A report on the

Assessment of Child Admission and Outflow
at the Tbilisi Infant House

2010
Tbilisi, Georgia
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General information:
The Tbilisi Infant House is a pivotal large scale institution within the capital of Georgia. Its residents are infants and children from birth to 6 years of age, with and without disabilities. It has been the focus of concern for a number of years\textsuperscript{1,2}

Since 2006 to the present day, the number of children in the institution has varied from 112 to 139. Despite evident improvements in the physical environment and the standard of general child care and the increased capacity of its staff, the sheer number of infants entering the institution and the nature of its service continues to detrimentally affect the early childhood development of its residents. Prolonged length of stay, woefully inadequate adult/caregiver to child ratios and an unacceptably high mortality rate continue to be three of the major problems that contribute to this problem.

There are eight groups of children in the TIH who live in separate rooms. Two recent positive changes are that siblings within the institution now are able to know each other, and some rooms house a mix of children with and without disabilities. However, the average number of children in each group is now 17. Each group currently is staffed with 1 senior caregiver and 2 junior caregivers, but functionally a maximum of two is present and sometimes nobody is present. Anyone who has children would quickly realize that it is impossible to feed, change, manage, socialize or simply care for this number of infants and children at any one time with these adult child ratios and can lead to chaos, neglect and abuse.

The maximum official capacity of the institution is 160 including beneficiaries of the “Shelter for mothers and infants” that is within the TIH complex. On average the shelter serves 10 beneficiaries at any given time. This would reduce the maximum allowed number of children in the rest of the institution to 150 on average. This is the equivalent to almost 19 children per group. In addition, as of July 2010, the number of senior caregivers will be halved. It is simply unrealistic to expect any care for these children under these circumstances.

**Number of children at the end of each month\textsuperscript{3} from 2009 up until today**

\begin{table}
\begin{tabular}{|c|c|c|c|c|c|c|c|c|c|c|c|c|c|c|c|c|c|}
\hline
Month & Jan-09 & Feb-09 & Mar-09 & Apr-09 & May-09 & Jun-09 & Jul-09 & Aug-09 & Sep-09 & Oct-09 & Nov-09 & Dec-09 & Jan-10 & Feb-10 & Mar-10 & Apr-10 & May-10 \\
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\begin{flushleft}
\textsuperscript{1} Report to Professor K Pagava on research at Nutsubidze St Infants Orphanage by Dr JM Rawls and Dr BS Parsonson, Applied Psychology International, 1999
\end{flushleft}

\begin{flushleft}
\textsuperscript{2} An Assessment of the Quality of Psycho-Social Care and Education of Infants living at the Tbilisi Infant House at Nutsubidze Street, Children of Georgia, 2006
\end{flushleft}

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\textsuperscript{3} In the beginning of June 2010 the number reached 139.
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Admission, Outflow and Mortality

The dynamics of admission and outflow (both leaving the institution and death) over the 2009-2010 period was studied for all the children who entered or exited the Tbilisi Infant House in these years.

The information on admission and outflow was collected from the infant house administration monthly summary records. The database was designed in Microsoft Excel and the following data were entered for each child: Name, gender, date of birth, date of admission, admission source, admission diagnosis, discharge date and discharge form. Later, cases with incorrect data were additionally checked and amended by data gathered from TIH records and/or from interviews of administration and staff.

The high number of children in the TIH has fluctuated but still remains high, again increasing over the course of 2010, because more children come in than go out. The graph below shows that during 2009 – 2010 (including May 2010) admissions were higher than outflow/releases and mortality. The main reason is insufficient gate-keeping mechanisms. Difficulties in outflow from January 2010 (reasons explained later in the document) has caused a gradual increase in the number of children to 139 by mid-June 2010.

Admission, outflow and mortality of TIH children in 2009 and half of 2010.

Admission into Tbilisi Infant House

An analysis of child admission during 2009 – 2010 shows that most children are admitted from throughout the Georgian regions. Geographic distribution was identified through the thorough study of the documents available in TIH. In some cases the home address of the child that the mother/parent provided varied from the actual address of permanent residence. One of the major reasons for this is that single mothers abandoning their child often go to Tbilisi to give birth in order to avoid stigma and/or conflict within the family over undeclared relationships. In these cases, children are admitted to the institution by the Tbilisi child protection and guardianship services.
Most children admitted to the TIH during 2009-2010 were referred by statutory social workers of child protection and guardianship territorial units. Only 8% of children admitted to TIH are found in the streets. This fact demonstrates that almost all abandoned children (92%) are passing through an already existing child welfare system. Given that most children are abandoned within the first month of their life, it would benefit the child if they were fostered early in their life before any institutional harm occurs⁴. Potentially it is possible to administer this gate-keeping service through the existing child welfare system. The problem of inadequate prevention is related to insufficient or missing preventative services.

