ICare

# International Classification of Alternative Care of Children

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# Introduction

# Background and rationale

The UN Convention on the Rights of the Child (CRC)[1] calls on governments and other stakeholders to ensure the development of every child to the maximum extent possible and recognizes that every child should grow up in a family environment. To enhance implementation of the CRC, the UN General Assembly adopted the 2009 Resolution on the Guidelines for the Alternative Care of Children (or the UN Guidelines).[2]

The UN Guidelines articulate a set of core principles for child welfare and protection policies:

1. prevention of unnecessary separation of children from their families and family networks;
2. if a child needs to be placed in alternative care: provision of suitable family-based care or, in limited circumstances, suitable residential care if "appropriate, necessary and constructive" and "in the child's best interest"; and
3. for children in alternative care: safe reunion and reintegration with their families or family networks.

These objectives are based on ample evidence and wide recognition of the immediate and long-term physical, psychological, emotional and social harm and damage caused by unnecessary separation of children from their parents or family and unsuitable alternative care, especially if care is provided in residential facilities.[3] Children with disabilities are disproportionately impacted by family separation and are overrepresented in residential care, where they are more likely to experience violence and exploitation. Some estimates suggest that as many as one in three children in residential care facilities have a disability.[4] In line with UN Member States' obligations and policy commitments stemming from the CRC, the UN Guidelines and other international instruments,[5] many countries are taking steps to support families in providing safe, inclusive and nurturing care; prevent unnecessary separation; prioritize family-based options when alternative care is deemed necessary; reduce the number of children living in residential care; and reunite children with their families in accordance with the child's rights and best interests.

Despite existing obligations, policies and reform efforts, children in alternative care are frequently missing in official statistics and national and international indicator frameworks. However, the availability, quality and comparability of data on children in alternative care have been explored under various initiatives,[6] showing that most countries collect some data on children in alternative care – largely statistics on stock and flow.

While some efforts have been made to standardize the measurement of alternative care of children, countries use different definitions and categorizations in administrative data systems and in surveys, which hampers international consistency and comparability of statistics on this population of children. Key challenges in measuring alternative care of children include differences in concepts and definitions of what constitutes residential care among countries, the distinction

1 United Nations, Convention on the Rights of the Child, United Nations, New York, 20 November 1989, <www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child>.

2 United Nations General Assembly, *Guidelines for the Alternative Care of Children*, 2009, <https://digitallibrary.un.org/record/673583>.

3 Cantwell, Nigel, et al., *Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children'*, Centre for Excellence for Looked After Children in Scotland, Glasgow, 2012, <https://pure.strath.ac.uk/ws/portalfiles/portal/263862550/Cantwell-etal-Strathclyde-2013-Moving-Forward-Implementing-the-Guidelines-for-the-Alternative-Care_of-Children.pdf>; García Quiroga, Manuela, and Catherine Hamilton-Giachritsis, 'Attachment Styles in Children Living in Alternative Care: A systematic review of the literature', *Child & Youth Care Forum*, vol. 45, 2016, pp. 625–653, <https://doi.org/10.1007/s10566-015-9342-x>; Goldman, Philip S., et al., 'Institutionalisation and Deinstitutionalisation of Children 2: Policy and practice recommendations for global, national, and local actors', *Lancet Child & Adolescent Health*, vol. 4, no. 8, 2020, pp. 606–633, <www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30060-2/fulltext>.

4 Nowak, Manfred, *United Nations Global Study on Children Deprived of Liberty, Project Report*, United Nations, Geneva, 2019, <https://eprints.bournemouth.ac.uk/38497>.

5 United Nations Committee on the Rights of the Child, Children's Rights and Alternative Care: Outcome report, 2021, <www.ohchr.org/sites/default/files/2022-06/13Jun2022-DGD-Outcome-report-and-Recommendations.pdf>; United Nations General Assembly, Resolution Adopted by the General Assembly on 18 December 2019, 2020, <https://documents.un.org/doc/undoc/gen/n19/426/12/pdf/n1942612.pdf>.

6 United Nations Children's Fund Europe and Central Asia Regional Office, *Children in Alternative Care: Data to strengthen child protection systems and outcomes for children in Europe,* 2023, <www.unicef.org/eca/reports/children-alternative-care>; United Nations Economic Commission for Europe, *Statistics on Children, Spotlight on children exposed to violence, in alternative care, and with disabilities*, 2022, <https://unece.org/sites/default/files/2022-10/ECECESSTAT20225.pdf>.

between residential and family-based care at the country level and the distinction between different types of family-based care.

The 2022 Conference of European Statisticians (CES) guidance[7] concludes with a recommendation for countries to adopt standardized definitions and classifications for the main types of alternative care and for subtypes of family-based care and residential care. However, as the CES guidance underscores, there are currently no internationally accepted standard definitions or classifications for statistics on children in alternative care. The definition of alternative care and the different types of care outlined in the UN Guidelines do not serve as statistical definitions or classifications.

## Purpose of the International Classification of Alternative Care of Children

The International Classification of Alternative Care of Children (ICare) addresses a crucial need for globally accepted operational concepts, definitions and principles to ensure a standardized approach to collecting and classifying statistical data regarding the alternative care of children. Additionally, it aids in categorizing care arrangements according to agreed characteristics and can be utilized in research for sampling or data analysis. Furthermore, the ICare can be a useful policy tool for resource allocation, system differentiation, and the monitoring and evaluation of care reform efforts over time.

The ICare addresses differences in how the three main types of alternative care of children – family-based care, residential care and independent living – are defined by outlining their standard elements. It also includes illustrative lists of the types of arrangements that constitute family-based care, residential care and independent living. This list is as comprehensive as possible while remaining open to the inclusion of types that may emerge in the future.

The ICare applies to all types of data on alternative care of children, including administrative records and data collected in dedicated surveys on children in alternative care, as well as in more general surveys or censuses.

At the international level, the ICare aims to:

- measure in a consistent and comprehensive way the various types and categories of alternative care of children, irrespective of differences in legislation across countries.
- enhance comparability of statistics among countries.

At the national level, the ICare aims to:

- serve as a model to provide structure for and organization of statistical data on alternative care of children across different data sources (i.e., administrative records, surveys and censuses).
- enhance consistency and comparability within and across sectors. In some countries, children receive alternative care in residential facilities run by different sectors, such as social welfare, health, education and home affairs, which collect and report data separately, contributing to the multiplicity of definitions, interpretations and classifications rather than their standardization.
- provide the basis for disaggregating data on alternative care of children, including the minimum set of variables to be collected across data sources.
- enable national statistical offices and line ministries to improve data quality on alternative care of children.
- create data that are based on human rights and that will enhance the capacity of national governments to develop, implement, monitor and evaluate effective public policies and programmes to prevent unnecessary family separation and, if needed, provide suitable alternative care for children, prioritizing family-based care, deinstitutionalization of the alternative care system and safe transitions for all care leavers.

The development of the ICare is not the end goal but rather the beginning of a process. Such a process will require long-term implementation, with dedicated investment in national-level capacity and tools to support the collection of statistical data aligned with the ICare.

7 *Statistics on Children.*

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## Considerations in developing the ICare

An important feature of all international classifications is the ability to capture and describe existing phenomena using the most objective and tangible criteria available. This feature is particularly relevant for the alternative care of children, a field that still contains a wide range of approaches from both policy and practice perspectives. The ICare aims to describe the reality of children in alternative care – across all forms, durations and reasons – rather than prescribing what that reality should be. In other words, the ICare is descriptive rather than prescriptive in that it can be used to capture the number and existing types of alternative care arrangements at any given time and place, without making a judgment about whether those numbers or arrangements are good or bad for children. The analysis of these figures over time, along with trends cross-checked against specific contexts, will offer national actors and other stakeholders the necessary background to assess the evolution of this reality.

There is a general understanding in the field that the alternative care of children falls into two main categories: family-based care and residential care.[8] However, one ongoing debate concerns alternative care arrangements referred to as 'family-like care', 'small group homes', 'small-scale residential care' and 'family-type care'. The UN Guidelines acknowledge

8 For definitions, see Chapter 4.

but do not define family-like care.[9] For the purposes of a classification, which requires mutually exclusive categories,[10] family-like care is included within residential care, as it is not provided by private individuals (but rather by paid or voluntary staff).

In accordance with the UN Guidelines, when alternative care is deemed necessary, family-based care should be prioritized.[11] However, when it comes to residential care, the debate remains unresolved as to whether the size of a facility is or should be a key criterion to distinguish between large-scale institutions and small group homes. Most agree that residential facilities housing a large number of children are detrimental to children's development and well-being,[12] but there is still disagreement over whether residential facilities housing smaller numbers of children can be equally harmful.[13] Small size alone does not guarantee better care or outcomes for children. The quality of care also depends on 'institutional culture'[14] and is linked to factors such as the facility's location, length and purpose of placement, staff-to-child ratio, standards and oversight, staff routines or shifts, focus of care, relationship between carers and children, staff training and skills, individualized care plans, children's consultation and participation, and monitoring of placements.[15]

Furthermore, especially among disability rights actors, there is a strong stance that residential care should never be an option for children with disabilities, regardless of the facility's size.[16] In many countries, the deinstitutionalization process has neglected children with disabilities, failing to provide conditions and support services for reunification with their families and delaying the development of family-based or independent living alternatives.[17]

Characteristics of residential care facilities, such as size and other descriptions of the care arrangement, are detailed in the ICare using specific disaggregating variables.[18] Furthermore, the category of residential care encompasses care provided in facilities primarily designated for other services – such as health care, education or rehabilitation – but which may be repurposed for alternative care. Examples include long-term alternative care of babies in maternity hospitals or the alternative care of children in juvenile detention centres.

Finally, the ICare introduces independent living as a distinct third category of alternative care of children, alongside family-based care and residential care. This arrangement recognizes the agency, capacity and autonomy of some children to live independently while still receiving external support from adults.

9 The UN Guidelines do not define what family-like care is, but they list it as one of the typologies of alternative care. See para. 29(c)iii.

10 See Chapter 2.

11 *Children's Rights and Alternative Care*, p. 33; *Guidelines for the Alternative Care of Children*, para. 53.

12 Shawar, Yusra Ribhi, and Jeremy Shiffman, 'The De-Institutionalization Debate and Global Priority for Children's Care', Working Paper, Johns Hopkins University, 16 March 2020, <https://eq-bg.org/wp-content/uploads/2021/09/Shawar-Shiffman-2020-pdf-112.pdf>.

13 Porter, Robert, Miriana Giraldi and Fiona Mitchell, *Function, Quality and Outcomes of Residential Care: Rapid evidence review*, CELCIS, Glasgow, 2020, <https://bettercarenetwork.org/library/the-continuum-of-care/residential-care/function-quality-and-outcomes-of-residential-care-rapid-evidence-review>; United Nations Children's Fund Europe and Central Asia Regional Office, *White Paper: The role of small-scale residential care for children in the transition from institutional to community-based care and in the continuum of care in the Europe and Central Asia Region*, 2020, <www.unicef.org/eca/media/13261/file>.

14 European Expert Group on the Transition from Institutional to Community-based Care, *Common European Guidelines on the Transition from Institutional to Community-based Care*, November 2012, p. 25, <https://deinstitutionalisation.com/wp-content/uploads/2017/07/guidelines-final-english.pdf>.

15 Every Child, *Scaling Down: Reducing, reshaping and improving residential care around the world*, 2011, <https://resourcecentre.savethechildren.net/pdf/4270.pdf>; Porter, Giraldi and Mitchell, *Function, Quality and Outcomes of Residential Care*.

