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VII. IDEAL COMPONENTS AND CURRENT CHARACTERISTICS OF ALTERNATIVE CARE OPTIONS FOR CHILDREN OUTSIDE OF PARENTAL CARE IN LOW-RESOURCE COUNTRIES

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Utilizing the United Nations Convention on the Rights of the Child and the Guidelines for the Alternative Care of Children, this paper examines critical components and current characteristics of alternative care for children in low-resource countries. It begins by exploring the role of values within policy and practice related to child welfare. Then a brief examination comparing alternative care in high- versus low-resource countries is presented. Alternative care includes a continuum approach beginning with family support and reunification, kinship care, foster care, domestic adoption, and ending with intercountry adoption. Specific examples are provided from Eastern Europe, Latin America, and Africa. The paper concludes with the need for more research related to alternative care outcomes that could inform policy and practice.

Child welfare is understood as any policy, service, or program related to the safety, security, health, and well-being of children; obscured in this definition is recognition that families are the critical component in the welfare of children. The major framework influencing child welfare globally is the 1989 United Nations Convention on the Rights of the Child (CRC), ratified by almost every country in the world with the exception of Somalia and the United States (United Nations, 1989). The preamble of the CRC recognizes the family as the natural environment for children and requires the State to provide support and assistance to ensure that families are able to care for their children (United Nations, 1989). Furthermore, the CRC, in Article 20 makes specific reference to children outside of parental care and their right to special protection and assistance as well as the role of the State to provide alternative *family* placements to children lacking parental care (United Nations, 1989).

Basic child welfare policies and programs focus on the protection of children from abuse, neglect, or exploitation. The highest child welfare or child protection systems include prevention, intervention, remediation, and any improvement in the lives of children *and* families. An additional international

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convention that supports and promotes ethical alternative care placements is the *Hague Convention of 29 May 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption* (henceforth referred to as the Hague Convention). The Hague Convention framework provides protection for the child, the birth/biological family, and the adoptive family. It also promotes the principles that prioritize placement within the biological family first, then extended family care, domestic adoption, and intercountry adoption (ICA) only when all other domestic care options have been deemed inappropriate and/or not in the child's best interest (The Hague Convention, 1993). Group or institutional care can be an option but only if there is a child assessment that concludes this is the best placement option for this specific child and not the default option because other alternatives have not been developed.

Child protection is a more narrow perspective of child welfare. Protecting children from neglect, violence, exploitation, abuse, commercial sexual exploitation, trafficking, child labor, and harmful traditional cultural practices such as female genital mutilation/cutting or child marriage is an integral component of protecting their rights to survival, growth, and development (United Nations, 2008). Yet, an exclusive focus on protection narrows the domains that affect the health, development, welfare, and lives of children. To protect children and promote their interests, an array of community services and programs related to permanency that concurrently promotes well-being must be developed. While child rights organizations frequently refer to child protection, child welfare is a better descriptor.

The Basis of Practice and Policy

"Ideal components" means the best practices used to design, implement, monitor, and evaluate the continuum of child welfare services and programs for vulnerable children. The ideal components currently influencing policy and practice worldwide are mostly experientially based and evidence-informed. Rarely, if ever, does research directly translate into best practices and just as rarely is there an effort to critically evaluate what has come to be viewed as best practices with research. When there is research evidence, most of it is based in high-resource countries and not in low-resource countries.

This paper presents the ideal components and current characteristics of alternative care options for children outside of parental care, specifically focusing on low-resource countries. The one issue that has to be acknowledged in this discussion is that of values. Values, more than evidence, drive policy and practice decisions about the care of orphaned, abandoned, separated, or vulnerable children. When values conflict with evidence, it is frequently values that have significant influence. For example, while evidence suggests that reunifying children with birth families does not always lead to as positive

developmental outcomes as does placing them in foster care or in adoption (Julian & McCall, 2009), the value base as well as the CRC and the Hague Convention support family reunification as the care option that should be explored before others (The Hague Convention, 1993; United Nations, 1989). Therefore, the state of the field of child welfare services is a mix of values, experientially based, evidence-informed, evidence-supported, and some evidence-based interventions, services, policies, programs, and practices.

Child Welfare Systems in High- Versus Low-Resource Countries

High-resource countries, in support of the substantial evidence showing that family-based care is better than institutional placement, typically emphasize a family-based system of child protection. This means if children are not with their birth family, they are placed within another type of family alternative (kinship family, foster family, adoptive family). The foundation of most child protection systems in high-resource countries is to strengthen and preserve families whenever possible, unless there is a very compelling reason not to do so as determined within a legal framework. The principle of the child's best interest also plays a large role in determining the placement decision. In contrast, the foundation of most child welfare systems in low-resource countries is primarily institutional care or informal kinship care. Save the Children and EveryChild, UK-based international child rights and welfare organizations, reports that 90% of children in Africa live within extended family care (kinship care) as does 30–50% of children in the Central and Eastern Europe and Confederation of Independent States (EveryChild, 2009; Save the Children UK, 2007). Yet many traditional caring mechanisms such as kinship care, especially in Africa, have been stretched to the limit as caregivers are expected to care for more children with little or no formal government support. In response to this growing concern, institutional care has dramatically increased throughout Africa and Asia (EveryChild, 2009). Social services to support and strengthen families are usually not as well developed in low-resource countries; most emphasis is placed on creating structures to provide only the most basic care to children such as water, food, and medicine.