Health and Diagnosis of children admitted to the TIH

This study covered 265 children admitted or discharged from the TIH during 2009 and half of 2010. The majority of children (153) admitted to the TIH were classified on admission as “healthy”. In addition, 21 children also were classified as “healthy” but had some form of disability or health issue, and another 91 children were classified as “disabled” upon entrance.

Original records of children’s health condition when admitted showed a prevalence of healthy children. Later, when each child’s medical records and current conditions were analyzed during this study, inconsistencies in admission diagnoses and conditions of children were found. The health conditions were checked from admission diagnoses and then rechecked from medical records and from interviews with Children of Georgia (CoG) and TIH staff directly working with those children. Twenty-one (21) children were found to be misdiagnosed as healthy, when in fact they had disabilities and/or health problems. Two probable reasons for this misclassification are:

- Rapid discharge from hospitals (e.g., too early to diagnose)
- Misdiagnosis by primary health care or maternity houses for reasons unknown.

Examination of records during this review also indicated that some children (8%) were initially misclassified as healthy and later reclassified as special needs.

For the purpose of this study all the children were classified into the following 3 groups:

1. Healthy (H)- Healthy children who were truly healthy when admitted (seen as green on the graph).
2. Reclassified with disability (RD)- Children who were classified as healthy when

⁴ Keeping children out of harmful institutions, Save the Children UK, 2009
admitted, but in a reality had some form of disability or health issue (seen as red on the graph). This group includes one child with severe disabilities/health problem.

3. **With disabilities (D)** - Children classified as disabled upon entrance (Seen as purple)
   This group includes 22 children with severe disability or health problems.

The information on these groups was analyzed in terms of age of admission, gender, and length of stay into the institution, outflow/placement, and mortality, and will be discussed in that order.

### 1. Age at Admission

Analysis of admission age data shows that most children (80%) are admitted to the institution in their first year of life. Furthermore, at least half of all children (144 children – 53%) are abandoned and admitted to the TIH during the first month of infancy. It appears that parents are making the decision to abandon their child at its birth. In the case of children with disabilities, abandonment appears to be marginally delayed, perhaps reflecting the dilemma for them over the fact that they now have a disabled child whom they may not know how to care for and/or who may be discriminated against.

The preventative services need to be targeting those two groups differently. Counseling advice should be given to pregnant mothers before the babies are born and/or at the maternity houses. Support for mothers of children with special needs also needs to occur after the baby is born to prevent abandonment and to build parental skills and foster family relationships.

The likelihood of abandonment decreases as children get older although admissions still occur for children over the age of two. This later abandonment is thought to be because of family poverty and/or inadequate parenting skills. Again, these are preventable social problems that could be addressed effectively by both state and NGO services as an alternative to institutionalization.
Again, far fewer children are abandoned when they are older, but the ratio of healthy children remains double that of the children with disabilities combined with children reclassified as having disabilities. Even though data on older children reflects larger periods of time, the total number of admissions is still smaller than admissions of 1 to 2 month old infants.

2. **Gender**

Marginally more boys (54%) than girls (46%) are abandoned. It is clear that in the healthy children group there are almost equal proportions of girls and boys. In the other two groups (that is children with disabilities) there are proportionally more boys than girls admitted. Possible reasons for that might be that girls are considered easier to bring up, manage and may still be useful in the household, in comparison with boys who are expected to work outside.

3. **Length of stay in the Tbilisi Infant House**

Information on children’s length of stay at the TIH can be divided into the following intervals:

- Up to 3 months
- From 3 to 12 months
- From 13 to 23 months
- From 24 months and more

The data presented in the graph below illustrates length of stay at the TIH for children who have been both admitted and discharged from the TIH. It does not include children still remaining at the TIH. Many of the “healthy” children (68%) are leaving the institution within 12 months of their initial admission. The majority of healthy children go to their own families, foster care, adoption or guardianship, and a few go to another institution. On the other hand, it is evident that children with disabilities and/or health problems can remain in the institution longer than healthy children and almost 41% of them stay for more than 2 years.
The majority of “healthy” children stay in the TIH less than 3 months. This has important implications for potential preventative services of emergency placement (short term/emergency foster care). For example, in the case of the children in this study, having emergency foster care available for 3 months rather than the existing one month period would have avoided institutionalization for 33 children (during January 2009 – May 2010). It could be done with the help of existing services if there were changes to the current legislation and adequately prepared and funded services.

