A local right to health for children

Why a human rights-based approach to youth care can guide Dutch municipalities in a period of youth care decentralization

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Introduction

> Universal access to health care has been undermined by austerity measures and the economic crisis. Cuts in health services and difficult economic and social conditions are beginning to have a measurable impact on the health of the population in many countries. Yet the right to health is guaranteed by international and European human rights instruments. Everyone's access to health care without discrimination belongs to the core content of this right.[1]
>
> *-Nils Muiznieks, Commissioner for Human Rights of the Council of Europe*

In this human rights comment, Nils Muiznieks states that severe austerity measures in many European countries have undermined their human rights obligations in the area of the right to health. Indeed, the economic crisis begs for reforms to make health care services more cost-effective, he acknowledges, but this must be done in a way that does not impede on the quality and accessibility of health care services for the entire population.

The Netherlands has chosen for a creative approach in bringing back healthcare costs. Key to this approach is to decentralize a large amount of healthcare services which – coupled with austerity measures – should attribute to structurally decreasing healthcare costs.[2] This transition has taken place on the 1st of January 2015 – when the Youth Act, the Participation Act and the Social Support Act entered into force – and has mainly decentralized policy areas that affect the welfare of children, the elderly, persons with a disability or persons suffering from a mental disorder. For municipalities, this means they are responsible for the care of socially disadvantaged groups and a large segment of citizens that are unable to fully participate in society.

By decentralizing several healthcare services to municipalities, the Dutch healthcare system is increasingly resembling a Nordic model of healthcare service delivery.[3] Several Nordic countries have, in the last fifteen years, moved to decentralize responsibility for healthcare service delivery to municipalities as a way 'to ensure broad popular participation, responsiveness to patient and citizen needs, and efficient care production.'[4] Swedish municipalities are responsible for social care and social assistance, including for example elderly care, care of the disabled and youth care for children and adolescents. Municipalities are responsible for providing support and assistance to people in vulnerable situations, and any such support or assistance is to be based on

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[1] Muiznieks, N., 'Maintain universal access to healthcare', in: *Human Rights Comment* (Strasbourg 2014).

[2] Zonneveld, J., 'Decentralisation. An integrated approach', in: *presentation by project leader Integrated Services at Ministry of the Interior* (The Hague 2014).

[3] Saltman, B.R. and others, *Nordic Health Care Systems. Recent Reforms and Current Policy Challenges* (New York 2009), p. 10.

[4] Saltman, B.R. and others, 'Consolidating national authority in Nordic health systems', in: *Eurohealth. Quarterly of the European Observatory on Health Systems and Policies* (London 2013).

the needs of the individual.[5]

Legitimizing the Dutch approach of decentralization in combination with austerity measures is the idea that municipalities 'can do more, with less' because they are situated much closer to their actual beneficiaries than the central government, participate more often in meaningful exchanges with their inhabitants and can therefore deliver custom-made healthcare services that will better align with their inhabitants' needs.[6] Although this line of reasoning seems sound, it still raises the question how a process of devolution - aimed at cutting healthcare costs in a relatively short timeframe - will influence the health of the population in the Netherlands.

All Dutch municipalities have an obligation to ensure the right to the highest attainable standard of health for its citizens. Moreover, the concept of progressive realization implies that States take measures to the continual progress on the status of this right. The Netherlands has ratified – or agreed to ratify – the most important international human rights treaties that include the right to health: the International Covenant on Economic, Social and Cultural Rights (Article 12), the Convention on the Rights of the Child (Article 24) and the Convention on the Rights of Persons with Disabilities (Article 25). After ratification, all levels of government (including municipalities) are under an obligation to harmonize policy and practice with the concerning treaty.[7]

But an intricate, dynamic process such as decentralization presents citizens with an insecure and uncertain future regarding their right to health. On the 28th of May 2014, several policymakers listed the large amount of parties involved in the transition, the relatively large ICT-component and the issue of civil participation as risks that endangered a safe and smooth transition.[8] Furthermore, from a human rights perspective the National Ombudsman for Children Marc Dullaert voiced two pressing concerns in the area of youth care. First, he argued that municipal autonomy in a decentralized youth care system would create friction with codified children's rights:

