	NO	DON'T KNOW	DISEASES NATIVE TO INDIA
			1. amebiasis
			2. "oriental sore" (cutaneous leishaniasis)
			3. tape worm
			4. hook worm
			5. other worms: (indicate type if known)
			6. cholera
			7. bacillary dysentery or shigellosis
			8. typhoid
			9. typhus
			10. tick-borne relapsing fever
			11. Sindbis
			12. chickungunya
			13. West Nile Fever
			14. dengue fever
			15. Kyasanur Forest Fever
			16. yeast
			17. tinea
			18. other: (list)

13. Directions: Below is a list of health problems and illnesses. If you were informed that your child had the illness or condition while living in India, place an X in the column labeled IN INDIA.

If an illness or condition was newly diagnosed or confirmed after examination by your doctor in this country, place an X in the column labeled AFTER COMING HOME.

IN INDIA	AFTER COMING HOME	CONDITIONS AND ILLNESSES	IN INDIA	AFTER COMING HOME	CONDITIONS AND ILLNESSES
		1. anemia			20. leprosy
		2. apneic spells (blue spells, but not congenital heart disease)			21. malaria
		3. blindness			22. malnutrition
		4. cataracts			23. measles
		5. cerebral palsy (CP)			24. mental handicaps
		6. cleft palate/lip			25. microcephaly
		7. club foot/feet			26. missing limbs
		8. compromised growth (small for age)			27. parasitic infections
		9. congenital heart disease			28. physical handicaps
		10. cytomegalovirus (CMV)			29. pneumonia
		11. developmental delays			30. polio
		12. epilepsy			31. prematurity/low birthweight
		13. feeding problems			32. retrolental fibroplasia
		14. fungal infections			33. rickets
		15. hearing problems			34. salmonella
		16. Hepatitis B			35. scabies
		17. kyphosis			36. scoliosis
		18. lice			37. spina bifida
		19. skin disorders, rashes (describe)			38. syphilis
					39. tuberculosis
					40. whooping cough
					41. other: (please list)

Page 4

14. When you first saw your child did he/she appear (check all that apply)

malnourished  
 dehydrated  
 unusually irritable  
 subdued and quiet  
 to have "travel diarrhea"  
 withdrawn  
 none of the above  
 other: (please describe)

15. Was your child tested for any of the following within the first year after coming to your home from India by your physician or health care provider?

YES	NO	DON'T KNOW	DISEASE NAME	YES	NO	DON'T KNOW	DISEASE NAME
			1. salmonella				6. parasitic infections
			2. Hepatitis B				7. CMV; cyto-megalovirus
			3. tuberculosis				8. other: list below
			4. malaria				
			5. leprosy/ Hansen's Disease				

16. Has your child had a positive T.B. (tuberculosis) skin test?
- hasn't been tested  
 don't know  
 no  
 yes
17. Was your child diagnosed with tuberculosis?
- no, did not have tuberculosis  
 yes  
 don't know (If checked "don't know" go to question #19)
18. If your child was diagnosed with tuberculosis, was it
- active  
 inactive  
 don't know
19. Was your child treated with antituberculosis medicine (BCG) in India?
- yes  
 no  
 don't know

20. Has your child had a positive Hepatitis B test?  
 hasn't been tested ( If not tested go to question #24)  
 no (If "no", go to question #24)  
 yes
21. If "yes" is your child a Hepatitis B carrier?  
 yes  
 no
22. To your knowledge was your child ever symptomatic of illness indicative of Hepatitis B?  
 yes  
 no
23. Has your family been vaccinated for Hepatitis B?  
 yes  
 no
24. What informational and support resources did you use regarding Hepatitis B?
25. Was your child tested for salmonella when he/she first came to the United States?  
 no (If "no", go to question #35)  
 don't know (If you "don't know" go to question #35)  
 yes
26. If "yes" who first tested you child for salmonella?  
 physician/health care provider  
 county health department  
 hospital/clinic
27. Did your child have a positive salmonella test?  
 no (If "no", go to question # 35)  
 yes