Children with disabilities are more likely to remain in the institution the older they get. For several years there were no adequate services to assist those children to transition out of the TIH. These children require far more specialized and individual care than can be provided inside the institution at the present time despite some improvements in staff attitude as a consequence of input by the NGO Children of Georgia. These children will need better care whilst they are inside the TIH. This can be achieved by adequate caregiver to child ratios (by decreasing the number of children), improving staff skills, and incorporating proper services that focus on staff/child preparation for outflow and support for potential families that facilitates child safety and welfare.

4. “Outflow” from the Institution
Seventy (70) healthy children were transferred out to other locations and 4 remained but died during 2009 - half of 2010. Of those who were transferred, 23 children were re inte grated, 6 children were adopted, 18 children were placed in guardianship, 19 children were placed in foster care and 4 children moved to other institutions.

Of the children reclassified as disabled, 2 were transferred to other locations (1 child was adopted and 1 child moved to another institution) and 4 died during 2009 - half of 2010.

Twenty-four children with disabilities were transferred out to other locations (3 children were reinte grated, 7 children were placed in guardianship, 10 children were placed in foster care and 4 children moved to other institutions) and a staggering 30 children with disabilities died over this same period.

Analyses of placement of children from TIH shows that family placement is mostly happening for healthy children whereas children with disabilities are almost never adopted locally, and rarely placed in kinship care.

5 Includes placement in kinship care
alternative family type care. In essence, children with disabilities have a far smaller chance of leaving the institution and going to a family type environment. Unfortunately, there is little chance of adoption within Georgia for children with disabilities as there is no demand. In contrast, there is a large waiting list to adopt children with no disability. There is better chance for children with disabilities of international adoption but this process takes a very long time, thereby decreasing the chances for adequate early childhood development and/or relevant physical, social and emotional assistance for these children.

A total of 9 children (4 healthy and 5 with disabilities) were transferred to other institutions. It needs noting that the transfer of children to other institutions is to Senaki, Kovelji, and Tskneti institutions where the physical conditions and quality of care is worse than in the TIH. The problems in those institutions include poor hygiene, physical violence and neglect. This can cause huge psychological stress and possible regress in child development for those children who already have special needs and are less capable of coping with transitions and/or inappropriate methods of managing their needs. Unfortunately, real difficulties exist in finding (safe and appropriate) family placements for these children. The creation of specialized small group homes might therefore be the only option for their deinstitutionalization.

Another factor contributing to the low rate of deinstitutionalization of children with disabilities is the official status of “disability”. As the expenses of children in the TIH are covered by the state health insurance program, they can get only those services which are in their health insurance policy. However, the policlinic expense for defining the status of disability is not covered by the existing state insurance (as of the date of this report). The CoG “Family Support Services” in the TIH had several cases where children with disabilities would have benefitted from having this disability status which would have allowed rehabilitation programs funded by state. Children with this status currently get state financial pension if they are in their family. Reintegration would be encouraged if these children could receive state support in healthcare and rehabilitation services.

The following graph illustrates outflow for children over the longer period of 2007 – to mid 2010. It shows changes across the different forms of outflow. Foster care rate dominated the outflow options in 2007 and even more so in 2008. In 2009 the number of children going into foster care reduced to 21 and by May 2010 only 1 child has been fostered. It interesting to note that there was a transition of child welfare system from the Ministry of Education and Science of Georgia to the Ministry of Health, Labor and Social assistance in 2009. Prior to 2009, foster care was encouraged in two major ways: first, priority was given to foster parents to have the right to adopt; and second, foster parents were paid more to foster children with disabilities than to foster healthy children. From 2009 foster parents who were motivated to adopt children were not given priority and the Social Service Agency (SSA) started to work directly on adoption and guardianship which, in most cases, was absolutely the same group as those foster parents motivated to adopt a child in the future. The only difference being that they would not be paid by the State.

6 Based on the information from TIH administration currently there is process of changing insurance provider which might cover status definition costs for TIH children.
An increase in guardianship occurred after a hiatus in mid-2009 when there was an increase in mortality rate at the TIH. The SSA immediately responded by decreasing the number of admissions to the TIH and accessing the guardianship option open to them to increase outflow. However, this was a short-lived response lasting only it seems whilst this matter was a priority to the State Services. Since new legislation in March 2010, if the SSA wants to place a child with foster-parents or into guardianship, the birth parents have first to agree to this or suspend/stop their parental rights. This process can take more time to get Court approval. The overall effect is a reduction in outflow from the TIH. It is clear from the graph below that there has been very little movement of children out of the TIH during the first half of 2010.
5. Mortality

The number of TIH infants dying is clearly contributing to outflow figures. Analyses of mortality rates within each group revealed that the highest rate of death is in the group of children with diagnosed disabilities. However the four cases of death in the “Healthy” group is also alarming. The information from records kept at the TIH about causes of death and a list of diagnoses are described below.