> The rights of the child cannot be implemented in 403 slightly different ways since these rights are indivisible and have been agreed upon. Thus, my concern is whether a certain minimum of the right to accessible and good quality of youth care can be guaranteed.'[9]
>
> *-Marc Dullaert, National Ombudsman for Children*

[5] Information supplied by policy experts within (SALAR) the Swedish Association of Local Authorities and Regions (Stockholm 2014).
[6] Rijksoverheid, 'Decentralisatie van overheidstaken naar gemeenten' (September 23rd, 2014).
[7] Amnesty International and the Association of Netherlands Municipalities (VNG), 'Goed bezig. De betekenis van mensenrechten voor gemeenten', in: *Brochure* (The Hague 2012), p. 5.
[8] Ministeries van BZK, VWS, SZW en V&J en de VNG, Decentralisatiedag voor gemeenteambtenaren, raadsleden en wethouders, Den Bosch 28 mei 2014.
[9] Eerste Kamer der Staten-Generaal, 'Verslag van een gesprek met deskundigen', in: *33.684/Dossier Jeugdwet* (20 februari 2014), p. 3.

Dullaert noted – secondly – that municipalities might not be able to maintain the continuity of youth care and the same health infrastructure for children due to the excessive focus on cost-effectiveness and the short timeframe of the transition.

The central government has followed a twin-track approach to prevent these worries from materializing. On the one hand, several Ministries have taken a reactionary approach to prevent a post-transition disaster. On the 28th of August 2014, State secretaries Van Rijn (Health, Welfare and Sport) and Teeven (Security and Justice) elaborated on possible interventionist measures regarding municipalities that have made insufficient progress in the area of youth care.[10] These interventions – ranging from implementing a national framework of minimum guarantees, obligating municipalities to cooperate together in organizing their youth care and temporarily centralizing certain aspects of youth care – would account to a form of temporary co-rule, negating aspects of municipal autonomy which directly opposes the concept of decentralization.[11] On the other hand, the Ministry of the Interior has confirmed that local empowerment is necessary if municipalities are to be equipped with the means to secure a genuine transition and equalize the risks and challenges associated with the decentralization of youth care. [12]

In this research, I will analyze to what extent a policy oriented human rights-based approach (HRBA) to youth care can offer guidance to Dutch municipalities during the decentralization of youth care. A human rights-based approach seeks to regulate the relationship between government and citizen through the notions of duty-bearer and rights-holder. It aims to integrate human rights into the plans and processes of any policymaking actor. In that way, it could contribute to local empowerment by fostering municipal awareness of the possible challenges and risks in a situation of austerity measures and devolution of powers. It offers a common language that puts the health interests of children at the forefront of policy choices and can formulate certain core principles that municipalities have to adhere to. Finally, it can increase the capacity and responsiveness of healthcare workers and institutions by offering practical examples in which essential aspects of the right to health are respected, protected and realized.

Chapter one introduces the concept of a right to health and the obligations this implies on States. The central question that this chapter seeks to answer is what is understood by a

[10] Tweede Kamer der Staten-Generaal, Kamerstuk 31839 nr. 410/vergaderjaar 2013-2014, 'Jeugdzorg', in: Brief van de staatssecretarissen van volksgezondheid, welzijn en sport en van veiligheid en justitie aan de voorzitter van de Tweede Kamer der Staten-Generaal (28 augustus 2014), p. 3-5.
[11] De Vet, K.J., 'Commentaar: Systeemverantwoordelijkheid', in: *VNG Magazine* 12 (20 juni 2014), p. 7.
[12] In the decentralized healthcare system, responsibility is shared between the Ministries of Health, Welfare and Sport (VWS), Security and Justice (VenJ) and Social Affairs and Employment (SZW). The Minister of the Interior (BZK) oversees the functioning of the public administration and subsequent governance of the system, known as *systeemverantwoordelijkheid*.