A modern child welfare system based on children's rights prioritizes family-centered and family-based systems of care, providing appropriate services, supports, and assistance to enable families to care for and protect their children. Furthermore, the modern system includes services that promote the support of children outside of parental care, moving beyond protecting and providing the basic needs of children to meeting all the needs of children (physical, developmental, educational, psychosocial, spiritual, etc.) and building policies and practices to support family-based and community-based care.

FAMILY SUPPORT TO HELP PARENTS KEEP OR REUNIFY THEIR CHILDREN

Family support services are designed to keep children safe, promote their health, development, and well-being, and prevent unnecessary out-of-home placement by helping families cope with stressors, providing an array of basic services, and helping families obtain needed services. To strengthen and preserve families and to assist families with reunification, antipoverty programs are a major intervention.

Types of Poverty Reduction Strategies

Cash transfers (CTs), one antipoverty strategy, are income maintenance programs designed to support families. A CT is the distribution of a predetermined amount of cash, based on means testing or other beneficiary identification mechanism such as child disability, to supplement the income of a family/household and, in some cases, to be the sole source of income (Vadapalli, 2009).

CT can be of two types. Unconditional cash transfer allocates cash with no expected behavior of the receiving family/household; a family is given money with the expectation that the money is used to keep children in families and to help children develop. Conditional cash transfer dispenses cash conditional on an expected behavior of the beneficiary, such as taking parenting classes, regular visits to a health clinic for the child, or enrollment of the child in school.

The most common barriers found in getting any type of a CT to a family include inadequate identification of beneficiaries; lack of funding or high cost of access to the program; and lack of awareness of the program (Vadapalli, 2009).

The impact of CT on child developmental outcomes is not well developed, and caution should be exercised to not oversimplify the debate on understanding the impact of CT on children and families (De Brauw & Hoddinott, 2008). Even though a plethora of research exists from continents such as Latin America, mostly focusing on process issues (who enrolls, percent of eligible persons enrolled, etc.), there are not outcomes consistently studied comparing these two types of transfers (Farrington & Slater, 2006). Conditional transfer places decision making in the mothers' hands; this can lead to increased overall well-being in children and maternal bargaining power (Martinelli & Parker, 2003). A lower maternal bargaining power within the family system has been linked to children's risks of receiving a decreased allocation of goods and opportunities (Martinelli & Parker, 2003). Yet, well-being is such an encompassing concept and no specific developmental outcomes are specified.

A South African study of a CT program reported significantly positive nutritional changes among young children (Aguero, Carter, Woolard, 2007). A Brazilian CT program led to an increase in girls' education attainment decreased participation in child labor practices for boys (De Carvalho Filho, 2000), an improvement in girls' health and nutrition (Duflo, 2003), and better height outcomes (Aguero et al., 2007). CT programs demonstrate modest impact on some areas of child development for younger children (Attanasio, Battistin, Fitzsimmons, Mesnard, & Vera-Hernandez, 2005; Fernald, Getler, & Neufeld, 2008; Morris, Olinto, Flores, Nilson, & Figueiro, 2004) and on children's health (Lagarde, Haines, & Palmer, 2007). There is an assumption that one effect of CT is that families remain preserved, although this has never been examined and is difficult to adequately measure.

Job Skills Development

A significant aspect of poverty that influences the well-being of children is their parents' ability to earn an income. Many parents in low-resource countries live in abject poverty and lack the necessary skills for gainful employment. Interventions implemented to offset poverty include job-skill programs and microenterprise development (Riley-Behringer, 2009). Job-skill programs have had mixed results. In part, there is frequently not a good match between market needs and the skills that training is intended to develop, or participants are prepared for the lowest wage jobs that do little to improve their overall quality of life. More importantly, underlying issues of substance abuse, mental health, and domestic violence are not resolved. Without effectively dealing with these interpersonal factors as well as appropriate job training, the likelihood of success remains minimal. Stedfast and Chen (1996) and Copestake and colleagues (2010) suggest that while microenterprise are very popular, they have a mixed impact families and children

Kinship Care

Many low-resource countries promote informal kinship care as a third strategy to preserve the family (Riley-Behringer, 2009; Save the Children UK, 2007; Tolfree, 2007; UNICEF, 2004), with the value that kinship care is family preservation. This is especially true in sub-Saharan Africa which has been drastically impacted by the onset of HIV and AIDS and where an estimated 12 million children are orphaned due to the diseases caused by the virus (UNAIDS, UNICEF & USAID, 2004). In many sub-Saharan African countries, extended families have assumed responsibility for more than 90% of all double orphans (both parents are deceased) and single orphans (one parent is

deceased) not living with a surviving parent. In Central and Eastern Europe, an increasing group of children is growing up in kinship care as parents are migrating to Western Europe for employment.

Kinship care is the full-time care, nurturing, and protection of a child by someone other than a parent who is related to the child biologically, by legal family ties, or by a significant prior relationship (see www.cwla.org/programs/kinship/kinshipaboutpage.htm). *Informal kinship care* is any private arrangement provided in a family, whereby the child is looked after by kin. It is the least expensive option for governments since the government is not involved. *Formal kinship care* describes arrangements that have been ordered or authorized by an administrative body or judicial authority; it usually involves an assessment of the family for the child and the provision of some kind of continuing support and monitoring. Since formal kinship care requires government intervention, this increases the costs for this intervention. Informal kinship care is the most common form of alternative family care worldwide for children who are not with their biological parents.