16 Disability Rights International, *Protecting Children from Inherent Dangers of Institutionalization and Ensuring Participation of Children with Disabilities in Decision-making Processes, Submission to the Day of General Discussion of Children's Rights and Alternative Care*, n.d., <www.ohchr.org/sites/default/files/documents/hrbodies/crc/discussions/2021/submissions/subm-2021-day-general-ngos-ngo-coal-disability-rights-international.docx>; Office of the United Nations High Commissioner for Human Rights, 'General Comment No. 5 on Article 19 - The right to live independently and be included in the community', 2017, para. 16, <www.ohchr.org/en/documents/general-comments-and-recommendations/general-comment-no5-article-19-right-live>; United Nations Committee on the Rights of Persons with Disabilities, *Guidelines on Deinstitutionalization, including in emergencies (CRPD/C/5)*, Geneva, October 2022, <www.ohchr.org/en/documents/legal-standards-and-guidelines/crpdc5-guidelines-deinstitutionalization-including>.

17 *White Paper: The role of small-scale residential care for children in the transition from institutional to community-based care and in the continuum of care in the Europe and Central Asia Region.*

18 See Chapter 5.

# Frameworks and resources used to develop the ICare

The starting point for the establishment of the ICare is the notion found within the CRC that all children are entitled to special protection and assistance when temporarily or permanently deprived of their family environment, or when – in their own best interests – they cannot be allowed to remain in that environment.[19]

The UN Guidelines[20] provide further guidance to Member States on fulfilling their obligations under the CRC. The ICare follows the same logic as the UN Guidelines by differentiating among the different forms of alternative care, i.e., family-based care, residential care and independent living, corresponding to the three categories of the ICare. Furthermore, the UN Guidelines provide some definitions of alternative care arrangements, which the ICare uses and adapts. Nevertheless, some key terms are undefined in both the CRC and the UN Guidelines (e.g., care, parental care, alternative care and parents). The ICare fills those gaps by using tangible characteristics that aspire to be as universally applicable and exhaustive as possible.

The Convention on the Rights of Persons with Disabilities – adopted by the UN General Assembly in 2006[21] – and the guidance produced by the treaty body articulate additional international standards for children's care, including the provision of alternative care. These standards include General Comment No. 5 on article 19 on the right to live independently and be included in the community (2017)[22] and the Guidelines on Deinstitutionalization, including in emergencies (2022).[23]

19 Convention on the Rights of the Child, art. 20.

20 *Guidelines for the Alternative Care of Children*.

21 United Nations, Convention on the Rights of Persons with Disabilities, United Nations, New York, 30 March 2007, <www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>.

22 'General Comment No. 5 on Article 19 - The right to live independently and be included in the community', para. 16.

23 *Guidelines on Deinstitutionalization, including in emergencies (CRPD/C/5)*.

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The 2019 UN General Assembly Resolution on the Rights of the Child, focusing on children without parental care, has further advanced international understanding. This comes a decade after the adoption of the UN Guidelines.[24]

The ICare also adopts and uses some definitions of relevant key terms as defined in the International Classification of Violence against Children (ICVAC).[25] The ICare uses other guidance provided by inter-agency groups and alliances, as well as journal articles and grey literature. The full list of references is available at the end of this document.

Finally, the ICare was developed following the principles and guidelines of the UN Committee of Experts on International Statistical Classifications.[26]

## Process of building the ICare

In October 2023, following recommendations from the CES, UNICEF presented a proposal to develop a statistical classification to the UN Committee of Experts on International Statistical Classifications, the central coordinating UN body for all work and review of proposed new international statistical classifications.[27] The Committee supported UNICEF's proposal and recommended it for consideration by the UN Statistical Commission[28] at its fifty-fifth session from 27 February to 1 March 2024. The UN Statistical Commission endorsed the proposal, and UNICEF was appointed to develop the new classification.[29]

In March 2024, plans for the development of the statistical classification were presented during the joint UN Economic Commission for Europe/UNICEF Expert Meeting on Statistics on Children. The meeting report includes the recommendation that national experts support this workstream by engaging in the ICare's review and pilot.[30]

A first draft of the ICare was prepared with inputs from 30 child protection and care experts between November 2024 and February 2025.

A subsequent draft of the ICare was the subject of a global consultation between March and August 2025. Representatives of over 40 countries volunteered to participate in the consultation, which involved national statistical offices, line ministries and regional statistical organizations.

A further draft was piloted by nine countries in September

24 Resolution Adopted by the General Assembly on 18 December 2019.

25 United Nations Children's Fund, *International Classification of Violence against Children*, UNICEF, New York, 2023, p. 35, <https://data.unicef.org/resources/international-classification-of-violence-against-children>.

26 Hancock, Andrew, 'Best Practice Guidelines for Developing International Statistical Classifications', 2013, <https://unstats.un.org/unsd/classifications/bestpractices/Best_practice_Nov_2013.pdf>; United Nations Statistics Division, *Fundamental Principles of Official Statistics*, 1994, <https://unstats.un.org/unsd/statcom/doc94/e1994.htm>. The UN Committee of Experts on International Statistical Classifications was charged by the UN Statistical Commission at its thirtieth session, held from 1 to 5 March 1999, with improving cooperation on international classifications and ensuring harmonization and convergence among classifications in the International Family of Statistical Classifications (E/1999/24, chap. VII). See Hoffmann, Eivind, and Mary Chamie, 'Standard Statistical Classification: Basic principles', *Statistical Journal of the United Nations Economic Commission for Europe: Journal of the International Association for Official Statistics*, vol. 19, no. 4, 2002, pp. 223–241, <https://journals.sagepub.com/doi/abs/10.3233/SJU-2002-19401>; United Nations Economic Commission for Europe, *Generic Statistical Information Model (GSIM): Statistical Classifications Model, version 1.1*, December 2013, <https://unstats.un.org/unsd/classifications/expertgroup/egm2015/ac289-22.PDF>.

27 United Nations Statistics Division, *Meeting of the United Nations Committee of Experts on International Statistical Classifications*, 2023, <https://unstats.un.org/unsd/classifications/expertgroup/UNCEISC_2023.cshtml>.

28 The UN Statistical Commission, established in 1946, is the highest decision-making body for international statistical activities, responsible for setting statistical standards and the development of concepts and methods, including their implementation at the national and international level.

29 United Nations Economic and Social Council, *Committee of Experts on International Statistical Classifications: Note by the Secretary-General*, 2023, <https://unstats.un.org/UNSDWebsite/statcom/session_55/documents/2024-21-Classifications-E.pdf>.

30 United Nations Economic Commission for Europe, *UNECE/UNICEF Expert Meeting on Statistics on Children*, 2024, <https://unece.org/info/Statistics/events/384462>.

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2025, and the pilot results were reviewed and discussed at a workshop in Florence, Italy (8–10 October 2025). The workshop yielded substantive insights into the relevance and cross-national applicability of definitions and categories of alternative care arrangements. Expert feedback focused on:

- national feasibility, including alignment with existing data capacities, current data availability and discrepancies with domestic definitions.
- current capacity to produce data on the proposed disaggregating variables and related implications for data collection, reporting and alignment with the ICare framework.

These technical evaluations informed iterative refinements to the ICare framework and validated its operational feasibility and usefulness to countries, supporting its phased integration into national statistical systems.

The ICare was approved by the UN Committee of Experts on International Statistical Classifications in November 2025 and recommended for endorsement by the UN Statistical Commission as an international statistical standard. At its fifty-seventh session in March 2026, the UN Statistical Commission formally endorsed the ICare and recommended its inclusion in the International Family of Classifications.[31]

31 United Nations Economic and Social Council, Statistical Commission, *Draft report of the fifty-seventh session*, March 2026, <https://unstats.un.org/UNSDWebsite/statcom/documents/57>, accessed 31 March 2026.



CHAPTER 2

# Principles used in the ICare

# Definition of alternative care of a child

In the absence of an internationally agreed-upon definition of alternative care of a child, the ICare has developed one based on key concepts such as 'care of a child', 'parent' and 'caregiver'. These concepts are defined on the basis of universal characteristics and are intended for use in implementing and applying the statistical classification, while acknowledging the existence of diverse understandings across countries and cultures.

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**Care of a child**[32] refers to meeting a child's:

- physical needs, including adequate food, shelter, clothing and rest/sleep.
- cognitive needs, including language and communication skills, problem solving, attention control, working memory and critical thinking.[33]
- socioemotional needs, including individual needs such as the need to be safe and secure, to be loved and to have a sense of self-worth, and relational needs such as to feel a sense of belonging, to get along with others and to form relationships.[34]

Care of a child also includes protecting her/him from danger,[35] violence[36] and exploitation.[37]

The care of a child is an ongoing process, can be short- or long-term,[38] and takes into consideration the child's developmental

32 The care of a child represents a continuum that ranges from neglect to optimal care. It is provided by adults including parents and alternative caregivers. It is crucial to understand that care extends beyond merely meeting a child's needs; it also encompasses fulfilling and respecting her/his rights. The definition provided here is not exhaustive but corresponds to the essential needs and rights that must be met as a minimum standard. It is important to emphasize that the inability to meet all these needs or the failure to protect a child from danger does not automatically imply the need for alternative care. This definition does not represent a standard by which to assess the quality of care. The decision for alternative care is made on a case-by-case basis, depending on the individual circumstances of the child. When formal, this determination is made through an assessment conducted by social services or other recognized local entities.

33 Harvard University, 'Navigate the Complex Field of Social and Emotional Learning', <http://exploresel.gse.harvard.edu>, accessed 13 February 2025.

34 'Navigate the Complex Field of Social and Emotional Learning'.

35 **Danger** is defined as exposure to any existing or potential hazard that has the possibility of resulting in injury, pain, damage or loss. A **hazard** is a dangerous phenomenon, substance, human activity or condition. See International Federation of Red Cross and Red Crescent Societies, 'Hazard Definitions', <www.ifrc.org/fr/media/13366>, accessed 13 February 2025; United Nations Office for Disaster Risk Reduction, 'Definition: Hazard', <www.undrr.org/terminology/hazard>, accessed 13 February 2025.

36 **Violence against children** refers to any deliberate, unwanted and non-essential act, threatened or actual, against a child or against multiple children that results in or has a high likelihood of resulting in death, injury or other forms of physical and psychological suffering. See *International Classification of Violence against Children*, p. 13.

37 **Exploitation** is defined as the act of taking advantage of another for one's own advantage. See European Migration Network of the European Commission, 'EMN Asylum and Migration Glossary', 2025, <https://home-affairs.ec.europa.eu/networks/european-migration-network-emn/emn-asylum-and-migration-glossary_en>, accessed 13 February 2025.

38 Care of children is an ongoing process and not the result of single or isolated acts. It can be understood as providing primary care of the child on a daily basis.

stages, support needs[39] and evolving capacities. Meeting these needs might require having access to and obtaining medical,[40] educational[41] or other services.[42]

**Alternative care**[43] refers to the care of a child by person/s other than the parent/s[44] when the latter is/are unable[45] or unwilling to care for the child or abandon or relinquish her/him. Alternative care can be formal or informal and may be provided on a short- or long-term basis.

**Formal** alternative care is "all care provided in a family environment which has been ordered by a competent administrative or judicial authority and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures."[46]

**Informal** alternative care is "any private arrangement provided in a family environment, whereby the child is looked after on an ongoing or indefinite basis by relatives or friends (informal kinship care) or by others in their individual capacity (...) without this arrangement having been ordered by an administrative or judicial authority or a duly accredited body."[47]

A **parent** refers to a person who contributes biologically to the creation of a child or one who legally acquires parental status.[48]

A **child** is defined as "every human being below the age of eighteen" in accordance with article 1 of the CRC.[49]

39 **Support needs** are especially important for children with disabilities who have the same needs (e.g., food, shelter and nurturing care) as other children but may require specific support to have those needs met (e.g., assistive technology like wheelchairs or the use of sign language).