human rights-based approach to healthcare and what implications this has for States. I will start by exploring the first linkages between health and human rights in the post-Second World War period to see how health and human rights have historically been interwoven into a fabric of discursive reality. Then, I will move on to look at several influential theoretical frameworks that discuss a States' obligations to the right to health from a human rights-based perspective. Pivotal to this research are Henry Shue's tripartite typology of state obligations to human rights[13], the core obligations to the right to health and the overarching human rights-based AAAQ principles to the right to health (availability, accessibility, acceptability and quality).[14]

In the second Chapter I will depart from a general, theoretical conception of a States' obligation to the right to health to work towards a more meaningful framework for municipalities. The central question is what obligations municipalities have regarding the right to health for children. To answer this question I will 'localize' the aforementioned theoretical conceptions. First, I will take a look at what obligations municipalities have regarding the right to health. Secondly, I will bridge the gap between healthcare and youth care and examine what additional obligations municipalities have regarding children and adolescents. Thirdly, I will try to answer the question in what way a human rights-based approach to youth care is policy oriented by looking at several local examples of human rights implementation in the Netherlands.

The third Chapter aims to identify the challenges and risks associated with the decentralization of youth care. First, I will elaborate on the current decentralization of youth care in the Netherlands: what kinds of responsibilities are decentralized to the local level and how do municipalities cope with these new tasks? Secondly, the contemporary historical origin of the decentralization of social services will be explored by using primary sources. What were the incentives of decentralization and what do these texts say about the risks of providing social services at a local level? To complement this historical approach, modern decentralization literature and policy papers offer clear notions on the challenges and risks that are faced by municipalities in the Netherlands, amongst which the inequitable distribution of resources, insufficient human resource capacity and the negative outcomes of the associations between health sector reform and privatization are just a few.[15]

After we have been able to see how a human rights-based approach to healthcare can be translated to the local context and what the major risks and challenges are in the area of decentralization, the last chapter takes a more empirical approach. Chapter four focuses on answering the question how Swedish municipalities – that have a decade of experience with local

[13] Shue, H., *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (2nd ed, Princeton 1980), p. 52.
[14] UN Committee on Economic, Social and Cultural Rights, 'The Right to the Highest Attainable Standard of Health', in: General Comment No. 14 (Geneva 2000), p. 12.
[15] Regmi, K., *Decentralizing Health Services: A Global Perspective* (New York 2014), p. 11-12.

youth care – have actively implemented a rights-based approach to address the main identified risks of the decentralization of youth care.[16] By empirically constructing several cases, this cross-country analysis will offer valuable lessons for Dutch local decision-makers on how to integrate a human rights-based approach into their policymaking efforts. But before I do this, I will shortly explore the youth care system in Sweden and the systemic differences between the Dutch and the Swedish youth care systems. Finally, by empirically constructing several cases in Swedish municipalities, this chapter makes an effort to translate the body of this research from paper to practice.

In the conclusion I will reflect on the use of a policy oriented rights-based approach to youth care by municipalities. Since this research has combined theoretical assumptions with empirical findings, it will be able to reflect on the strengths and weaknesses of such an approach when trying to address different challenges and risks associated with youth care decentralization.

[16] The Swedish Government, *A National Human Rights Action Plan 2002-2004* (Stockholm 2001), p. 17 and *A National Human Rights Action Plan 2006-2009* (Stockholm 2005), p. 37, 50, 65-67.

Chapter one. A human rights-based approach to healthcare

Introduction

The bulk of academic literature on human rights-based approaches deals with development cooperation policy. But in general, a human rights-based approach refers to a conceptual framework that seeks to empower people to know and claim their rights and increases the accountability of people and institutions that are responsible for respecting, protecting and fulfilling those rights.

In order to discuss a policy oriented human rights-based approach to youth care, we need to analyze the concept of a children's right to health. As this concept is rooted in the first linkages between health and human rights, this chapter begins with the historical development of the right to health. Having examined the historical origins of the right to health, we will consider its implications for States' duties and take a look at the first conception of a child's right to health in international human rights law: the Convention on the Rights of the Child.