Kinship care has several psychologically beneficial outcomes for children: (1) Caregivers familiar to children can help reduce the trauma of separation from their birth parents (Berrick, Nedell, Barth, & Jonson-Reid, 1998); (2) kinship care reinforces children's sense of identity and self-esteem (Stozier, McGrew, Krisman, & Smith, 2004); (3) it preserves family, community, ethnic, and cultural ties (Farmer & Moyers, 2008; Wilson & Chipunga, 1996); and (4) it promotes maintaining sibling relationships (Beeman & Boisen, 1999). Yet, informal kinship care is not without risks to children. Sometimes, the child in a kinship arrangement is forced into menial tasks not required of birth children, subject to physical or emotional abuse, removed from school to provide child care, or sexually exploited by another child or adult in the kin household (Madhavan, 2004). There are a multitude of risks and benefits to both caregivers and children within kinship arrangements; outcomes are influenced by socioeconomic status, prior relationship between the caregiver and the child, and age of the caregiver.

Best Practices in Preserving and Reunifying Families

Family Assessment

The foundation of best practices is an accurate assessment of the family and their situation. A comprehensive assessment may not be needed, often is not formally conducted, and in most low-resource countries there is not advanced training or personnel for comprehensive assessments. However, it

is critical to assess what type of help is needed to support the family, the resources the family has to build upon, and what next steps will best assist the family. Included in the family assessment is the type and severity of risks to children. Assessments should place priority on cases where preservation or reunification is likely to happen rapidly, putting more resources in these cases (Kelley, 2000). Each country must determine the family assessment model or protocol they will use.

One core protocol for family assessment and risk assessment needs to be developed and used nationally and then contextualized to incorporate cultural or regional specifics. The protocol should be flexible enough to meet the needs of different communities and cultural groups, including subprotocols for different regions or subcultures, but in both policy and practice there should be only one core or standard protocol to follow. Each country will need to develop its own knowledge base about cases where success is likely and cases where success is unlikely. This practice requires child welfare staff who are knowledgeable and skilled in assessing families and risk assessment—evaluating the nature and severity of risks to children given various family circumstances. As information is being gathered in the process of a family assessment, specialized assessments may be required. These specialized assessments could be for developmental issues of the child, mental health problems, the use of alcohol or other drugs, or challenges and disabilities that affect parenting. The recommendations arising out of specialized assessments must be incorporated into the service plan.

Family assessments in low-resource countries typically involve families completing paperwork. Many low-resource countries recognize that substance abuse and mental illness are challenges but often lack the expertise to adequately assess or treat these problems. Since the 1990s, there has been a steady increase in psychology and social work academic programs in former communist and sub-Saharan countries; this new wave of helping professionals have some knowledge in these areas as well as other areas negatively impacting family stability. The new helping professionals often lack adequate professional experience but are gaining that experience over time.

Service Plan

The purpose of a family assessment is to provide the information needed to address the individual needs of family members in a service plan. The service plan identifies interventions and actions to address the family's needs and to facilitate the changes necessary to reduce risks to children and increase family stability. This practice requires a system of case planning and case review that moves from assessment to goal setting to monitoring the impact of interventions on families and children. The service plan can be simple,

such as the central government will provide a monthly stipend to support a family for 2 years when the wage-earning parent was killed in a mudslide (a Guatemala case). The Guatemalan social worker met the family every quarter to ascertain continued need for funds, to make sure the parent still has custody and care of her children, and to monitor the progress of the parent moving toward some type of earning.

Services

For family preservation or family reunification, intensive services and support are essential for success (Kelley, 2000). Services must be concrete and include provision of housing, income support, food, medical care, transportation, and employment location and/or training. For children with a plan of reunification, one critical factor is geographical proximity to relatives that facilitates visiting, which is a significant predictor of reunification (Warsh, Maluccio, & Pine, 1994). Family connections can only be maintained if the child is located near the family, which is part of the planning.

Kinship care requires some additional competencies for best practices. Social service workers must be trained in the unique role of kinship caregivers, the challenges caregivers and children may face, and the types of support and monitoring that may be required. The suitability of kinship care for the children must be assessed on a case-by-case basis. Such assessment should include the viability, safety, and stability for children in kinship care before any other placement plan is made, and a case plan should specify the types of supports and monetary resources necessary for the placement. Kinship caregivers and children require many of the same services necessary to strengthen and preserve birth families (see list of services below). Support groups for kin caregivers should be developed and conducted in neighborhood centers as a cost-effective strategy to assist families. Other social supports for kin caregivers should be developed to help reduce feelings of isolation because social support brings stability to kinship families.

Programming for successful kinship care should include the following services:

- Financial support, including benefits, vouchers, CTs, and in kind payments.
- Access to healthcare, including prevention, treatment, and rehabilitative services (e.g., for HIV and AIDS, drug and alcohol abuse, and disabilities).
- Education, formal and informal, for caregivers.

- Early intervention for children in high-risk situations.
- Access to daycare and respite care, especially in the case of children with disabilities.
- Support groups and parenting classes that provide psychological support to caregivers; training in key topics such as crisis management, child nutrition, and child development; and, psychosocial services including direct work with children.