40 **Medical or health service** is any service (i.e., not limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of sick people. See World Health Organization, *Health Systems Strengthening Glossary*, n.d., <https://cdn.who.int/media/docs/default-source/documents/health-systems-strengthening-glossary.pdf>.

41 **Educational services or institutions** provide full-time education for students in a system designed as a continuous educational pathway. This system is referred to as 'initial education', defined as the formal education of individuals before their first entry into the labour market, i.e., when they will normally be in full-time education. See United Nations Educational, Scientific and Cultural Organization, *International Standard Classification of Education*, ISCED 2011, UNESCO Institute for Statistics, Montreal, Canada, 2012, para. 37, <https://unesdoc.unesco.org/ark:/48223/pf0000219109>.

42 **Other services** include, but are not limited to, early intervention services, inclusive of childcare for children with disabilities, specialized services and social protection. **Social protection** is defined as "a set of policies and programmes aimed at preventing or protecting all people against poverty, vulnerability and social exclusion throughout their life-course, with a particular emphasis towards vulnerable groups." See United Nations Children's Fund, *UNICEF's Global Social Protection Programme Framework: Executive summary*, 2019, <www.unicef.org/media/64606/file/UNICEF-social-protection-programme-framework-exec-summry.pdf>. Such protections include 1) social transfers, such as cash transfers, public works and child and disability grants; 2) programmes to ensure access to services, such as those for the removal of user fees and health insurance; and 3) social support and care services, including family support counselling and referrals. See United Nations Children's Fund, 'UNICEF's Approach to Social Protection', 2016, <www.unicef.org/easterncaribbean/media/851/file/Social-Inclusion-Summaries-%20UNICEF's-Approach-to-Social-Protection-2016.pdf>.

43 The UN Guidelines use the term 'children without parental care', defined as "children not in the overnight care of at least one of their parents for whatever reason and under whatever circumstances" (para. 29a). The ICare developed a more detailed and objective definition of alternative care in order to clearly determine the scope of the classification and its boundaries. Nevertheless, in the ICare, 'children in alternative care' and 'children without parental care' are understood as synonyms.

44 *Common European Guidelines on the Transition from Institutional to Community-based Care,* p. 28.

45 **Being unable** refers both to personal conditions of the parents (illness, disability, addiction, detention, death or other personal factors impeding the exercise of parental care) and conditions related to contexts that parents cannot choose or influence (poverty, armed conflicts, natural disasters, lack of specialized services for children with special needs or disability, etc.), even when provided with the necessary means, knowledge of and access to relevant services. According to the UN Guidelines, "Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care, for receiving a child into alternative care or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family". See *Guidelines for the Alternative Care of Children*, para. 15.

46 *Guidelines for the Alternative Care of Children*, para. 29 (b.ii).

47 Although spontaneous forms of non-professional caregiving are not systematically captured in administrative records, they can be identified through surveys and population censuses; accordingly, it is essential for the ICare to also include classifications for such alternative arrangements. See *Guidelines for the Alternative Care of Children*, para. 29 (b.i).

48 Parental status, which is the legal recognition of someone as a child's parent, is acquired differently in different countries (i.e., via adoption, surrogacy, etc.). For the ICare, each country should use the definition of legal parental status as per its national legislation. Acquiring parental status does not encompass assuming caregiving roles in substitution of parents (e.g., foster parents or guardians), nor does it include informal caregiving arrangements within extended or blended families. For classification purposes, these scenarios are considered forms of alternative care.

49 Convention on the Rights of the Child, art. 1.

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## The unit of classification

The ICare's unit of classification[50] is the alternative care arrangement.

An **alternative care** arrangement refers to the selection of caregiver/s and a care setting for a child in need of alternative care.

For the purposes of the ICare, a **caregiver**[51] is a person who provides care to the child in lieu of her/his parents. Caregivers can be professionals who are specifically recruited or who volunteer to provide alternative care for children, such as in the case of residential care. In the case of family-based care, caregivers integrate caregiving into their personal and professional lives and provide alternative care in private households. Within the context of family-based care, caregivers may receive subsidies or financial support from social services to help with the costs associated with caregiving. However, this financial support does not equate to being hired for a job; it is meant to assist with expenses for the care of the child rather than serve as a salary.[52]

50 The classification unit is the basic unit to be classified (e.g., in an activity classification, this would be the establishment or enterprise; in an occupational classification, it would be the job). See Expert Group on International Economic and Social Classifications, 'Short Glossary of Terms', working document, n.d., <https://unstats.un.org/unsd/classifications/bestpractices/glossary_short.pdf>.

51 A caregiver might or might not have full parental responsibility that can also be shared with parents. See Fulford Melville, Louise and Rebecca Smith, *Alternative Care in Emergencies Toolkit 2013*, 2013, <https://resourcecentre.savethechildren.net/document/interagency-working-group-unaccompanied-and-separated-children-2013-alternative-care>; United Nations High Commissioner for Refugees, *Guidelines on Supervised Independent Living for Unaccompanied Children*, 2021, <www.unhcr.org/sites/default/files/legacy-pdf/61bc48844.pdf>.

52 There might be exceptions wherein professional foster carers are given a salary to enable them to provide full-time, complex, specialized care to a child without the need to simultaneously earn a living.

A **care setting** is the living environment where children are cared for. In the case of family-based care and independent living, settings include private households, either of the caregivers or the children. In the case of residential care arrangements, care settings include collective living quarters, which can be owned or run by public entities as well as private organizations, religious congregations, companies or individuals. In applying the ICare, it is essential to distinguish between 1) children in alternative care arrangements – placements made primarily to meet alternative care needs – and 2) children in conflict with the law subject to non-custodial judicial measures. The latter group comprises children alleged or recognized to have infringed the penal law and placed in residential settings outside formal detention. These placements are not alternative care arrangements and fall outside the scope of the ICare framework.

The ICare covers alternative care arrangements in times of peace, periods of internal or international armed conflict,[53] as well as contexts of natural disasters and other humanitarian crises and emergencies. Care arrangements therefore also include care in emergency shelters, camps and reception centres, as well as interim foster care or supported independent living for unaccompanied and separated children,[54] refugee children, migrant children and children formerly associated[55] with armed forces[56] or groups.[57]

## Application of the principles of statistical classifications

The ICare is based on established statistical practices and principles. By definition, a statistical classification is: "A set of categories which may be assigned to one or more variables registered in statistical surveys or administrative files and used in the production and dissemination of statistics. The categories are defined in terms of one or more characteristics of a particular population of units of observation."[58]

Care has been taken to ensure that the following core principles of an international statistical classification are adhered to within the ICare:

**Mutual exclusivity**: Every elementary manifestation of the phenomenon under study should be assigned to one, and only one, category of the ICare such that there are no overlaps.

53 According to the Geneva Conventions of 1949, an armed conflict not of an international character (or an **internal conflict**) "occurs in the territory of one of the High Contracting Parties" (common article 3). An **international armed** conflict exists in "all cases of declared war or of any other armed conflict which may arise between two or more of the High Contracting Parties, even if the state of war is not recognized by one of them" (common article 2). See International Committee of the Red Cross, *Geneva Conventions: Additional protocols and commentaries*, 1949, <https://ihl-databases.icrc.org/en/ihl-treaties/geneva-conventions-1949additional-protocols-and-their-commentaries>.

54 In the context of armed conflict, mass population displacement, natural disasters and other crises, **separated children** are those separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may therefore include children accompanied by other adult family members. **Unaccompanied children** (also called unaccompanied minors) are children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so. See International Committee of the Red Cross, *Inter-agency Guiding Principles on Unaccompanied and Separated Children*, 2004, p. 13, <www.unhcr.org/sites/default/files/legacy-pdf/4098b3172.pdf>.

55 **Children associated with armed forces or groups** refers to "any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys, and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes." See United Nations Children's Fund, *The Principles and Guidelines on Children Associated with Armed Forces or Armed Groups (The Paris Principles)*, UNICEF, February 2007, <www.refworld.org/reference/research/unicef/2007/en/42827>.

56 The **armed forces** of a party to the conflict comprise all organized armed forces, groups and units that are under a command responsible to that party for the conduct of its subordinates. See International Committee of the Red Cross, 'Rule 4. Definition of Armed Forces', ICRC, Geneva, n.d., <https://ihl-databases.icrc.org/en/customary-ihl/v1/rule4>, accessed 7 October 2024.

57 A **non-state armed group** is a dissident armed force or other organized armed group that, under responsible command, exercises such control over a part of its territory as to enable it to carry out sustained and concerted military operations. See McDonald, Gabrielle Kirk, and Olivia Swaak-Goldman, 'Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II)', in *Substantive and Procedural Aspects of International Criminal Law: Documents and Cases*, vol. II, Brill, Leiden, 2000, pp. 259–265, art. 1(1), <https://doi.org/10.1163/9789004531406_026>.

58 Hancock, 'Best Practice Guidelines for Developing International Statistical Classifications', p. 5.

The ICare classifies each alternative care arrangement into a single Level 1 category. If a child experiences more than one type of care arrangement, such as in the case of a child moving from residential care to family-based care, each care arrangement is classified separately and assigned to different categories, thereby adhering to the principle of mutual exclusivity. Each category's description clearly describes the respective care arrangement, with additional guidance provided by examples, inclusions and exclusions, which further clarify the boundaries of each category.

**Exhaustiveness**: Every possible manifestation of the phenomenon under study should be included in the ICare.

While the ICare aims to cover all possible alternative care arrangements, it must be applied with practical considerations. The varied understandings and practices of alternative care across countries, along with the entrenched use of certain types of care (especially residential care for specific groups such as children belonging to minority populations or children with disabilities), make it challenging to list all possible forms comprehensively. Therefore, a realistic goal for the ICare is to capture care arrangements widely recognized as alternative care options in many countries, at a detailed level that balances practicality and policy relevance internationally. Nevertheless, while certain alternative care arrangements – such as supported child-headed households or supported independent living – may be context-specific and only applicable in some countries, their widespread presence warrants inclusion in the ICare and data collection efforts to ensure statistical relevance and accuracy. Additionally, the ICare will be regularly reviewed to include new or emerging types of alternative care arrangements not yet classified.

**Statistical feasibility**: It is possible to effectively, accurately and consistently distinguish between the categories in the ICare on the basis of the information available, for example, as responses to questions that can be reasonably collected on

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administrative forms. [59] However, this practice can constrain the practicality of using the ICare, particularly when administrative data are used to supplement or replace statistical or survey data. The guidance on statistical feasibility is to carefully consider how to use a classification in statistical and administrative data collections. With well-designed coding tools and procedures, the ICare enables effective coding into the correct categories, as confirmed during the country pilot.

## Criteria used to build the ICare

Alternative care of children can be understood and classified from various perspectives: the setting where the care is provided, the relationship between the children and caregivers, the reasons for providing the care, the length of placement and whether the arrangement is informal or formal. In developing this classification, priority has been given to criteria that are particularly relevant from a policy standpoint. The ICare categories and the resulting data should offer information that is easily understood and useful for developing policies aimed at preventing the unnecessary use of alternative care and providing the best options when it is necessary. For instance, data organized according to the ICare should help answer questions about trends and comparisons in different types of alternative care arrangements, variations based on children's ages, and whether the length of placements is related to children's backgrounds.