Finally, Article 12 of the International Convention on Economic, Social and Cultural Rights (ICESCR) and the practice of the Committee on Economic, Social and Cultural Rights (CESCR), including its own General Comments, provide highly useful material when interpreting a States' duties to Article 24 and 25 of the CRC. Therefore, the second section of this Chapter will explore three theoretical frameworks, incorporated by the CESCR in General Comment No. 14 (2000), that explore a States' obligation to human rights and the right to health.

1.1 Historical background

The concept of a children's right to health can trace its origins to the first linkages between health and human rights. In general, this process took shape during the aftermath of the Second World War, when there existed a 'general sense of awareness that the atrocities committed during and preceding this war should not be repeated, and that mechanisms should be established to offer protection against such abuses.'[17] Having experienced the apocalyptic destruction that the Second World War had caused and the horrible scientific experiments that the Nazis' eugenic and national-socialist worldview had legitimized, the world's leaders regarded the protection of universal citizens' health as fundamental to the attainment of peace and security in the world.

In the years following the Second World War several international human right treaties were adopted that incorporated the right to health.[18] In this regard, an important landmark was the constitution of the World Health Organization (WHO) in 1946, the first document that

[17] Toebes, B. a.o., *Health and Human Rights in Europe* (Antwerp 2012), p. 3.
[18] Toebes, B. a.o., *Health and Human Rights in Europe*, p. 3.

mentioned the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'[19] In the wake of the WHO, the right to health would be enshrined in several international human rights declarations and treaties: the Universal Declaration of Human Rights (UDHR 1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR 1967) and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD 1969).

When we take a look at the adoption of the right to health in European law, the right to health is firmly anchored in the (revised) European Social Charter of the Council of Europe (1996) and the Charter of Fundamental Rights of the European Union (2000), which has the same legal value as any European Union treaty. Although a formal 'right to health' was not included in the European Convention of Human Rights (ECHR 1953), its provisions on the right to life and the prohibition of torture and inhuman or degrading treatment have been used by the European Court of Human Rights in cases related to the quality of- and access to healthcare.[20]

Arguably the first and most significant declaration of human rights standards by the United Nations, the UDHR has been described as "the parent document, the initial burst of idealism and enthusiasm, terser, more general and grander than the treaties, in some sense the constitution of the entire movement, the single most invoked human rights instrument."[21] It spoke of health as a human right for all, protecting 'everyone' and denying human rights protection to 'no one'.[22] This perceived universality of human rights was translated to the right to health in Article 25(1), which mentions the right for everyone to 'a standard of living adequate for the health and well-being of himself and of his family'.[23]

Notwithstanding the fact that the UDHR accounts for the most ambitious standard-setting attempt in the area of human rights up to date, it was recognized that the universality of economic, social and cultural rights could not be expected to be translated from paper to practice in the same way as certain civil and political rights. The consigning state parties acknowledged that these rights could only be implemented when states would allocate sufficient resources to the protection of this right. The provision to the right to social security states that:

> 'Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and

[19] International Health Conference, *Constitution of the World Health Organization* (New York 1946), p. 1.
[20] B. Oomen, 'Small places: the home-coming of human rights', in: *Inaugural lecture prof. dr. Barbara Oomen* (Middelburg 2011), p. 4.
[21] H.J. Steiner & P. Alston, *International Human Rights in Context. Law, Politics, Morals* (Oxford 2007), p. 120.
[22] S.C. Carey , M. Gibney and S.C. Poe, *The Politics of Human Rights: the Quest for Dignity* (Cambridge 2010), p. 11.
[23] United Nations General Assembly, *Universal Declaration of Human Rights Article 25(1)* (Paris 1948), p. 7.