Of the healthy children 4 children died. The reason of death is unclear in 2 cases, was recorded as pneumonia in 1 case, and recorded as hypostasis/edema of brain and lungs in 1 case.

Of the children reclassified as children with disabilities 4 children died. The reasons of death were pneumonia in 2 cases, acute viral infection in 1 case, and unknown in 1 case.

Of the group of children with disabilities, 30 children died. The reasons of death were pneumonia for 8 children, pneumonia with sepsis for 4 children, sepsis for another 4 children, peritonitis for 1 child, edema (swelling) of the brain and lungs for 1 child, heart and lung failure for 1 child, spinal hernia for 1 child, hydrocephaly for 4 children, hypovolumic shock (insufficient blood volume) for 1 child, hypoxemic shock (insufficient oxygen) for 2 children, and unknown for 1 child.

Some of the children from the last two groups had severe disabilities related to congenital developmental disorders, severe neurological disorders (brain or spinal hernia, hydrocephaly), heart diseases and genetic disorders. There was a very high mortality rate in this group of children as 11 children died from 23 (48%).

None of those children have ever transferred to family type alternative care. There was a recent transition of two children to another institution from that group, but those children died soon after transfer.

This group of children requires complex medical care or sophisticated palliative care because of the severity of their problems. Proper care services are not provided for those children at the TIH and some of those children are repeatedly sent to hospitals and back to the TIH. Many of these modes of death are painful and miserable and should have been avoided. It is strongly recommended that proper palliative care service are created as soon as possible to take into account the complexity of these children’s needs and reduce preventable deaths.
The graph below shows that the outflow of children to outside placements decreased from 2007 to 2009 but, at the same time, the mortality rate increased from 23 during 2007 to 32 in 2009. In this way, the residency rates remained relatively stable over this period.

Overall, of the admissions from 2009 – mid 2010, 37% remain inside the TIH, 19% have died, 4% went to another institution and the remaining 40% have been deinstitutionalized in some way. Hence, once admitted to the TIH, any child (especially one with disabilities) has an unnecessarily high chance of remaining inside and/or dying.
Current admission and prevention system

To understand the intake of children in the TIH, the current system of admission was included in the assessment process. The chart below reflects the current system showing the existence of a certain level of prevention and preventative services but also underlining the inefficiency of gate-keeping.

Gate-keeping mechanisms for prevention of infant abandonment currently include family support and counseling services to provide psychological support for parents, and some financial support to house a baby at home. A shelter for mothers and infants also exists providing temporary accommodation for young mothers.

In future, services need to include parent training programs to help parents of children with special needs to cope with the additional pressures of living with a child with disabilities; emergency foster care especially for little infants because they are most likely to be admitted at that age with high likelihood of finding long term placements within a family; day care centers / kindergartens for children up to 2 years. The latter does not exist and its formation is particularly important as it will help parents to have the time for work and thereby increase their ability to keep their child at home. It also facilitates appropriate child development which then increases the likelihood of them becoming participating and happier members of the society.
Review of current Legislation on Adoption and Foster care

A review of the existing child welfare legislation revealed restraints on gate-keeping and deinstitutionalization (see following flow chart).

Firstly, there is a problem related to placing children in foster care. This problem is most evident with children already in the TIH because many of the mothers have “temporarily” placed their children there but do not visit their children, and they have not agreed to forfeit their parental rights or agreed to placement of their child in foster care. Children can be placed in foster care only if a parent allows the SSA to place their child in foster care or parental rights are suspended or stopped. Because of this stipulation, statutory social workers are not able to place children in foster care and the children remain in limbo without access to family type environments. In these cases social workers have to apply to the Court to suspend or stop parental rights which requires approximately 5 more months.

Secondly, emergency foster care cannot be used as a gate-keeping mechanism because its duration is limited to 30 days.
Thirdly, the procedures described in legislation require significant time to define adoption status. If a child is found in the street and reintegration is not possible, a minimum of 3 months is required to define the child’s status for adoption and/or transfer the child to long term family placement.

Fourthly, in the past, legislation existed to reduce the possibility of mothers selling their own children. This changed in March 2010 to allow agreements between parents and potential adoptive parents to jointly apply to the SSA so that the care of the child can be transferred from one to the other. Obtaining the status of eligibility for adoption can take from 1,5 to 5 months.