A few criteria have been used to build the hierarchical structure of the ICare to ensure that the categories meet various information needs. Specifically, the following criteria have been used to form the ICare categories:

- the setting where the alternative care is provided
- the caregiver/s responsible for the care of a child
- the type of care provided
- whether a child lives alone or with adults

Based on these criteria, alternative care arrangements are grouped in homogeneous categories, which are aggregated at two different hierarchical levels:

- **Level 1** includes categories that reflect the different settings where alternative care is provided and the caregivers providing it. There are four Level 1 categories designated to cover all care arrangements within the scope of the ICare (see Table 1).
- **Level 2** represents subcategories of Level 1 care arrangements further categorized by additional elements such as the relationship between caregivers and a child (i.e., whether they are related), the formality of the care arrangement (i.e., formal or informal[60]), the designation of care settings (i.e., whether alternative care is provided in facilities specifically designated or used for the purpose) and the relationship between children in care (related or otherwise) and their capacity to take care of younger children with external adult support.

The ICare categories in Levels 1 and 2 are intended to be complete and to encompass every possible alternative care arrangement.

**Table 1: Level 1 categories**

| Category # | Category name |
|---|---|
| 1 | **Family-based alternative care**[61] |
| 2 | **Residential alternative care** |
| 3 | **Independent living** |
| 9 | **Other forms of alternative care not elsewhere classified** |

Level 1 and 2 categories are presented in Chapter 4. Definitions were derived from different sources, including international

59 Hancock, 'Best Practice Guidelines for Developing International Statistical Classifications', p. 10.

60 Formal and informal as per definitions on page 12.

61 The ICare adopts the term 'family-based alternative care' in accordance with the widely recognized terminology established by the UN Guidelines on the Alternative Care of Children. However, for consistency with definitions and enumeration practices used in household surveys and censuses, the ICare relies on the notion of 'household' rather than 'family'. See further definitions in Chapter 4.

treaties, guidance and jurisprudence; existing statistical classifications and guidance on related matters; and grey literature and articles. Footnotes in this document provide further definitions, caveats and relevant references that are critical to understanding the various categories and concepts.

The numerical coding of the categories is in accordance with their level in the ICare: Level 1 categories are the broadest and have a one-digit code (e.g., 1); Level 2 categories have a three-digit code (e.g., 101). Annex 1 provides the detailed structure of the ICare.

The ICare categories describe different types of alternative care arrangements. However, other details are also important to fully understand patterns and trends in the alternative care of children and to conduct detailed analyses.

For example, when creating statistics on residential alternative care, it is helpful to disaggregate the data by child characteristics (such as disability status, nationality and parental status) and by facility characteristics (such as size, child-to-caregiver ratio and whether they are public or private). To do this, additional variables (or 'tags') are provided to enable coding of extra information about the care arrangement. This helps enrich the analysis with specific details about a child in care, caregivers and the management and settings of the care arrangements, which can be indicative of the quality of care experienced by a child.

Since the unit of classification is the alternative care arrangement, from an individual perspective, a child can experience different kinds of alternative care arrangements, provided by different caregivers, and in settings providing different types of care. In other words, multiple disaggregating variables can be tagged to different care arrangements as necessary to define their relevant patterns and characteristics.

The way data systems handle additional variables for datasets on the alternative care of children varies widely across countries. This variation depends on factors such as specific policy needs, the capacity for recording and processing data at different levels (i.e., local, regional and national), the development of the national child protection information system and how

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automated and digitalized the data collection is. In particular, whether the system is paper-based or computer-based affects its ability to support a detailed structure of these disaggregating variables.

Based on their policy relevance and national applicability, the following sets of disaggregating variables should be applied to alternative care arrangements:[62]

- **Child descriptions:** age, sex, disability status, parental status, previous alternative care experience, other background characteristics (including nationality and ethnicity) and relationship with other children sharing the same care setting;
- **Caregiver descriptions**: financial compensation, certification, sex and ethnicity;
- **Descriptions of care arrangement set-up and management**: authority or person who made the care arrangement decision, length of the care arrangement, reasons for the care arrangement, reasons for ending the care arrangement, and planning and monitoring of the care arrangement; and

62 See Chapter 5.

- **Descriptions of residential care facilities**: owner of facility, authority licensing and overseeing the facility, status of facility, location of facility, number of children accommodated in the facility, caregiver-to-child ratio, access to services and safety of facility.

The disaggregating variables are organized into three tiers (see **Table 2**):

- Tier I includes only one variable that is indispensable to classify a care arrangement as an alternative care arrangement of a child: the child's age while in care. This variable is found under child descriptions.
- Tier II includes a minimum set of disaggregating variables that are critical for policy relevance:
  - Under child descriptions: age when entering and exiting care, sex, disability status, parental status, previous alternative care experience, other background characteristics and relationship with other children sharing the same care setting
  - Under caregiver descriptions: financial compensation and certification of caregiver
  - Under care arrangement set-up and management: authority that decided the care arrangement, length of care arrangement, reasons for care arrangement and reasons for ending the care arrangement
  - Under descriptions of residential care facilities: owner, licensing and status of facilities; number of children accommodated; location; and caregiver-to-child ratio
- Tier III includes additional variables that are not strictly necessary for the identification of alternative care of children but are important for conducting comprehensive and detailed analyses of alternative care arrangements.

Variables are not mutually exclusive, and multiple and concurrent characteristics of the alternative care arrangements can be tagged simultaneously. Chapter 5 provides a detailed list and rationale attached to each disaggregating variable.

**Table 2: Overview of Tier I, Tier II and Tier III disaggregating variables**

| Child | Caregiver | Care arrangement set-up and management | Residential care facilities |
|---|---|---|---|
| Age while in care (I) | Financial compensation of caregiver (II) | Authority or person who made the care arrangement decision (II) | Owner of facility (II) |
| Age when entering/exiting care (II) | Certification of caregiver (II) | Length of care arrangement (II) | Authority licensing and overseeing the facility (II) |
| Sex (II) | Sex (III) | Reasons for care arrangement (II) | Status of facility (II) |
| Disability status (II) | Ethnicity (III) | Reasons for ending the care arrangement (II) | Number of children accommodated in the facility (II) |
| Parental status (II) | | Planning and monitoring of care arrangement (III) | Location of facility (II) |
| Previous alternative care experience (II) | | | Caregiver-to-child ratio (II) |
| Other background characteristics (II) | | | Access to services (III) |
| Relationship with other children sharing the same care setting (II) | | | Safety of facility (III) |

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CHAPTER 3

# Application of the ICare

# Classifying alternative care arrangements

To implement the ICare, it is necessary to properly allocate any given alternative care arrangement to one of the ICare categories. This requires knowledge of the ICare structure before attempting to classify the different forms of alternative care arrangements.

As previously mentioned, the ICare is a hierarchical classification. The first step of classification involves identifying the appropriate Level 1 category for the care arrangement in question. Each Level 1 category is defined by the setting in which alternative care is provided and the characteristics of the caregivers providing the care. For example, all arrangements in which alternative care is provided by individuals in a private household are classified under Level 1, category 1. Similarly, all arrangements where alternative care is provided in collective living quarters are classified under Level 1, category 2. Finally, if a child lives independently in a private household with external adult support, the arrangement should be classified under Level 1, category 3.

Subsequently, alternative care arrangements must also be classified into a Level 2 category. This can be achieved by identifying the shorthand name in national legislation/policy, where it exists, such as foster care, or by consulting the definitions used in the national data collection system and following guidance from the illustrative examples and inclusions and exclusions lists. In the case of population-based surveys conducted by national statistical offices and other institutions, the ICare can be used to prepare a code book with instructions on how to code answers to a given set of questions on the alternative care of children.

Residual categories, represented by the term 'other' in the category name, exist for cases where a care arrangement cannot be classified in an established category. Care arrangements should be classified into these residual categories only when absolutely necessary and only after a thorough review of the full classification to ensure that no category has been overlooked.

Chapter 4 of this document provides definitions for the Level 1 and Level 2 categories. Annex 2 contains an alphabetical index of all alternative care arrangements covered by the ICare.

# The use of illustrative examples, inclusions and exclusions

**Illustrative examples**

Each category includes a list of illustrative examples of alternative care arrangements. These are not subcategories but common arrangements belonging to the respective category. They provide practical guidance in the allocation of care arrangements and distinguish the boundary between one category and another. In the case of residential alternative care, the illustrative examples reflect some of the most common settings and places where such care arrangements occur.

For instance, the illustrative examples under foster care (101) include interim foster care in situations of displacement, conflict and emergencies as one type of care arrangement, and pre-adoption foster care as another type, both belonging to this subcategory. Illustrative examples are not exhaustive, and the list can be further expanded in the future.

**Inclusions**

The categories, when necessary, also include a list of borderline manifestations that could belong there, despite not presenting all the characteristics of the alternative care arrangements and having the potential to be classified elsewhere.[63] For example, parent and baby fostering is classified under foster care, even though both the child and parent are placed within a foster family. For inclusion cases, the ICare uses the concept of predominance, based on relevance; in cases where one

63 *Generic Statistical Information Model (GSIM): Statistical Classifications Model*, version 1.1, paras. 55, 72.

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alternative care arrangement presents several characteristics, the most predominant one has been used to classify it under a specific category.

**Exclusions**

Most categories also have a list of exclusions or examples of care arrangements that are classified elsewhere despite similarities to the category in question. Following each excluded care arrangement is the code referring to the category to which it should be classified. For example, the exclusions under residential care in designated facilities indicate that cluster foster care provided by individuals in their own households and living close to one another should be coded to 101 (foster care). In some cases, manifestations that fall outside the boundaries of the ICare[64] are reiterated as exclusions and should not be classified within its framework. These manifestations are therefore not accompanied by any corresponding code.

Together, illustrative examples, inclusions and exclusions reinforce mutual exclusivity. They clarify boundaries between categories to ensure individual alternative care arrangements can be assigned to one category only.

64 See page 22 on the boundaries of the ICare.

# The boundaries of the ICare

It is important to be aware that the ICare, like the UN Guidelines,[65] does not apply to the following situations:

- A child deprived of her/his liberty by decision of a judicial or administrative authority as a result of being alleged as, accused of or recognized as having infringed the penal law, not because she/he is in need of alternative care. However, situations in which a child has been alleged as, accused of or recognized as having infringed the penal law and is in need of alternative care are within the scope of the ICare. For example, a child placed in foster care following family breakdown who is simultaneously alleged as having infringed the penal law falls within the scope of the ICare, as the alternative care arrangement exists independently and not as a consequence of the penal proceedings.

- Care by adoptive parents from the moment a child is effectively placed in their custody pursuant to a final adoption order, from which point, a child is in parental care. The ICare is applicable to alternative care arrangements that might precede adoption, such as during pre-adoption placement or probatory placement of a child with prospective adoptive parents. Kafalah, however, is within the scope of the ICare as a form of alternative care. Unlike adoption, Kafalah maintains family ties, the transfer of inheritance rights and a child's family name.[66]

- Short-term arrangements wherein a child voluntarily stays with relatives or friends for recreational or leisure purposes and reasons not connected with the parents' general inability or unwillingness to provide care.

- A child living with her/his mother in a shelter for victims of domestic violence.

- A homeless child, as she/he might be eligible for and awaiting an alternative care arrangement but is not yet in alternative care.