An example of successful low-cost family preservation programs exists in Ethiopia where Family Health International has worked to strengthen local partners to support families affected by HIV and AIDS and prevent family breakdown (Family Health International, 2010). Their approach uses local nongovernmental organizations (NGOs) to monitor and support community-based organizations that have a core team of community volunteer caregivers. These caregivers receive training and then provide support to households with chronically ill members, placing specific focus on child safety, health, development, and school attendance. The volunteer caregiver acts as a referral to other social welfare services, including access to education support, housing, and health services, provides psychosocial support to all members of the household, promotes income-generating opportunities for family members, and in the case of caregiver death works to secure alternative care and support of the children. The program is implemented in 13 urban areas across the country and has provided support to more than 21,000 persons living with HIV and AIDS and more than 126,000 orphans and vulnerable children (Family Health International, 2010).

While there may not be many services in low-resource countries, as part of strengthening and supporting families, families should be referred to programs that do exist. Some services, such as support groups, take little resources except a willingness of a professional or paraprofessional to take the initiative. Other services, such as financial support and health care, require resources, but this does not necessarily have to be governmental; many NGOs provide services for specific problems or in specific areas. Thus, while feasible, the development and maintenance of services to support families remains a major challenge in low-resource countries.

Foster Care

Foster care refers to situations where children are placed by or with the approval of a government authority in a qualified, approved, and supervised family for the purpose of providing alternative family care (United Nations, 2010). A foster family agrees to meet (i.e., foster) the developmental,

psychosocial, medical, educational, and spiritual needs of a child who is not able to live with his/her own parents or extended family.

Types of Foster Care

Foster care can be temporary or long term, and it can be formal or informal. *Formal foster care* describes arrangements that have been ordered or authorized by an administrative body or judicial authority. It usually involves an assessment of the foster family for the child and the provision of some kind of continuing support and monitoring. *Informal foster care* is a private arrangement made between the two families. Informal foster care is practiced in many countries, especially in Africa. *Specialized foster family care* provides for children with special needs (e.g., a child with HIV/AIDS or psychiatric disorders), and *crisis foster care* is used when there is an emergency and the child requires temporary care (Groza & Bunkers, 2008).

Effectiveness

Chapin (1915, 1917; Gray, 1989) was one of the first researchers to conclude that infants were at a great risk for developmental difficulties and a quick death when placed in institutions. Acting on this belief, he began a boarding-out or family fostering system, in which hospitalized infants were placed in the homes of private families. The effects on infants were dramatic—they not only survived but also thrived in the families. Many decades later, similar comparison research was completed in Romania by The Bucharest Early Intervention Group which showed that if children from institutions are randomly assigned to high-quality foster care in the first few years of life, they show marked improvement in cognition, attachment, and development relative to children who remain in institutional care (Nelson et al., 2007; Smyke, Dumitrescu, & Zeanah, 2002; Zeanah, Smyke, & Dumitrescu, 2002; Zeanah et al., 2003). Other studies have shown that children in foster care also show better overall development than children in institutional care and are able to meet developmental benchmarks while children in institutional care did not (Chapin, 1915; MacLean, 2003; Tarullo, Bruce, & Gunnar, 2007; Van Londen, Juffer, & Van IJzendoorn, 2007). Further, foster children show less insecure and disorganized attachment than institutionalized children (Van den Dries, Juffer, Van IJzendoorn, & Bakermans-Kranenburg, 2010), and sensory processing and regulatory problems are less likely to occur for children in foster care than group or institutional care (Cermak & Groza, 1998). Miller, Chan, Comfort, and Tirella (2005) reported that, compared to institutional care, children in foster care have better physical growth and cognitive functioning. In the same vein, Van den Dries and colleagues (2010) found

that children adopted from foster care outperformed children adopted from institutional care in mental and motor development. Children in foster care are less likely to have major health issues, such as hepatitis and tuberculosis, compared to children cared for in an institutional setting (Mandalakas et al., 2007). Gavrilovici and Groza (2007) also found that children in foster care in Romania were less likely than their counterparts in institutional care to suffer from abuse and exposure to violence.

Best Practices in Providing Foster Care

Key best practices in foster care are stability; confidentiality; respect of the cultural, linguistic, and spiritual identity of the child, foster family, and biological family; and a multidisciplinary team approach to assessment, case management, case planning, and support for foster families (Davis, Brown, & Groza, 2009). A main element of foster care is that children are cared for in a family environment. They do not change identity and, when it is in the best interest of the child, the children maintain relations with the biological and/or extended family, community, and ethnic group. The UN Guidelines for the Alternative Care of Children (United Nations, 2010) provide an excellent framework for components of best practice foster care programming. In addition, foster families require support from professionals; poorly supported foster families may bring similar risks to foster children, particularly in newly developed foster systems.

In Romania, foster care was developed to assist in the deinstitutionalization of children as well as to constitute the preferred placement when babies were being abandoned at the hospital. Children under 2 years could not be placed in an institution (according to Romanian law), and because there are not enough foster families, there is an increase of children being abandoned at hospitals after 2000 (Groza, Conley, & Bercea, 2003). The specific model developed for foster care in Romania is based on long-term foster care and foster parents are treated as part of the child welfare workforce, even receiving a title as *mama profesionista* or professional mothers. The Bucharest Early Intervention Project in Romania demonstrated that foster care is a much better alternative for children than institutions and this research provided part of the foundation for policy and practice change in Romania (Nelson et al., 2007; Smyke, Zeanah, Fox, & Nelson, 2009), as did pressure from the EU.