28. Was your child repeatedly tested until a negative stool was obtained?  
 yes  
 no  
 don't know
29. How many months did your child shed (pass) salmonella stools?  
 Don't know  
 (fill in the number of months)
30. Did your child have diarrhea while shedding salmonella?  
 yes  
 no
31. Is your child a carrier of salmonella?  
 yes  
 no  
 don't know
32. Did a diagnosis of salmonella affect child care arrangements? (for example: day care or baby sitting)  
 no  
 yes
33. If "yes" please describe how it affected your child care plans and how you coped with/or made alternative plans.
34. Salmonella follow-up was done by:  
 county health department  
 private health care provider (doctor, nurse, HMO)  
 was not followed
35. In your opinion, what resources were the most informational and supportive in learning about salmonella:  
 health care provider (doctor, nurse)  
 county health department  
 nothing  
 other: (literature, friends, etc. please list)

36. Does your child have vision problems?  
 no  
 yes
37. If "yes" are they:  
 correctable by: (circle) glasses surgery other  
 noncorrectable
38. Does your child have hearing problems?  
 no  
 yes
39. If "yes" are they:  
 correctable by: (circle) surgery hearing aids other  
 noncorrectable
40. Does your child have any feeding problems?  
 no  
 yes
41. If "yes" are/were they related to:  
 poor suck  
 milk intolerance (allergy)  
 digestive tract disorder  
 no feeding problems  
 don't know  
 other: (describe)
42. Does your child have a milk intolerance?  
 no (If "no", go to question #45)  
 yes
43. If "yes", what are the symptoms? (describe)
44. What milk/dairy substitutes do you utilize?
45. Does your child have a congenital heart defect?  
 no  
 yes
46. If "yes", will or did this defect require surgery?  
 no  
 yes
- If you know the name of this defect please name it:
47. Has your child been diagnosed with developmental delays?  
 no  
 yes
48. If "yes", do they differ from those you were aware of before your child came to you from India?  
 no  
 yes
49. How did they differ? (briefly describe)

Page 8

50. Did you select a physician or other health care provider for your child prior to your child's arrival home?  
 no  
 yes
51. Did you select your child's physician or other health care provider based on  
 your personal knowledge of the physician  
 recommendations from other parents with children from India  
 recommendations of parents with children not from India  
 other reasons: (describe)
52. Did the health care provider (physician, nurse practitioner, other) you selected have experience in the care of people from India and /or Asia prior to caring for this child from India?  
 yes  
 no  
 don't know
53. Was the health care provider you selected to care for this child a:  
 pediatrician  
 general practitioner/family practice physician  
 nurse practitioner  
 other: (describe your health providers specialty)
54. How satisfied have you been with the physician or other health care provider you selected?  
 (select one response)  
 very satisfied  
 satisfied  
 no strong feelings one way or another  
 dissatisfied  
 very dissatisfied
55. If you were dissatisfied with the physician or other health care provider you selected was it due to:  
 his/her lack of understanding of children from India  
 lack of teaching and support in relation to your child's health problems  
 other: (describe)

56. What resources were most useful to you in planning for the arrival of your child?
57. What unknowns were the most frightening to you?
58. What (if any) life-threatening illnesses or conditions does or did your child have? (please describe)
59. What has happened?
60. How have you dealt with it?
61. Have any previously undetected health problems become evident as your child grows older?  
\_\_\_\_ no  
\_\_\_\_ yes
62. If yes, what are they: (list)
63. How have you dealt with these problems?
64. Do you worry about any future problems? (please describe)



- Page 10
65. Which of the following have you used for support or for information? (check all that apply)

SUPPORT	INFORMATION	GROUP OR SERVICE
		1. OURS
		2. PLAN, Inc.
		3. informal gathering of pre-adopt group
		4. other parents who have adopted from India
		5. Indian Cultural Association
		6. other:(list)

The following questions will gather information about your family.

66. Who is responding to this questionnaire?  
 mother of child  
 father of child  
 both  
 neither, please state who
67. What was your marital status when your child came home?  
 single  
 married  
 divorced  
 widowed
68. What is your marital status at this time?  
 single  
 married  
 divorced  
 widowed
69. Did your health insurance company provide health care coverage for your child from India?  
 yes  
 no
70. If "no", why not?

Please describe how you have managed without health insurance.

Thank you for your time and thought!