# Relationship with other international classifications

The ICare has multiple linkages with the ICVAC.[67] Several of the ICare's definitions for key terms are derived from the ICVAC, including those for violence, physical and psychological needs, harmful acts, international and internal armed conflict, and children associated with armed forces and groups.[68] Key variables, such as background characteristics of the child and guidance on how to collect them, are also taken from the ICVAC.[69] It is important to note, however, that the two classifications utilize distinct units of classification, and although some overlap exists in the data collection processes (i.e., for violence against children in care settings), it is minimal.

65 *Guidelines for the Alternative Care of Children*, para. 30.

66 In the context of children's care, ***Kafalah*** is defined as the commitment by an individual or family (*kafil*) to voluntarily take responsibility for the daily care, education, safety and protection of a child (*makful*) deprived of family care, in the same way a parent would do for her/his biological child. *Kafalah* can be both formal and informal in nature. See United Nations Children's Fund Eastern and Southern Africa Regional Office, *An Introduction to Kafalah*, 2023, p. 4, <www.unicef.org/esa/documents/introduction-kafalah>.

67 *International Classification of Violence against Children*.

68 *International Classification of Violence against Children*, p. 22.

69 *International Classification of Violence against Children*, p. 42.

# Implications for national statistical systems

Existing data on alternative care of children highlight the great variety across countries in the agencies that are responsible for gathering and producing data on children in alternative care. In many countries, this responsibility is shared across multiple government agencies and authorities. These agencies can include national statistical offices, line ministries (e.g., for social welfare, education and health), child welfare and protection agencies and non-governmental organizations (NGOs).[70] Although differences in the availability of data exist across countries, the main sources used to collect data on alternative care of children include administrative records, followed by population censuses and surveys.[71] An additional challenge is presented by the fact that children living in residential care facilities, and therefore out of family care, are bypassed by traditional household surveys, which use private households as the observation unit.[72]

To generate data using the ICare, multiple sectors and institutions at both national and subnational levels must be involved. Countries may need to combine data from different sectors and institutions to capture all the variables in the ICare, emphasizing the importance of data standardization and sharing. National statistical agencies can play a key role in coordinating and harmonizing this data production.

# Implementation and maintenance plans

The production and coordination of statistical data on alternative care of children involves multiple sectors, such as social welfare and child protection, social protection, education and health, as well as different levels of administration.

Integrating the ICare at the national level will be a gradual process that depends on the maturity of data collection systems in each country. National statistical agencies and relevant ministries that collect data on alternative care of children have contributed to the development of the ICare and will be its primary users and implementers at the national level.

The ICare is expected to be periodically revised and updated based on its implementation, challenges and lessons learned at the national level. It will also be accompanied by a training tool and manual to support its implementation and use.

70 Eurochild and the United Nations Children's Fund, *Better Data for Better Child Protection Systems in Europe: Mapping how data on children in alternative care are collected, analysed and published across 28 European countries*, 2021, p. 31, <https://eurochild.org/uploads/2022/02/UNICEF-DataCare-Technical-Report-Final-1.pdf>.

71 Petrowski, Nicole, Claudia Cappa and Peter Gross, 'Estimating the Number of Children in Formal Alternative Care: Challenges and results', *Child Abuse & Neglect*, vol. 70, 2017, pp. 388–398, <https://doi.org/10.1016/j.chiabu.2016.11.026>.

72 United Nations Children's Fund, *Data Collection on Children in Residential Care: Protocol for a national census and survey on children in residential care (provisional draft)*, UNICEF, 2022, <https://data.unicef.org/resources/data-collection-protocol-on-children-in-residential-care>; United Nations Children's Fund Europe and Central Asia Regional Office, *Making Children Count in Population and Housing Census: Recommendations based on practices of United Nations Economic Commission for Europe countries in 2020 round*, 2024, <https://unece.org/statistics/documents/2024/09/informal-documents/making-children-count-population-and-housing>.

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CHAPTER 4

# Statistical definitions

SECTION 1

## Family-based[73] alternative care

Alternative care[74] provided to a child by a private individual/s in a private household,[75] including in emergency contexts[76]

| | |
|---|---|
| **101 Foster care**<br>Alternative care of a child,[77] ordered by a competent authority, provided by a caregiver/s who has/ve been selected, qualified, matched, approved and supervised for providing such care[78] | **Illustrative examples**: interim foster care in situations of displacement, conflict and emergencies;[79] emergency foster care;[80] short- or medium-term fostering;[81] long-term foster care;[82] treatment/specialized foster care;[83] short break/respite |

73 The ICare adopts the term 'family-based alternative care' in accordance with the widely recognized terminology established by the UN Guidelines on the Alternative Care of Children. However, for consistency with definitions and enumeration practices used in household surveys and censuses, the ICare relies on the notion of 'household' rather than 'family'.

74 **Alternative care** refers to the care of a child on an ongoing basis, by person/s other than the parent/s when the latter is/are unable or unwilling to care for the child or abandon or relinquish her/him. See page 12.

75 **Household** is defined as "arrangements made by persons, individually or in groups, for providing themselves with food and other essentials for living. A household may be either (a) a one-person household, that is to say, a person who makes provision for his or her own food and other essentials for living without combining with any other person to form a multiperson household; or (b) a multiperson household, that is to say, a group of two or more persons living together who make common provision for food and other essentials for living." See United Nations Statistics Division, *Principles and Recommendations for Population and Housing Censuses (Rev. 3)*, 2017, para. 2.33, <https://unstats.un.org/unsd/demographic-social/Standards-and-Methods/files/Principles_and_Recommendations/Population-and-Housing-Censuses/Series_M67rev3-E.pdf>. A **private household** differs from an institutional household, which "comprises persons whose need for shelter and subsistence are being provided by an institution. An institution is understood to be a legal body for the purpose of long-term inhabitation and provision of services to a group of persons (adults, children)." See *Making Children Count in Population and Housing Census*, para. 26.

76 **Emergency contexts** include armed conflicts, disasters and other crises. See Inter-Agency Standing Committee, <https://interagencystandingcommittee.org>, accessed 29 October 2024; United Nations Children's Fund, 'UNICEF in Emergencies: Humanitarian action is central to UNICEF's mandate and realizing the rights of every child', <www.unicef.org/emergencies>, accessed 29 October 2024.

77 **Alternative care** refers to the care of a child on an ongoing basis, by person/s other than the parent/s when the latter is/are unable or unwilling to care for the child or abandon or relinquish her/him. See page 12.

78 Derived from the *Guidelines for the Alternative Care of Children*, para. 29(c)ii. Original definition: "Situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family that has been selected, qualified, approved and supervised for providing such care."

79 **Interim foster care in situations of displacement, conflict and emergencies** is intended as foster care for separated children, pending tracing and care planning in the aftermath of an emergency or during armed conflict. See Family for Every Child, *The Place of Foster Care in the Continuum of Care Choices: A review of the evidence for policymakers*, 2015, p. 10, <https://bettercarenetwork.org/sites/default/files/The%20Place%20of%20Foster%20Care%20in%20the%20Continuum%20of%20Care%20Choices.pdf>.

80 **Emergency foster care** is intended as foster care for the unplanned placement of a child for a limited time period, typically from a few days up to several weeks, when it is deemed essential to remove a child quickly from a particular situation. See *The Place of Foster Care in the Continuum of Care Choices*, p. 10.

81 **Short- or medium-term fostering** is the planned placement of a child in foster care for typically a few weeks or months. It provides a safe place for a child to live until it is possible to reunite the child and the parents, place a child in extended family care, or arrange an alternative longer-term or permanent option in accordance with the child's developing care plan. See *The Place of Foster Care in the Continuum of Care Choices*, p. 10.

82 **Long-term foster care** is the placement of a child in foster care for an extended period, often until the child reaches adulthood, when other permanent options (such as adoption) are not available or not feasible. In some settings, long-term foster care is referred to as 'permanent foster care'. See *The Place of Foster Care in the Continuum of Care Choices*, p. 10.

83 **Treatment/specialized foster care** is family-based care provided by families that are recruited and given special training and ongoing consultation to provide treatment. Most treatment foster care programmes offer multiple services, including behaviour management and problem-solving training, special education, counselling, acquisition of independent-living skills, intensive care management, and individual, family and group services for children and parents. This specialized form of foster care is useful for young people who might otherwise have difficulty in maintaining a placement in regular foster care, e.g., children with serious behavioural or mental health problems. See *The Place of Foster Care in the Continuum of Care Choices*, p. 10.

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| | foster care;[84] pre-adoption foster care;[85] cluster foster care;[86] foster care for a child who has been trafficked or sexually exploited; foster care for an unaccompanied/separated child seeking asylum/international protection; remand fostering;[87] professional/specialized foster care;[88] special guardianship order/guardianship care/tutorship provided by non-related caregivers/custody;[89] supported lodging homes[90]<br><br>**Inclusions**: professional substitute family;[91] formal extrafamilial Kafalah;[92] parent and baby fostering[93] |

84 **Short break (or respite) foster care** is where the foster carer supports the parent to care for her/his child by providing day, evening, weekend or other short-term care of the child on a regular basis. It can also be used as one-off care for a pre-determined period, for example, when a parent is hospitalized. It is different from emergency foster care in that it is planned, and children and their families often have a relationship with the foster carers. See *The Place of Foster Care in the Continuum of Care Choices*, p. 11.

85 **Pre-adoption fostering/fostering for adoption** may be used to ensure that the prospective adopting family is able to meet the needs of the child, or to enable parents and older children to have an opportunity to reconsider their decision. Fostering for Adoption places a child with foster carers who are also approved as adopters while final decisions are made about adoption. See *The Place of Foster Care in the Continuum of Care Choices*, p. 11.

86 **Cluster foster care** describes the development of a network of foster families who can provide each other with mutual support. The households are typically located within a close distance of each other, enabling easier organization and provision of support and services. Cluster foster families often care for children who have experienced trauma. See *The Place of Foster Care in the Continuum of Care Choices*, p. 11.

87 **Remand fostering** is a type of fostering placement that offers children who are on remand by the courts a foster home to live in. This is typically while the children await their court proceedings. See Capstone Foster Care, 'Remand Fostering', <www.fostercareuk.co.uk/about-fostering/types-of-fostering/remand-fostering>, accessed 4 February 2025.

88 **Professional/specialized foster care** is where the carers receive a salary and essentially a work contract to be available full-time to provide complex care.

89 A **special guardianship order/guardianship care/tutorship/custody** is an arrangement in which a child is cared for by, and living with, the person appointed by a competent authority as her/his legal guardian. Most guardians are close relatives or family friends, but they may also be foster carers, social workers, members of a state guardianship body or representatives of a care institution. See United Nations Children's Fund Europe and Central Asia Regional Office, *White Paper: Development of foster care in the Europe and Central Asia Region*, 2024, pp. 34–35, <www.unicef.org/eca/media/34291/file/Development%20of%20foster%20care%20in%20the%20Europe%20and%20Central%20Asia.pdf>. A **legal guardian** is a person who has the legal rights and responsibilities to care for another person. A child's legal guardian will normally be the child's mother or father unless they have had their parental rights removed by a court order. Children without a legal guardian will require representation in the decision-making process to ensure their rights, opinions and best interests are protected. See Fulford Melville and Smith, *Alternative Care in Emergencies Toolkit 2013*, p. 12.

90 **Supported lodging homes** offer emotional support and essential life skills to adolescents at risk of homelessness. Adults host these young individuals in their homes, though they do not hold the same legal responsibilities as foster parents. Each adolescent is also assisted by a dedicated social worker. See Barnardos, 'Types of Foster Care', <www.barnardos.org.uk/foster/types-of-fostering>, accessed 15 October 2024.