In Colombia, the foster care program is well developed and most children are placed in foster care, particularly those available for adoption. The foster care family helps explain things to the child while the child is in a safe environment and helps in the preparation of the child for the adoptive placement.

Provisions, Protection, and Protection: Useful Best Practice Components

Provisions

The need for stability in placement is of utmost concern when providing foster care. Therefore, careful case assessment and management should occur at the time the child enters foster placement. The assessment should be thorough with the end goal being stability and ideally permanency. Article 113 of the UN Guidelines for the Alternative Care of Children states that the records on children in care should be complete, up-to-date, and secure. They should include information on their admission and departure, and the form, content, and details of the care of each child along with any appropriate identity documents and other personal information. Information on the child's family should be included in the child's file as well as in the reports; there should be a system of regular evaluations of the birth family, foster child, and foster family. The record should follow the child throughout the alternative care period and be consulted by professionals responsible for his/her current care (United Nations, 2010).

Children in alternative family care have the right to confidentiality, and foster care providers should strive to ensure that right is respected by all persons involved in the care of the child and the management or oversight of that care. Children in care are more vulnerable and the details of their personal and familial issues must be treated with respect, dignity, and confidentiality. Several articles of the UN Guidelines for Alternative Care reflect the importance placed upon the principle of confidentiality. Article 97 of the Alternative Care Guidelines states that children in care should have access to a person of trust in whom they may confide (United Nations General Assembly & Human Rights Council, 2010). The child should be informed that legal or ethical standards may require breaching confidentiality under certain circumstances. Such circumstances may be outlined in national legislation. All alternative care services should have a clear policy on maintaining the confidentiality of information pertaining to each child and that all caregivers are aware of and adhere to the policy (United Nations, 2010).

Protection

Children in foster care have the right to provision of basic needs (i.e., food, shelter, clothing, education) as well as the right to protection from abuse and other harms. Foster care providers should ensure that proper evaluation criteria and processes are in place so that all efforts are made to ensure that children will be safe in foster care and that caregivers have no record or history of abusive behavior. The UN Guidelines for the Alternative

Care of Children includes a significant number of references to the role of the State, as primary duty bearer of children's rights, to ensure that children are protected when placed in out-of-home care, taking into specific consideration the age, maturity, vulnerability, and concerns of the child (United Nations, 2010).

When a child is placed in alternative family care, contact with his/her biological and/or extended family, as well as with other persons close to him or her such as friends, neighbors, and previous caregivers, should be encouraged and facilitated, in keeping with the child's protection and best interests. Ensuring that contact and involvement with the child's cultural, ethnic, and linguistic groups is facilitated as much as possible is also a component of best practice in foster care provision. Article 118 of the UN Guidelines supports this view by stating that foster care should be identified in each geographic locality so that children are able to maintain ties to family, community, and cultural group (United Nations, 2010). If this is not possible, then the child should be provided with consistent and updated information about his/her family, community, or cultural group.

Child Participation

Child participation is the third component of best practice, in accordance with the CRC (Tolfree, 2005). This is probably the most difficult component to ensure because it requires a delicate balance between encouraging child participation, determining what information is appropriate for the child to know, and most importantly, training of professional staff to have skills necessary to solicit the information in a child-sensitive and age-appropriate manner. This component is significantly influenced and determined by the customs and cultural practices of the place and persons involved and should be modified to meet both the rights of the child as well as fit with cultural traditions. Obviously, this is not always easy and requires great skill and clarification on all fronts. The UN Guidelines reflect the importance of participation in alternative care by stating in Article 93 that "all caregivers should promote and encourage children and young people to develop and exercise informed choices, taking account of acceptable risks and the child's age and according to his/her evolving capacities" (United Nations, 2010, p. 15).

This component is challenging to implement in both high-resource and low-resource countries. The development of a quality family foster care program is difficult enough, and often the resources needed for child participation in foster care decisions are not available. Many low-resource countries have embodied in law and practice child participation/consent for intercountry and domestic adoption (see United Nations, 2009), but few have laws or public policy for child participation/consent for foster care.

DOMESTIC ADOPTION

Domestic or national adoption is a process whereby a child is placed legally and permanently with a parent or parents other than the birth (biological) mother or father in his or her country of origin or habitual residence. In accordance with the subsidiarity principle outlined in the Hague Convention, domestic adoption is preferred to ICA.

Types of Adoption in Low-Resource Countries

Ideally, the adopted child is given the same legal status as if the child had been born to the family. In low-resource countries or countries in which adoption runs counter to strong cultural traditions emphasizing primacy of bloodlines, legal domestic adoption is often not as prevalent as in higher resourced countries.