Appendix D  
Questionnaire Item Justification

## INSTRUMENT DEVELOPMENT

CHART REVIEW DATA.

Items #1 through #8

Rationale: To supplement information provided by returned questionnaires concerning individual children in each adoptive family. To determine waiting time between Home Study, assignment of a child from IMH, and the child's arrival in Oregon. The birth dates and arrival dates help to establish age at arrival and current age.

Reference: See review of the literature.

QUESTIONNAIRE.

Items #1 through #4, and Items #66 through #68

Rationale: To explore adoption behavior of the sample as well as intercountry adoption patterns. Establish the family configuration of the sample families.

Reference: See review of the literature, specifically: Walker, L.O. (1978) "Adoptive Parent Questionnaire" obtained from author.

Item #5 through #8

Rationale: To gather information about the growth of the sample children in relation to other population norms.

Reference: WHO (1978) and Food Specialities Limited, New Delhi, India.

Items #9, #48, #49, #57

Rationale: To establish what the parents were aware of prior to their child "coming home".

Reference: Based on what is reported in the review of the literature as well as the author's experience with the population as a participant observer.

Appendix E  
Raw Data for  
Questionnaire Items  
#5, 6, 7, 8, 13 and 15

Arrival weights and heights for females older  
than six months of age

Age in Months	Weight in Kilograms	Height/Length in Centimeters
12.31	missing	missing
7.67	missing	missing
9.34	6.80kg	missing
21.22	11.45kg	78.70cm
13.54	7.26kg	68.60cm
14.61	7.03kg	68.90cm
15.67	13.60kg	missing
6.11	5.07kg	55.90cm
97.57	24.04kg	137.00cm
96.23	missing	missing
79.27	29.50kg	missing
145.28	29.50kg	136.00cm
129.15	34.50kg	123.00cm
166.77	33.10kg	147.00cm
142.19	33.60kg	147.00cm
103.01	30.40kg	178.00cm
193.60	40.40kg	150.00cm
110.74	31.70kg	132.00cm
155.48	34.50kg	132.00cm
121.52	34.00kg	123.00cm
77.86	20.40kg	114.00cm
95.10	15.00kg	112.00cm
84.56	18.60kg	104.00cm
128.79	31.30kg	135.00cm
108.31	missing	122.00cm
75.08	20.40kg	119.00cm

Arrival heights and weights of males older than  
six months of age

Age in Months	Weight in Kilograms	Height/Length in Centimeters
58.01	15.90kg	99.10cm
8.81	missing	missing
12.74	5.78kg	69.80cm
12.21	7.25kg	missing
47.17	14.00kg	94.60cm
94.93	18.14kg	114.00cm
72.92	18.20kg	107.00cm
77.76	16.80kg	97.00cm
89.46	21.30kg	127.00cm
142.36	missing	missing
150.10	27.20kg	137.00cm
69.58	18.14kg	104.00cm
123.25	19.96kg	114.00cm
89.06	22.70kg	missing

Questionnaire Item #8:

139

Frequency of testing within the first year after "coming home", as reflected by parental response.

YES	NO	DON'T KNOW	DISEASE NAME	YES	NO	DON'T KNOW	DISEASE NAME
121	49	15	1. salmonella				6. parasitic infections
76	72	22	3. Hepatitis B	105	55	19	7. CMV (cyto- megalovirus)
115	52	10	3. tuberculosis	9	93	57	8. other: (list)
11	119	31	4. malaria				
3	124	29	5. leprosy (Hansen's Disease)	11	85	17	

## Questionnaire Item #13:

Number of cases as reported by the sample parents, on 200 children.