91 **Professional substitute family** describes a care arrangement in which a child lives with unrelated caregivers in their private household, and the caregivers have a labour contract with a residential facility. The residential facility provides supervision to foster caregivers.

92 In the context of children's care, ***Kafalah*** is defined as the commitment by an individual or family (*kafil*) to voluntarily take responsibility for the daily care, education, safety and protection of a child (*makful*) deprived of family care, in the same way a parent would do for her/his biological child. *Kafalah* can be both formal and informal in nature. In **extrafamilial *Kafalah***, a child is placed with a person or people who are not biologically related. **Formal *Kafalah*** can be judicial or notarial: a **notarial *Kafalah*** takes place when a private contract or arrangement is established between the biological parents and the *kafil* parents, and then validated through a notarial deed drawn up by a notary; a **judicial *Kafalah*** is granted following a legal procedure, through a regular or Kadhi's Court, that establishes the relationship between the *kafil* and *makful*. See *An Introduction to Kafalah*, pp. 4–6.

93 Parent and baby fostering is a foster placement in which a child is placed with her/his primary carer (typically the mother) together in a foster placement to allow the primary carer to benefit from parenting guidance and support. This is particularly used for school-age parents, parents with learning disabilities or care leavers who might require modelling of good parenting. See *The Place of Foster Care in the Continuum of Care Choices*, p. 11.

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| | **Exclusions**: kinship care (102); temporary placement of a child with relatives or family friends due to short-term parental needs[94] |
| **102 Kinship care**<br>Alternative care[95] provided by a person/s related or known to the child (other than the parents), whether formal or informal in nature,[96] within her/his/their own household or the household of the child | **Illustrative examples**: kinship care by grandparents, aunts, uncles, adult siblings and other close or distant relatives;[97] social kinship care;[98] intrafamilial Kafalah;[99] informal kinship care arrangements/confiage;[100] formal kinship care;[101] voluntary or diversion kinship care;[102] foster kinship care;[103] special guardianship order/guardianship care provided by family members or family friends;[104] care by trusted adults[105]<br><br>**Exclusions**: foster care (101) |
| **109 Other forms of family-based alternative care not elsewhere classified**<br>Other forms of family-based alternative care not described in 101–102 | **Illustrative examples**: spontaneous foster care;[106] informal extrafamilial Kafalah[107] |

94 **Short-term parental needs** include hospitalization, travel or other transient circumstances.

95 **Alternative care** refers to the care of a child by person/s other than the parent/s when the latter is/are unable or unwilling to care for the child or abandon or relinquish her/him. See page 12.

96 Derived from *Guidelines for the Alternative Care of Children*, para. 29(c)i. Original definition: "Family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature".

97 Family for Every Child, *How to Support Kinship Care: Lessons learnt from around the world*, 2024, p. 14, <https://familyforeverychild.org/resources/kinship-care-guidance>.

98 **Social kinship care** is provided by close friends or persons known to the child and connected via her/his community or religion. See *How to Support Kinship Care*.

99 In **intrafamilial *Kafalah***, a child is cared for by a member of her/his nuclear or extended family, or someone who is biologically related. See *An Introduction to Kafalah*, pp. 4–6 and footnote 92.

100 **Informal kinship care arrangement/confiage** is a private care arrangement provided in a family, wherein the child is looked after on an ongoing or indefinite basis by relatives or friends or by others in their individual capacities, at the initiative of the child, her/his parents or other person, without this arrangement being ordered by an administrative or judicial authority or a duly accredited body. See *Guidelines for the Alternative Care of Children*, para. 29(b)i; *How to Support Kinship Care*, p. 13.

101 **Formal kinship care** is when the child is in the legal custody of the state but lives with kin. See *How to Support Kinship Care*, p. 126.

102 **Voluntary or diversion kinship care** is when children live with kin because of an investigation of abuse that has determined that the child cannot remain safely with her/his parents. The child welfare agency helps arrange care by relatives but does not take legal custody of the child. See *How to Support Kinship Care*, p. 126.

103 **Foster kinship care** is where kin caregivers receive foster care grants from the State.

104 See footnote 89.

105 Adults trusted by the parents or family, including godparents, mentors, spiritual guides and community members.

106 **Spontaneous foster care** is where a family not related to the child takes her/him in without any prior arrangement. This is a frequent occurrence during emergencies and may involve families from a different community in the case of refugee children. See Better Care Network, 'Glossary of Key Terms', <https://bettercarenetwork.org/glossary-of-key-terms>, accessed 15 October 2024.

107 In **informal extrafamilial *Kafalah***, a child is placed with a person or people who are not biologically related via an informal agreement that is not a legal decision. See *An Introduction to Kafalah*, p. 6.

SECTION 2

## Residential alternative care

Alternative care[108] provided to a child in collective living quarters,[109] including in emergency contexts,[110] by paid, unpaid or voluntary staff[111] ensuring continuous, 24-hour in-house care[112]

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| **201 Residential care in designated facilities[113]**<br>Alternative care provided to a child in facilities specifically designated as having the primary purpose of delivering such care | **Illustrative examples**: orphanages;[114] baby or infant homes;[115] children's centres/homes;[116] hospitals and residential schools specifically designed for children with disabilities;[117] reception centres for unaccompanied/separated children seeking asylum/international protection or awaiting expulsion from the country; children's villages;[118] group homes |

108 **Alternative care** refers to the care of a child by a person/s other than the parent/s when the latter is/are unable or unwilling to care for the child or abandon or relinquish her/him. Alternative care can be formal or informal and may be provided on a short- or long-term basis. See page 12.

109 **Collective living quarters** include "structurally separate and independent places of abode intended for habitation by large groups of individuals or several households (...). Such quarters usually have certain common facilities, such as cooking and toilet installations, baths, lounge rooms or dormitories, which are shared by the occupants. (...)". See *Principles and Recommendations for Population and Housing Censuses (Rev. 3)*, para. 4.453. Collective living quarters include, for example, hospitals, residential homes, prisons, military barracks, religious institutions, boarding houses and workers' hostels, as well as refugee camps. See Eurostat, 'Glossary: Household - social statistics', <https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:Household_-_social_statistics>, accessed 15 October 2024. Collective living quarters can be run by private individuals, bodies and religious organizations.

110 See footnote 76.

111 Staff – either remunerated or voluntary – specifically hired to provide alternative care to children. See Working Group on Children without Parental Care, *Identifying Basic Characteristics of Formal Alternative Care Settings for Children: A discussion paper*, 2013, p. 14, <https://resourcecentre.savethechildren.net/document/identifying-basic-characteristics-formal-alternative-care-settings-children-discussion-paper>.

112 *Identifying Basic Characteristics of Formal Alternative Care Settings for Children*, p. 17.

113 **Designated facilities** include facilities both intentionally created and/or formally or informally assigned for the specific purpose of providing alternative care. Care arrangements within designated facilities in which children spend weekend breaks or holidays with their parents, relatives or prospective adoptive parents are considered residential alternative care. Similarly, care arrangements within designated facilities in which children (or the residential facility) receive sponsorship or charitable support are considered residential alternative care.

114 An **orphanage** is a residential facility in which groups of children, whether orphan or otherwise, are cared for by paid personnel in a non-family-based environment. See Chik, Azlini, Siti Hajar Abdul Rauf and Lukman Z.M., 'A Cross Cultural Definitions of Orphanages', *International Journal of Research and Scientific Innovation*, vol. 3, no. 2, 2020, <www.researchgate.net/publication/344732158_A_Cross_Cultural_Definitions_of_Orphanages>. An **orphan** is a child under 18 years of age who has lost one or both parents to any cause of death.

115 **Baby or infant homes** are typically understood as residential facilities taking care of children up to the age of three. See United Nations Children's Fund Europe and Central Asia Regional Office, *White Paper: The role of boarding schools for vulnerable children in the Europe and Central Asia region*, 2024, <www.unicef.org/eca/media/34266/file/The%20role%20of%20boarding%20schools%20for%20vulnerable%20children.pdf>.

116 **Children's centres/homes** are residential facilities for the care and protection of children whose parents can no longer care for them. See Compass Children's Homes, 'What is a Residential Children's Home?', <www.compasschildrenshomes.com/what-is-a-childrens-home>, accessed 15 October 2024.

117 **Hospitals for children with disabilities** are residential settings where children live to receive continuous medical, therapeutic and rehabilitative care and whose needs cannot be met in family and community settings. **Residential schools for children with disabilities** are educational facilities where children reside full-time to access tailored instruction and integrated support for daily living. In both cases, these are not residential facilities designed to provide general health care or education for all children but are specifically designed to care for children with disabilities.

118 A **children's village** is a collection of small group homes located in one compound. Care is provided by a woman, selected and trained for the purpose, living with the children. While individual residential facilities host 6–10 children, they are grouped in villages that can collectively host over 100 children. See SOS Children's Villages, 'Quality Care', <www.sos-childrensvillages.org/our-work/protection/quality-care>, accessed 15 October 2024; SOS Children's Villages, 'We are SOS Children's Villages Uganda', <https://sos-childrensvillagesuganda.org/who-we-are>, accessed 15 October 2024; SOS Children's Villages Pilipinas, 'Bataan', <www.sosphilippines.org/overview-of-villages>, accessed 15 October 2024.

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| | for adolescents;[119] safe houses or emergency shelters;[120] transit homes;[121] respite group homes;[122] family-like and family-type group homes;[123] interim residential care in situations of displacement, conflict and emergencies;[124] single-bed children's homes[125]<br><br>**Inclusions**: mother and child shelters;[126] groups of children living independently in separate quarters of residential buildings[127]<br><br>**Exclusions**: supported/supervised independent living (301); cluster foster care (101); children in residential care facilities awaiting bail[128] |

119 **Group homes for adolescents** are for children who have left long-term residential care and need support transitioning to independent living. See Faith to Action Initiative, 'Short-Term Care, Small Group Homes, and Rehabilitative Care', 2016, <www.faithtoaction.org/short-term-care-small-group-homes-and-rehabilitative-care>, accessed 15 October 2024.

120 **Safe houses or emergency shelters** are small residential facilities for children needing to be separated from their families because of domestic violence or because they are in need of protection as they have been victims of human trafficking and sexual exploitation, formerly associated with criminal gangs or armed groups, associated with street violence, involved in armed conflict, affected by natural disasters, etc. See 'Short-Term Care, Small Group Homes, and Rehabilitative Care'.

121 **Transit homes** are facilities where children and young people live while waiting for placement into a suitable alternative care setting or while receiving support for integrating into the community. See 'Short-Term Care, Small Group Homes, and Rehabilitative Care'.

122 **Respite group homes** are residential facilities where parents can place their children for short-term care to meet special needs or take a break. This temporary separation helps support long-term family stability. See 'Short-Term Care, Small Group Homes, and Rehabilitative Care'.

123 **Family-like and family-type group homes** are arrangements wherein children are cared for in small groups, in a manner and under conditions that resemble those of an autonomous family, with one or more specific parental figures as caregivers, but not in those persons' usual domestic environment. Caregivers may receive financial or other support or compensation. See *Identifying Basic Characteristics of Formal Alternative Care Settings for Children*, p. 14.

124 Standard 19 in Alliance for Child Protection in Humanitarian Action, *Minimum Standards for Child Protection in Humanitarian Action (CPMS)*, 2019, <https://alliancecpha.org/sites/default/files/technical/attachments/CPMS_2019_Handbook_English.pdf>.

125 **Single-bed children's homes** refer to a residential care setting designed to accommodate just one child at a time. These homes are typically used for children who have complex needs, challenging behaviours or a history of placement breakdowns that make group living unsuitable.