In countries governed by Islamic Sha'ria law, the practice of adoption is forbidden. *Kafala* (similar to long-term guardianship) refers to a form of family-based care that does not involve a change of name or inheritance rights but does allow an unrelated child, or a child of unknown parentage, to receive care and protection in a family (Roby, 2004; Tolfree, 2007). There are two types of *Kafala. Kafgal itifaqiya* is a consensual *Kafala*; the birth parents or the birth mother gives her child to a family after drafting a binding legal contract. The second type of *Kafala* is for abandoned children, technically considered wards of the state; a family is legally bound by the state to give wardship, tutelage, or care to an abandoned child (Al-Kaabi, 2005; Bargach, 2002). *Kafala* is considered a permanent form of foster care and is specifically recognized as an alternative care option in Article 20 of the CRC (Vité & Boéchat, 2008).

"Informal" or "simulated" adoptions occur outside of the legal framework. In informal adoptions, the family "adopts" the child by just acting as if the child has always been in the family. No legal authority is involved and it can be as simple as a birth mother handing a child to another mother and just leaving the child in care of the new family. An example of this type of adoption is *gudifecha* practiced in some parts of Ethiopia. *Gudifecha* is an Oromo word for adoption meaning upbringing and full assimilation of an outsider (child) into a family (Beckstrom, 1972; Negeri, 2006). There is both legal and a cultural *gudifecha* that involves a ceremony and oath taking in front of the community or tribal leaders (Beckstrom, 1972; Negeri, 2006).

"Adopted" individuals sometimes never know they are not physically born to their parents. When adoption is known, adoptions are typically closed with no contact or ongoing information between birth parents and adoptive parents and adoptees (often referred to as the "adoption triad" or "adoption constellation"). This is has often been the case in countries such as South Korea,

India, and the Philippines. As adoption becomes more commonly accepted in different cultures, there tends to be greater openness between members of the adoption constellation (birth parents, adoptive parents, adoptees).

There is a significant tendency to adopt very young children, usually infants, and relatively healthy children of the same race or cultural background as the adopting parents. Adoptive parents also prefer adopting children without a history of physical or mental disabilities. In higher resource countries where adoption is more commonly practiced, greater numbers of children are adopted who are older, of different racial lines than their adoptive parents, and/or with disabilities.

The legal adoption process can be long, sometimes expensive, and complicated by an inefficient government, with relatively weaker child protection measures in place to ensure adequate pre- and postadoption follow-up for all members of the adoption constellation. Domestic adoption can be displaced or overshadowed by ICA, with the latter having greater financial resources that influence the adoption system. If countries ratify and implement the Hague Convention, in policy and practice, the emphasis of ICA over domestic adoption should not occur. Countries should be convinced to use domestic adoption whenever possible, consistent with the Hague Convention subsidiary principles and their own culture practices.

Best Practices for Domestic Adoption

Strong evidence exists that adoption is a superior means of promoting normal child development compared to institutional care (Johnson, 2002; Van IJzendoorn & Juffer, 2006). Although some developmental domains may have incomplete recovery, such as attachment and cognitive development, adopted children improve dramatically compared to their peers left in institutions. Results vary based on genetics, age at adoption, and preadoption adversity.

Domestic adoption is usually considered the best permanent care option when family preservation (including family reunification or kinship care) is not possible or is not in the best interest of the child (Hague Convention, 1993). Important issues to consider in developing a framework for practice around domestic adoption include child safety, child development, and the length of time a child is waiting for a nurturing permanent family-based care. The CRC indicates that domestic adoption should be made available to all children whose personal and family situation warrants it, without prejudice against their social situation, physical features, ethnicity, culture, and physical or mental health disorders (United Nations, 1989).

Formal or legal adoptions are infrequent or even unknown in some countries where families and communities have other traditional ways of ensuring long-term alternative child care in a family such as in rural East Africa. There

should be no presumption that promoting adoption in such situations is necessary or desirable. It is important to assess cultural and community values and practices related to adoption. Great care must be given not to disrupt preexisting traditional practices that essentially work in the best interest of vulnerable children in need of families; instead, these traditions should be built upon and strengthened as a positive alternative for children needing permanent family care.

The first step for developing adoption programs is to conduct an analysis of children in need of adoption, particularly children residing in institutions. The analysis should also include an in-depth assessment of the professional skills/capacities of the workforce involved in child welfare to identify training for developing skills in domestic adoption. Policies and key governmental and nongovernmental entities involved in child protection must be identified and developed. In countries where adoptive families exist, the families as well as adoptees themselves are excellent sources of information and should be key informants in the analysis exercise.

Specific best practices for domestic adoption include:

- Trained and certified social service workers in the areas of child development and adoptive family assessment to provide home study evaluations and case management services in the pre- and postadoption periods.
- Specific policy guidelines and safeguards pertaining to adoptive parent eligibility centering on effective parenting capacities, adoption orientation and training, and postadoption follow-up monitoring to determine the well-being of the family and adoptive child.
- Efficient systems related to declarations of adoption eligibility for children in need of permanent families to ensure that permanency is prioritized and placement of children into adoptive families occurs as soon as legally possible, thus preventing prolonged institutionalization.
- Registry of children available for adoption, with necessary confidentiality and dignity safeguards, that provides efficient information for adoption service providers to match children with adoptive families.
- Regulations and procedures that prioritize prospects for domestic over ICA (Hague Convention). These can include licensing for ICA based on proven commitment and practice of domestic adoption, time period during which children are on adoption registries where only domestic adoption is allowed (note, this should not be a prolonged period recognizing the negative impact that lack

of permanent family-based care has on children of being outside of permanent family care), and low fees or subsidized costs for domestic adoption based on adoptive family's income.