IN INDIA	AFTER COMING HOME	CONDITIONS AND ILLNESSES	IN INDIA	AFTER COMING HOME	CONDITIONS AND ILLNESSES
12	33	1. anemia	0	0	20. leprosy
		2. apneic spells (blue spells, but not congenital heart disease)	2	3	21. malaria
6	3	3. blindness	28	22	22. malnutrition
1	3	4. cataracts	1	1	23. measles
1	0	5. cerebral palsy (CP)	1	2	24. mental handicaps
3	11	6. cleft palate/lip	0	2	25. microcephaly
1	1	7. club foot/feet	0	0	26. missing limbs
4	1	8. compromised growth (small for age)	4	19	27. parasitic infections
16	33	9. congenital heart disease	3	8	28. physical handicaps
1	1	10. cytomegalovirus (CMV)	11	9	29. pneumonia
0	4	11. developmental delays	2	3	30. polio
8	23	12. epilepsy	50	30	31. prematurity/low birthweight
2	3	13. feeding problems	0	1	32. retrolental fibroplasia
12	28	14. fungal infections	0	0	33. rickets
3	9	15. hearing problems	6	39	34. salmonella
5	19	16. Hepatitis B	8	22	35. scabies
5	10	17. kyphosis	0	1	36. scoliosis
0	0	18. lice	0	0	37. spina bifida
9	16	19. skin disorders, rashes (describe)	0	0	38. syphilis
9	30		0	5	39. tuberculosis
			0	0	40. whooping cough
			13	26	41. other: (please list)



AN ABSTRACT OF THE THESIS OF  
TARA D. SMITH-GARCIA

For the degree of MASTER OF SCIENCE

Date of receiving this degree: June 12, 1987

Title: THE HEALTH STATUS OF CHILDREN FROM INDIA  
ADOPTED IN OREGON.

APPROVED: \_\_\_\_\_

Julia S. Brown, Ph.D., Thesis Advisor

The present study described the health status of children adopted by families in the state of Oregon, as well as explored the ways in which these adoptive families coped with health problems. Answers were sought to five questions: What was the health status of these children upon arrival in this country? Were they carriers of diseases endemic to India? What health problems developed later? Which of these problems were

anticipated and planned for, and which were unexpected? How did parents deal with these health problems, and what resources were available to them?

The sample selected for investigation consisted of all children placed by PLAN, Inc., from the International Mission of Hope in Calcutta, India, in Oregon families from 1978 to 1986. Questionnaires were mailed to 210 families that had adopted 258 children from India. The response rate was 78%. These questionnaires, supplemented by PLAN agency records, provided information regarding 200 children (128 females and 72 males), living in 166 families. Most of these children arrived in the United States as infants. Many were high risk infants, as evidenced by the high incidence of prematurity, low mean birth weight, and widespread malnutrition. Mean birth weights were 1.82kg for males, and 1.79kg for females, which fall 3 to 4 standard deviations below WHO norms for the world's children. At arrival, their weights were still far below the norms set for children in India.

The extent to which these children were carriers of diseases endemic to India cannot be accurately estimated from these data, because many children were apparently not tested for them. For example, only 62% were tested for salmonella, 58% for tuberculosis, and 68% for hepatitis B; but of those tested, 49% were diagnosed with salmonella, 9% with hepatitis B, and 2% with tuberculosis. Two other health problems endemic to India frequently reported by parents were parasitic infections and worms.

Parents were aware of some health problems before their children arrived. Other problems became evident upon arrival, or shortly thereafter. Such conditions included parasites, worms, cerebral palsy, and feeding problems. Still other conditions became apparent only later, as the child grew older. These included developmental delays, neurological disorders, heart defects, blindness, hearing losses, metabolic disorders, and mental illness.

To cope with and resolve these health problems, the parents used the resources of the PLAN agency, obtaining information from

newsletters and classes, as well as sought support in groups of other parents. They also used the resources of their health care providers, and other groups in their communities. Many were sustained by their religious faith. Despite all the problems noted, most parents expressed great satisfaction and joy in their children, and expressed no regrets in their decision to adopt from India.

Several recommendations are presented for future research and for nursing practice. In regard to research, longitudinal, analytical and comparative studies are suggested. Longitudinal studies of these children will permit followup on health problems, and provide subsequent health histories, family adjustment and outcomes. Analytical studies might explicate the interactions among the children's characteristics and health status, the families' composition and characteristics, and various resources and coping styles in effecting optimal outcomes for the adopted children and their adoptive families. Comparative studies would permit a determination of the similarities and differences in health

problems of children adopted from India, children adopted from other lands, and domestic adoptions. With regard to nursing practice, it is recommended that nurses prepare informational resources on specific health problems faced by adoptive families, help develop and participate in support groups for families, and become involved in developing better programs and policies at agency and community levels.