126 **Mother and child shelters** are homes where both mother and child can stay on a short-term basis while the mother is being empowered to adequately protect and care for her child. See 'Quality Care'.

127 These arrangements are commonly found in countries that have implemented deinstitutionalization policies. Small residential units, specifically designed to provide alternative care, are used to support children in their transition from institutional care to more independent living. See *White Paper: The role of small-scale residential care for children in the transition from institutional to community-based care*.

128 These are arrangements for children who have been charged with an offence and, instead of being held in detention centres, are placed in residential care under the supervision of local authorities.

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| **202 Residential care in facilities designated for other primary purposes**[129]<br>Alternative care provided to a child in facilities originally intended for purposes other than alternative care | **Illustrative examples**: long-term baby residential care in maternity hospitals; nurseries and school facilities[130] providing 24-hour residential care; school facilities for children with special needs, disabilities and/or vulnerabilities providing 24-hour residential care;[131] correctional facilities, prisons and other places of deprivation of liberty hosting children in need of alternative care[132]<br><br>**Exclusions**: hospitalization of children in need of medical care; correctional facilities, prisons, police stations and other places of deprivation of liberty for children alleged, accused or convicted of crimes[133] |
| **209 Other forms of residential alternative care not elsewhere classified**<br>Other forms of residential alternative care not described in 201–202 | |

129 Facilities designated for other primary purposes include schools, hospitals, vocational training centres, shelters or remand homes primarily established for education, health care, skill development or correctional purposes and for which providing alternative care is secondary and exists to serve and complement the primary purpose.

130 **Schools** include both public and private schools.

131 **School facilities for children with special needs, disabilities and/or vulnerabilities** are residential facilities for children who have dropped out of school, have engaged in risk practices, have been victims of violence, come from vulnerable families, have special educational needs and/or have disabilities. See *White Paper: The role of boarding schools for vulnerable children in the Europe and Central Asia region*.

132 These are situations where children in need of alternative care are placed in correctional facilities, prisons or other places of deprivation of liberty due to a lack of alternative facilities for them and not because they have been alleged as, accused of or recognized as having infringed the law.

133 **Correctional facilities, prisons, police stations and other places of deprivation of liberty** include facilities where children are deprived of liberty by decision of a judicial or administrative authority as a result of being alleged as, accused of or recognized as having infringed the law. See *Guidelines for the Alternative Care of Children*, para. 30(a).

SECTION 3

## Independent living

Alternative care[134] provided to a child living alone or in groups in private households by paid or unpaid staff, volunteers[135] or community members[136] who are available as needed and/or at planned intervals

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| **301 Supported/supervised independent living[137]**<br>Alternative care provided to a child living alone or in groups in private households by support workers and adult mentors[138] | **Illustrative examples**: shared accommodation with other children or adult care leavers;[139] individual child living alone and receiving support to maintain accommodation;[140] supported/supervised independent living arrangements for children with disabilities; supported/supervised independent living arrangements for unaccompanied and separated children<br><br>**Inclusions**: spontaneous or self-established independent living arrangements[141] |

134 **Alternative care** refers to the care of a child by a person/s other than the parent/s when the latter is/are unable or unwilling to care for the child or abandon or relinquish her/him. Alternative care can be formal or informal and may be provided on a short- or long-term basis. See page 12.

135 Staff – either remunerated or voluntary – specifically hired to provide alternative care to children. *See Identifying Basic Characteristics of Formal Alternative Care Settings for Children*, p. 14.

136 Individuals belonging to a community, defined as a "group of people sharing common characteristics or interests. A community can be either a geographically based group of persons or a group with shared interests or common demographic composition, irrespective of their physical location within a country." See United Nations Educational, Scientific and Cultural Organization Institute for Statistics, 'Data for the Sustainable Development Goals', <https://uis.unesco.org/en/glossary-term/community>, accessed 30 July 2025.

137 Supported independent living and supervised independent living are synonyms and used interchangeably. There is no universally established minimum age for supported/supervised independent living, and it often depends on the specific country's laws and guidelines. International guidelines, such as those from the United Nations High Commissioner for Refugees, emphasize that children should not be younger than 15 years of age, except when a younger sibling lives with a child who is older than 15 years and that the decision about the arrangement should be made based on the individual needs and maturity of the child. See *Guidelines on Supervised Independent Living for Unaccompanied Children*. For the purpose of this classification, each country should use the existing minimum age as per its national legislation.

138 **Mentors** can be professionals, friends or volunteers, duly trained. See Retrak, *Independent Living*, 2015, <https://bettercarenetwork.org/sites/default/files/Independent%20Living%20.pdf>.

139 **Shared accommodation with other children or adult care leavers** includes small apartments, publicly or privately owned, where adolescents leaving residential care, having an assessed capacity of autonomy, live together. See Faith to Action Initiative, 'Supported Independent Living and Care Leaving', 2016, <www.faithtoaction.org/supported-independent-living-and-care-leaving>, accessed 15 October 2024. A **care leaver** is a young person, typically over the age of 16, who is leaving or has left a formal alternative care placement. Care leavers can also include young people above the age of 18. Nevertheless, for the purpose of the ICare, only the care arrangements of children below the age of 18 would be classified as supported/supervised independent living. Depending on each country's laws and policies, she/he may be entitled to assistance with education, finances, psychosocial support and accommodation in preparation for independent living. See 'Glossary of Key Terms'.

140 **Individual child or care leaver living alone and receiving support** may be a child leaving institutional care and living in an apartment alone with financial and personal support from social workers or mentors to maintain accommodation (e.g., dealing with landlords and contracts, paying rent and utility bills). See *Independent Living*.

141 **Spontaneous or self-established independent living arrangements** refer to living arrangements established without the involvement of child protection actors. See *Guidelines on Supervised Independent Living for Unaccompanied Children*.

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|---|---|
| | **Exclusions**: residential care in facilities designated for other primary purposes (202); supported lodging homes[142] (101); independent living of emancipated children[143] |
| **302 Supported child-headed households**<br>Alternative care provided to a child by the older child/children[144] living together in their own private household, with adult support from the local community[145] and/or external agents other than family members[146] | **Exclusions**: children living without adult supervision in child-headed households; kinship care (102) |
| **309 Other forms of independent living not elsewhere classified**<br>Other forms of independent living not described in 301–302 | |

142 See footnote 90.

143 **Emancipation** refers to the legal process by which a minor is granted independence from parental authority, allowing her/him to make decisions and assume responsibilities typically reserved for adults. This can happen in different ways depending on the country and is subject to applicable national legislation. Emancipated children are not under an alternative care arrangement and should not be counted under the ICare.

144 Typically, an older child cares for siblings, cousins, nephews or nieces. Children can also be unrelated to each other.

145 For the purposes of this classification, 'adult support from the local community' may include extended family members and other trusted adults and friends.

146 Support can come from different sources and include food, clothing and emotional support. NGOs and other external agencies may offer support through programmes that provide financial aid, educational and vocational training, health care services and psychosocial support. Governments and legal bodies may offer protection and support to child-headed households by ensuring their rights to inheritance and property are upheld. See Better Care Network, 'Supported Child Headed Households', 2025, <https://bettercarenetwork.org/library/the-continuum-of-care/supported-child-headed-households>, accessed 5 March 2025; OVC Support, 'Supporting Child-Headed Households', 2016, <https://ovcsupport.org/resource/supporting-child-headed-households>, accessed 5 March 2025; Right for Education, 'How Child-Headed Families Affect Children', 2023, <https://rightforeducation.org/2023/02/17/child-headed-families>, accessed 5 March 2025.

SECTION 9

## Other forms of alternative care not elsewhere classified

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| **909 Other forms of alternative care arrangements not elsewhere classified**<br>Any type of alternative care arrangement not described in sections 1–3 | **Exclusions**: all exclusions from sections 1–3 |




CHAPTER 5

# Variables for disaggregation

## Indispensable variable to identify alternative care arrangements of children

| Child descriptions | |
|---|---|
| Age while in care[147] | 0–4<br>5–9<br>10–14<br>15–17[148]<br>Age not known |

## Minimum variables to identify and describe critical elements of alternative care arrangements

| Child descriptions | |
|---|---|
| Age when entering/exiting care | 0–4<br>5–9<br>10–14<br>15–17<br>Age not known |
| Sex | Male<br>Female<br>Sex not known |
| Disability status | Sensory disability<br>Physical disability<br>Cognitive disability<br>Speech disability<br>Psychosocial disability<br>Other disability<br>Disability status not known<br>Disability status not applicable |

147 Age should be collected by date of birth or in months/years. The upper limit of the age band includes the following 11 months. Therefore, a child who is 4 and a half years old falls within the first band (0–4). The age bands shown here are recommended for analytical purposes.

148 While recognizing that some children might age out and become adults while in care, the ICare exclusively applies to alternative care of children (i.e., individuals under 18 years of age).

| | |
|---|---|
| Parental status | Both parents living<br>Only mother dead<br>Only father dead<br>Both parents dead<br>Father absent and location known<br>Mother absent and location known<br>Father absent and location unknown<br>Mother absent and location unknown<br>Father unknown<br>Mother unknown |
| Previous alternative care experience | The child has previous experience of alternative care:<br>• in family-based care<br>• in residential care<br>• in supported/supervised independent living<br>• in all of the above<br><br>Previous alternative care experience not known<br>Previous alternative care experience not applicable |
| Other background characteristics[149] | Citizenship: country of origin, current citizenship, statelessness, migration status (migrant child, refugee child, child seeking asylum)<br><br>Ethnicity[150] |
| Relationship with other children sharing the same care setting | Sibling<br>Related but not siblings<br>Friend<br>Not related<br>Relationship not known<br>Relationship not applicable |

149 Depending on specific country contexts, data on children in other situations could be collected, such as:

- Children in street situations: "Children in street situations (...) comprise: (a) children who depend on the streets to live and/or work, whether alone, with peers or with family; and (b) a wider population of children who have formed strong connections with public spaces and for whom the street plays a vital role in their everyday lives and identities." See United Nations Committee on the Rights of the Child, 'General Comment No. 21 on Children in Street Situations (CRC/C/GC/21)', Geneva, June 2017, <https://digitallibrary.un.org/record/1304490?ln=en&v=pdf>.
- Children associated with armed forces and groups: "any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys, and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes". See *The Principles and Guidelines on Children Associated with Armed Forces or Armed Groups (The Paris Principles)*.

150 The decision to gather data on ethnicity will depend on national circumstances. As the Office of the United Nations High Commissioner for Human Rights has pointed out, disaggregating by ethnicity must take into account objective (e.g., language) and subjective (e.g., self-identification) criteria that may evolve over time. Moreover, although many population groups call for more visibility (for themselves) in statistics to inform on prevalent discrimination or disparities and to support targeted policy measures, being identified as a distinct group may be a politically sensitive issue, which may discourage disaggregation of data. Finally, the production of any statistical data also has implications for the right to privacy, data protection and confidentiality and may therefore require consideration of appropriate legal and institutional standards. See Office of the United Nations High Commissioner for Human Rights, *Human Rights Indicators: A guide for measurement and implementation*, OHCHR, Geneva, 2012, p. 22, <www.ohchr.org/en/publications/policy-and-methodological-publications/human-rights-indicators-guide-measurement-and>.

| Caregiver descriptions | |
|---|---|
| Financial compensation of caregiver | Paid staff<br>Volunteer<br>Recipient of child subsidy and non-salary-based fee[151]<br>Other forms of in-kind or cash compensation[152]<br>Financial compensation not known<br>Not applicable |
| Certification of caregiver | Relevant professional certificate[153]<br>Relevant professional training[154]<br>Background and criminal checks<br>Certification not known<br>Not applicable |

| Care arrangement set-up and management descriptions | |
|---|---|
| Authority or person who made the care arrangement decision | Judicial system<br>Social authority or local government<br>Social worker<br>Child<br>Parent<br>Other relative<br>Chief of village<br>Religious leader<br>Another administrative decision maker<br>Authority or person not known |

151 Caregivers receive subsidies or financial support from social services to help with the costs associated with caregiving.