- Well-documented and stored history of the adoptive child by service providers, including information on biological family and birth community, health conditions, and information regarding caregivers after birth parent separation.
- Establishment of adoptive family and adoptee associations for mutual support, critique, advice, and advocacy for best practices.
- Development and implementation of public education campaigns, including use of mass media, to promote the need for adoptive families and to overcome cultural stigmas associated with adoption.
- Ongoing interdisciplinary workshops, trainings, and forums to ensure best practices and adoption system reforms, recognizing that multiple sectors (i.e., legal, social welfare, philanthropy) are involved in adoption.
- Consideration and design of an amnesty program for families that have informally adopted children to come forward and legalize adoptions to ensure greater openness in adoption and child protection.
- Capacity and incentives of the nongovernmental sector to support and provide domestic adoption services. The NGO sector can leverage additional funding to drive best practices and often provide more sustained service experience than governmental sector.

Several low-resource countries have made substantial progress in developing domestic adoption programs. Ukraine conducted the first study of successful domestic adoptions in 2008 and has used the results of the study for policy, program development, and improving domestic adoption practice to increase domestic adoptions (Groza, Komarova, Galchinskaya, Gerasimova, & Volynets, 2010). The leadership for the domestic adoption initiative came from the Ministry of Family, Youth and Sports in collaboration with then President Viktor Yushchenko. In Romania, the increase in domestic adoptions in the 1990s was lead by the NGO sector. One study (Groza, 1999) found that while half of the families wanted to keep the adoption a secret, half were very willing to talk opening about their adoption and most would have adopted again if they could afford to adopt. Results from this study were used by the private NGO involved to recruit more families for domestic adoption

and improve the process for families to adopt domestically. Guatemala, after closing adoptions because of irregularities in ICA (Bunkers, Groza, & Lauer, 2009), has developed an adoption system that places emphasis on domestic adoptions.

INTERCOUNTRY ADOPTION

Commonly called international adoption, but also known as foreign adoption, cross-national adoption, and transnational adoption, ICA is a social and legal process whereby a child is legally adopted by a parent or parents from a country other than the birth country of the child. Ideally, the adopted child is given the legal status of children born to the family in the adoptive family's country.

Short History of ICA

The modern age of ICA began after the Korean War when significant numbers of children of mixed race began to be adopted by foreign families. Beginning in the early 1990s, a number of countries opened their systems to ICA, particularly China, Romania, and countries of the former Soviet Union. ICA grew exponentially worldwide. Of the top 20 receiving countries participating in ICA, the number of adoptions from other countries grew from 23,000 adoptions annually between 1993 and 1997 to approximately 45,000 in 2004 (Selman, 2006). Approximately half of the global totals of children adopted internationally are adopted by families from the United States (Selman, 2006, 2009).

Since 2005, world-wide totals for ICA have been dropping (Selman, 2009). By the end of 2010, ICA placements worldwide were approximately similar to placement numbers seen in the mid-1990s. Adoption agencies are experiencing a trend toward a greater proportion of children with special needs and older children being adopted internationally. This has significant implications for pre- and postadoption preparation and practice.

In demonstrating that domestic and international adoptees' behavior is more similar than it is different (Van IJzendoorn & Juffer, 2006), the most significant predictor of children's behavior is a negative preadoptive history (Groza & Ryan, 2002). Thus, preadoption information is vital for developing effective postadoption care plans. The preadoption conditions of children can be more important than the age of adoption for later postadoption problems (Cederblad, Hook, Irhammar, & Mecke, 2003; Juffer & Van IJzendoorn, 2005).

Best Practices

The adoption process for ICA is complex, dictated by both local and national laws of both sending and receiving countries. As stated above, the Hague Convention exists to protect children, birth parents, and adoptive parents, and it presents an opportunity for creating a policy framework for ICA. As of early 2011, 83 states had "entered into force" with the provisions of this treaty.

Although the Hague Convention provides a strong framework for the practical application of principles of child rights in ICA, it is not without its challenges. Mason (2001) claims that the Hague Convention places too much emphasis on the political will of an individual State. It has also been argued that implementation and interpretation of the principles contained within the Hague Convention, such as the role of a Central Authority mandated to oversee adoption issues, sometimes hinders the process and is not always in the best interest of children (Lammerant & Hofstetter, 2010; Oreskovic & Maskew, 2008).

Other shortcomings of the Hague Convention have been mentioned in regards to ICA practice between Hague compliant and non-Hague compliant States. One example, explored by Rotabi (2010), is the case of the United States (a Hague country) and Ethiopia (a non-Hague country). As part of the Hague ratification process, U.S. agencies went through a significant accreditation process. Ethiopia is not a signatory country and as such has allowed U.S. agencies that were not accredited under the U.S. accreditation system to process adoptions within their borders. This type of situation reflects what could be called "loop holes" resulting from individual interpretation and implementation of The Hague (Rotabi, 2010).

Regardless of their application, the articles of the Hague Convention represent the best framework of ICA principles and best practices to date.

Key provisions in The Hague Convention include:

- Establishment of central authorities and accredited bodies to ensure ICA processing is in keeping with applicable laws and there is accountability in service delivery.
- Vital provisions ensuring necessary informed consents for adoptable children and suitability of parents to adopt.
- Information and communication parameters concerning children and parents.
- Emphasis prior to ICA consideration on appropriate measures for children first to remain in their family of origin or placed with domestic adoptive families or foster care families (i.e. the continuum of care) if in their best interest (subsidiarity principle).