Children with disabilities are almost never adopted within Georgia. However, they can be adopted internationally but only if they have not been adopted locally for 8 months from the moment of receiving official status as a child available for adoption. This brings the whole process to up to 13 months. Given the severe needs of children with disabilities and/or health problems residing in the TIH (that could be treated more properly outside of Georgia), this waiting period is far too long.

On the other hand, if a child is abandoned and parents agree to abandonment in written form then this status can be defined sooner (1,5 month) and their child can be immediately placed in guardianship for adoption.

Conclusions and Recommendations
1. At present, the adult: child ratio in the TIH is absolutely inadequate for any individual or proper care. It is recommended that the ratio is immediately improved to adequate levels such as a one to five because of the age and needs of these children. Currently, all the caregivers are being trained to introduce individual care plans for the TIH children. Unless the ratio is improved, all individual care will be jeopardized and the children are likely to be increasingly and rapidly institutionalized.

2. The existing teams of 3 caregivers per room have to focus primarily on hygiene and physical care of the children. There simply is no realistic time for stimulation or emotional engagement of the residents. Therefore, additional technical personnel should be appointed to relieve the current caregivers from menial tasks so that caregivers can provide social, emotional and educational care of these children according to their individual needs.

3. There is a very high admission rate into the TIH. Strengthening the gate-keeping process by establishing preventative services should occur as soon as possible and, in the medium term (as soon as those services can handle admissions), have a moratorium on new admissions. Preventative services need to be in place in both the capital of Tbilisi and in the regions. These services should include emergency foster care, day care respite, counseling services, and finally non-financial material assistance to families. Inclusive pre-school education would make home placements for children with disabilities viable and is therefore a very necessary service.

4. There is a major problem with achieving early and correct diagnosis of disabilities. It is recommended that the expense of diagnostic procedures that provide the status of disability, currently done at polyclinics and maternity houses, is funded by the State insurance scheme. In
This way, financial support can be given for these children and this could improve the chances of children with disabilities receiving an accurate diagnosis and remaining with their family.

5. This study has clearly found that most abandonment is done before the infant is 2 months old. Therefore, services such as parent counseling and emergency foster placement should be prepared for this target group. This need is a priority and should be financed for this coming year.

6. Most of the healthy children leave the TIH within 12 months. However, the situation is very different for children with disabilities who remain far longer and who risk poor care, illness and death. These children need far better services to facilitate and maintain outflow into appropriate care. Services should include day care for children with severe disabilities and access to inclusive pre-schools which would prepare all the children for transition to the community. This service was facilitated by Children of Georgia with the cooperation of the TIH last year. However, despite the fact that the TIH was open to continuing this service, it was severely constrained in the last few months by bureaucratic problems over transporting the children to kindergartens.

7. Children are still being transferred to other institutions once they reach the age of 7 years. These children should be an immediate priority for finding alternative long-term family placements within the community in order to avoid the predictable stress and physical, emotional and psycho-social damage from living in these harmful institutions.

8. Even very young children can be quickly emotionally and socially damaged by institutional life. Every effort should be made to prevent this damage. It is well recognized that the younger the child is when they receive social, emotional and family support then the better the outcome. Those NGOs with experience in this area should be encouraged to provide services that contribute to socialization of institutional children to prepare them for foster or family placement.

9. An analysis of the crisis in mid-2009 indicates that effective gate-keeping processes can be implemented more effectively if the problem of intake is made a political priority. This needs to occur again but in a sustainable way.

10. The TIH is of the highest priority of all institutions because it has a very high turnover of admissions and outflow of children in a year (180 per year on average) and a high mortality rate. No other institution in the country has that size of turnover or that level of mortality. The current system continues to contravene the UN Charter on Children’s Rights because it fails to provide either proper gate-keeping, sufficient staff child ratios to provide basic care, proper healthcare, access to early childhood education or community socialization, or access to emotional care through family or family-type environments.

11. There is an unacceptably high mortality rate for children who are admitted to the TIH. The existing health care service fails to prevent deaths that are preventable (e.g., infection). Children with severe disabilities or health problems are at higher risk than healthy children of being denied proper palliative care, and much of their short life is a painful and tortured process towards death.

12. The current legislation is not supporting efficient gate-keeping by restricting emergency foster care to one month and by having delays in the process of determining placements into home
environments. It is recommended that NGOs with experience in child welfare participate in the revision of the current legislation and in the preparation of necessary amendments to it.