152 Caregivers who are not receiving full pay but do receive some form of compensation. For example, in low-income and some middle-income countries, many former residents of the care facility will stay on as staff but are rarely paid a salary. Instead, they will be compensated through being able to live in the facility for free, receiving food, having some transport costs covered, etc. They are often responsible for the care of the child.

153 Relevant professional certificates and training will depend on different country contexts and might include but not be limited to disciplines such as social work, child care, child development, special education, health and safety.

154 See footnote 153.

| | |
|---|---|
| Length of care arrangement[155] | 0–1 month<br>2–3 months<br>4–5 months<br>6–11 months<br>1 year<br>2 years<br>3–4 years<br>5–9 years<br>10–17 years[156]<br>Length of care arrangement not known |
| Reasons for care arrangement | Parental death<br>Parent whereabouts unknown<br>Physical violence[157]<br>Sexual violence, including for exploitation purposes[158]<br>Psychological violence, including exposure to violence in the home[159]<br>Neglect[160] or abandonment[161]<br>Child marriage<br>Substance abuse by parents<br>Parental psychiatric disorder |

155 The length of care arrangement should include the range from the date of entry into alternative care to the date of data collection in months/years. This is not the planned length of placement, but the actual time spent by the child in alternative care. The age bands shown here are recommended for analytical purposes. If a child has been in different types of care arrangements, each of them will be classified separately.

156 While recognizing that children might age out and become adults while in care, the length of care arrangement beyond 18 years is not recorded via the ICare, which exclusively applies to the alternative care of children (i.e., individuals under 18 years of age).

157 **Physical violence** is defined as "Any deliberate, unwanted and non-essential act that uses physical force against the body of a child and that results in or has a high likelihood of resulting in injury, pain or psychological suffering." See the *International Classification of Violence against Children*, p. 28.

158 **Sexual violence** is defined as "Any deliberate, unwanted and non-essential act of a sexual nature, either completed or attempted, that is perpetrated against a child, including for exploitative purposes, and that results in or has a high likelihood of resulting in injury, pain or psychological suffering." See the *International Classification of Violence against Children*, p. 30.

159 **Psychological violence** is defined as "Any deliberate, unwanted and non-essential act, verbal and non-verbal, that harms or has a high likelihood of harming the development of a child, including long-term physiological harm and mental health consequences." See the *International Classification of Violence against Children*, p. 32.

160 **Neglect** of a child is defined as "The deliberate, unwanted and non-essential failure to meet a child's physical or psychological needs, protect a child from danger, or obtain medical, educational or other services when those responsible for the child's care have the means, knowledge and access to services to do so." See the *International Classification of Violence against Children*, p. 35.

161 **Abandonment** is defined as "Any act by parents or other caregivers to leave behind a child with the intention to willingly relinquish parental responsibility, whether openly or anonymously." See the *International Classification of Violence against Children*, p. 36.

| | |
|---|---|
| | Parent in detention<br>Substance abuse by the child<br>Child behavioural problem<br>Lack of access to food and other basic needs<br>Disability of parents<br>Parental illness or disease<br>Homelessness<br>Access to education<br>Access to health care<br>Access to other services<br>Lack of inclusive and accessible community-based support for children with disabilities and their parents<br>Protection from trafficking and exploitation<br>Protection from conflict and disasters<br>Demobilization from armed forces or groups<br>Asylum seeking<br>Migration<br>Other reason<br>Reason not known |
| Reasons for ending the care arrangement | Reintegration/reunification[162] with family<br>Adoption<br>Reaching age 18 or other ageing-out limit<br>Completed education<br>Death<br>Change of placement<br>Moved to adult facility<br>Disappearance/escape<br>Violence/discrimination while in alternative care<br>Death of caregiver<br>Other reason<br>Reason not known |

162 **Reintegration** is defined as "The process of a separated child making what is anticipated to be a permanent transition back to his or her family and community (usually of origin), in order to receive protection and care and to find a sense of belonging and purpose in all spheres of life." **Reunification** refers to "The physical reuniting of a child and his or her family or previous caregiver with the objective of this placement becoming permanent." See Delap, Emily, and Joanna Wedge, *Guidelines on Children's Reintegration*, 2016, <https://bettercarenetwork.org/library/principles-of-good-care-practices/leaving-alternative-care-and-reintegration/guidelines-on-childrens-reintegration>.

## Descriptions of residential care facilities

| | |
|---|---|
| Owner of facility | **Public authorities:**<br>Local government<br>Provincial/regional government<br>National government (attached to ministry of education, ministry of social affairs, ministry of interior or other ministry)<br>Independent regulatory body<br><br>**Private entities:**<br>National private entity (civil society organization, religious congregation, company)<br>International private entity (civil society organization, NGO, religious congregation, company)<br>Private individuals<br>Private entity/individual who owns other facilities:<br>• in the same country<br>• in another country or countries<br><br>**Another owner (please specify):**<br>Owner not known<br>Not applicable |
| Authority licensing and overseeing the facility | Ministry of education<br>Ministry of social affairs<br>Ministry of interior<br>Ministry of health<br>Other ministry<br>Subnational authority<br>Authority not known<br>Not applicable |
| Status of facility | Registered as a residential care facility<br>Registered as a facility providing services other than residential care (i.e., education, health care, rehabilitation, correction)<br>Not registered<br>Licensed<br>Not licensed<br>Other status<br>Status not known<br>Not applicable |

| | |
|---|---|
| Location of facility | City[163]<br>Town and semi-dense area[164]<br>Rural area[165]<br>Location not known |
| Number of children accommodated in the facility | 1–3<br>4–6<br>7–9<br>10–12<br>13–15<br>16–25<br>26–50<br>51–100<br>101–200<br>201–500<br>501 and above<br>Number not known<br>Not applicable |
| Caregiver-to-child ratio[166] | 1:1<br>1:2<br>1:3<br>1:4<br>1:5<br>1:6–10<br>1:11–15<br>1:16–20<br>1:21–30<br>1:31 and above<br>Ratio not known<br>Ratio not applicable |

163 A **city** is a cluster of contiguous grid cells (each 1 km$^2$) that collectively meet two criteria:
- Minimum population: at least 50,000 people
- Minimum density: at least 1,500 inhabitants per km$^2$

See United Nations Human Settlements Programme, *Applying the Degree of Urbanisation — A Methodological Manual to Define Cities, Towns and Rural Areas for International Comparisons — 2021*, *Edition* UN-Habitat, 2021, p. 35, <https://unhabitat.org/applying-the-degree-of-urbanisation-a-methodological-manual-to-define-cities-towns-and-rural-areas>.

164 **Towns and semi-dense areas** are clusters of contiguous 1 km$^2$ grid cells that collectively meet two criteria:
- Minimum population: at least 5,000 people
- Minimum density: at least 300 inhabitants per km$^2$

See *Applying the Degree of Urbanisation*.

165 Rural areas do not meet the criteria for either cities or towns. They are typically characterized by low population density and dispersed settlements and are often dominated by agriculture, forestry or natural landscapes. See *Applying the Degree of Urbanisation*.

166 The ratio corresponds to the average number of caregivers whom the child shares with other children in the same facility. This ratio is often obtained on the basis of records and might not be adjusted for age groups. For the purpose of the ICare, a **caregiver** is a person who provides ongoing care to the child in lieu of her/his parents. Caregivers do not include administrative staff, cooks, drivers or general attendance staff of the residential care facilities.

# Additional variables for a detailed analysis of alternative care arrangements

| Caregiver descriptions | |
|---|---|
| Sex | Male<br>Female<br>Sex not known |
| Ethnicity | Variables to be determined at country level[167] |

| Care arrangement set-up and management descriptions | |
|---|---|
| Planning and monitoring of care arrangement | Child has an entry assessment record<br>Child has had best interest determined<br>Child has an individual care plan[168]<br>Child is consulted on the development of the care plan<br>Parents and caregivers are consulted on the development of the care plan<br>Child has her/his placement reviewed at least every year by a judicial or administrative authority<br>Child can have regular in-person family contact<br>Care arrangement monitored by an external authority<br>Care planning and monitoring not known<br>Care planning and monitoring not applicable |

167 The decision to gather data on ethnicity will depend on national circumstances. As the Office of the United Nations High Commissioner for Human Rights has pointed out, disaggregating by ethnicity must take into account objective (e.g., language) and subjective (e.g., self-identification) criteria that may evolve over time. Moreover, although many population groups call for more visibility (for themselves) in statistics to inform on prevalent discrimination or disparities and to support targeted policy measures, being identified as a distinct group may be a politically sensitive issue, which may discourage disaggregation of data. Finally, the production of any statistical data also has implications for the right to privacy, data protection and confidentiality and may therefore require consideration of appropriate legal and institutional standards. See *Human Rights Indicators*, p. 22.

168 **Individual care planning** refers to the structured process of assessing, documenting and coordinating the care and support required for a child in alternative care, tailored to her/his unique needs, circumstances and best interests. See *Guidelines for the Alternative Care of Children*, paras. 61–68.

| Descriptions of residential care facilities | |
|---|---|
| Access to services | Facility provides in-house education<br>Facility provides in-house specialized health care, including therapeutic services[169]<br>Facility provides access to universal/external education<br>Facility provides access to universal/external specialized health care, including therapeutic services<br>Children can access external services provided freely in the community<br>No access to services<br>Access to services not known |
| Safety and security of facility in compliance with standards of care | Facility has a child safeguarding and protection policy and/or code of conduct for staff<br>Facility has complaint mechanisms for children to raise concerns<br>Facility receives unannounced independent inspections<br>Facility has secure access to prevent unauthorized access<br>Facility has childproofing and emergency measures[170]<br>Facility has safe play areas<br>Facility has hygiene standards<br>Facility is accessible to persons with disabilities<br>Safety of facility not known<br>Security of facility not known<br>Safety and security not applicable |

169 Therapeutic services include but are not limited to physiotherapy, speech therapy and counselling.

170 Measures such as covering electrical outlets, securing furniture and using safety gates to prevent accidents, as well as plans for responding to emergencies (e.g., fire, earthquake, etc.).



# Annexes

# ANNEX 1
# Broad and detailed structure of the ICare

| SECTION 1<br>**Family-based alternative care** | |
|---|---|
| 101 | Foster care |
| 102 | Kinship care |
| 109 | Other forms of family-based alternative care not elsewhere classified |

| SECTION 2<br>**Residential alternative care** | |
|---|---|
| 201 | Residential care in designated facilities |
| 202 | Residential care in facilities designated for other primary purposes |
| 209 | Other forms of residential alternative care not elsewhere classified |

| SECTION 3<br>**Independent living** | |
|---|---|
| 301 | Supported/supervised independent living |
| 302 | Supported child-headed households |
| 309 | Other forms of independent living not elsewhere classified |

| SECTION 9<br>**Other forms of alternative care not elsewhere classified** | |
|---|---|
| 909 | Other forms of alternative care arrangements not elsewhere classified |

# ANNEX 2
# Alphabetical index

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