- Opposition to inappropriate financial gain in the ICA process.

The Hague process was designed, in part, to build ethical safeguards around ICA given concerns over financial improprieties often stemming from a transfer of money from higher to lower resourced countries and related shortcomings in the areas of transparency of practice and legal/enforcement structures to prevent abuse. Many children adopted internationally reach their adoptive families with varying degrees of physical growth retardation, cognitive delays, and socioemotional problems but most demonstrate remarkable recovery following adoption (Gunnar, Bruce, & Grotevant, 2000; Van IJzendoorn & Juffer, 2006). International adoptees have fewer behavior problems and are less often referred to mental health services than domestic adoptees (Juffer & Van IJzendoorn, 2005).

The following best practices warrant special attention for ICA, and are either expressly identified in the Hague provisions or consistent with the spirit of the treaty:

1. Always strive to keep siblings together in the adoption process and only separate them if it is determined to be in the child's best interest. Sibling placements are as stable as, or more stable than, placements of single children or separated siblings; and children do as well or better when placed with siblings (Hegar, 2005).
2. Ensure child participation in the decision-making practice when age appropriate.
3. Adoption should not be considered in the immediate aftermath of an emergency context, such as war or natural disaster.
4. Prohibit payment of adoption service providers on a contingency basis (i.e., payment only with placement), thus reducing risk of financial incentives overwhelming social service considerations in the child's best interest. Compensate adoption service providers consistent with ranges of established credible social service, legal, and other relevant sectors within respective countries.
5. Promote respectful consideration of children in adoptive family recruitment activities that are consistent with regulations and wishes of relevant officials and caregivers, particularly in web-based recruitment formats.
6. Maintain complete transparency in fees associated with adoptions.
7. Establish accreditation procedures that promote or support agencies that have an historic standing and capacity to provide post-adoption assistance well into the future for adoptive families.

8. Adoption service providers should provide and promote programs fostering understanding and connections to cultures and countries of origin of adoptees.

ICA offers family life for thousands of children every year that otherwise may not have one. While this is a positive aspect to ICA, there are also problematic aspects. The most serious concerns are raised around the issue of money.

Financial Considerations

Financial issues are among the most controversial surrounding ICA. In the United States, fees for adopting internationally, not including travel costs, range from a few thousand dollars to close to $40,000. In 2010, the U.S. Government provided up to a $13,170 tax credit for families who adopt domestically or internationally if their combined salary is under certain specified limits. A variety of private foundations provide subsidies to adopting families to improve prospects for adoption of children who have special needs and face difficult and/or lengthy placement prospects. Many ICA agencies provide significant fee reductions for the same purpose. High ICA fees and costs are associated with countries in which there are considerable undocumented payments.

Within the United States, there are no uniform standards as to how agencies involved with ICA set their fees. The fees vary widely according to country program and from agency to agency. ICA fees are a product of several factors: the relative cost of providing an adoption program in a country, the related issue of the mission/programmatic focus of the agency and its financial practices, sliding scale of fees for families depending on their income, subsidized fees to better enable adoption of children with special needs, and a competitive environment with other agencies in the recruitment of families for adoption.

ICA has a number of legitimate costs. This includes hiring Master-level Social Workers on the staff and program development specialists. Staff is hired in countries of origin, often at premium wages that come with having foreign language speaking and multicultural competencies. Many agencies provide a considerable amount of financial support to child welfare projects within the countries in which they have ICA programs. To varying degrees, these projects are supported both through fees and private donations. Agencies can also face considerable expenses and costs relating to meeting accreditation standards, both in the United States and in the sending countries.

The financial resources associated with ICA have helped to finance improvement in child care and facilities, informed best practices in domestic adoption, made adoption culturally more acceptable within countries, and

assisted in the development of models of foster family care as a temporary means of family-based care (see Selman, 2009). However, in a number of countries, there is evidence of money being used to induce the inappropriate release of children for adoption from birth parents or kin. All costs should be guided by the principles of the Hague Convention, which is a best practice.

Many children around the world who do not have permanent family-based care can and could benefit from ICA. The challenge of the future is for service providers and policy makers to direct a greater proportion of financial resources into the full range of alternative care options in an environment of best practices for children. This recognizes that relatively few out of the hundreds of thousands of highly vulnerable children worldwide will be placed into foreign families and many more can benefit from services that provide family-based care within their birth countries.

CONCLUSION

It is clear that family-based care is superior to institutional care. The relative lack of research on short-term and long-term costs of various alternatives of family preservation, family reunification, kinship care, foster care, and adoption needs to be addressed (see Chapter VIII).

We need better evidence to guide policies and practices and better evidence on how to actually promote best practices when the infrastructure to support these practices is lacking, as is often the situation in low-resource countries. Evidence can be used to support value decisions, or value decisions can be clearly articulated and the rationale provided when the evidence is contradictory. Too much of practice is guided by history and not evidence, and high-resource countries often try to promote models of care in low-resource countries that are inappropriate. Of most concern is the promotion of institutional care in low-resource countries by agencies and individuals from high-resource countries. The evidence clearly indicates that this is a poor strategy, and there are better alternative care options for children outside of parental care that should be funded and developed.

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