> resources of each State, of the economic, social and cultural rights indispensable for this dignity and the free development of his personality.'[24]

Thus, in explicitly stating that the advancement of economic, social and cultural rights were dependent upon the resources of each State, they encapsulated the idea that their ability to guarantee economic, social and cultural rights depended on the degree of development achieved. As human rights scholar Carey puts it: 'no individual has the duty to provide for all – and no state does either.[25]

Positive and negative obligations

So what duties do states have in ensuring compliance with economic, social and cultural rights – and specifically the right to health? Although this is still a source of international and academic contestation, one useful way to approach the issue of responsibility is the distinction made between positive and negative obligations.

In general, negative obligations are an obligation to not do something and positive obligations are an obligation to do something. A negative obligation can be illustrated by the often-heard phrase: "Hurt not others with that which pains yourself", which refers to the negative obligation not to harm other individuals. The obligation is the same for States, as the prohibition of torture requires States not to torture or inflict degrading treatment or punishment upon individuals.[26] In the case of positive obligations, the right to education obligates the State to take measures to ensure the fulfillment of this right. States have, for example, to take reasonable steps to protect individuals from infringement by other individuals.

Historically, civil and political rights have mainly been associated with negative obligations while economic, social and cultural rights were associated with positive obligations; so much so that they became known as negative and positive rights. This distinction is rooted in the ideological Cold War dispute in which the Western Bloc (the US and its NATO allies) emphasized the primacy of negative rights, while the Eastern Bloc (the USSR and members of the Warsaw Pact) would demonstrate a more positive attitude to positive rights.

Due to its Marxist-Leninist theoretical foundations, the Soviet Union had always emphasized the collective over the individual. This meant priority for the concept of positive obligations, which they believed empowered the Communist state to serve the well-being and 'self-realization' of its citizens. At the other end of the spectrum, social and economic rights had not been a part of the political tradition of the US in the same way it had been in many

[24] United Nations General Assembly, *Universal Declaration of Human Rights Article 22*, p. 7.
[25] S.C. Carey, M. Gibney and S.C. Poe, *The politics of human rights,* p. 49.
[26] S.C. Carey, M. Gibney and S.C. Poe, *The politics of human rights*, p. 43.

continental European states or in the USSR. Furthermore, American disinclination regarding the position of the Soviet Union stemmed from the fear that the positive attitude of the USSR towards the concept of positive obligations was a veiled attempt to reinstate the form of authoritarian control for which the UN system had been designed to prevent.

Isaiah Berlin, the noted Oxfordian political philosopher, set out the intricacies of this ontological distinction in 1958 during his famous inaugural lecture titled 'Two Conceptions of Liberty'. He purveyed the opinion that the different set of rights were based on a different, but overlapping conception of liberty:

> The first of these political senses of freedom or liberty (…), I shall call the 'negative' sense, is involved in the answer to the question 'What is the area within which the subject - a person or group of persons - is or should be left to do or be what he is able to do or be, without interference by other persons?' The second, which I shall call the 'positive' sense, is involved in the answer to the question 'What, or who, is the source of control or interference that can determine someone to do, or be, this rather than that?'[27]
>
> -Isaiah Berlin, *Two Concepts of Liberty*

In other words, negative liberty is freedom *from*. It concerns itself with the degree of autonomous human action without interference by others. If someone is prevented to do something which he might otherwise be able to do he is, to a certain degree, unfree. In general, the wider the area of non-interference, the wider the area of personal freedom. Taken to the extreme, this line of argument would vie for the total absence of authority or control over the actions of humans for this would constitute a situation of total freedom.

Positive liberty, on the other hand, has been coined as freedom *to*. It asks what is necessary in order for humans to reach their full potential, to become a rational human being, negating irrational impulses and uncontrolled emotional desires.[28] In that way, positive liberty implies a conception of freedom as 'self-mastery': an independent constitution of the self. To reach this state of being, it is the obligation of the State to actively create the conditions necessary for individuals to be self-sufficient or to achieve self-realization. Only when rationality guides all intentions and actions, the law (which is essentially restraining) is built by the consent of those individuals that knowingly and equally sacrifice part of their freedom to society in order to secure that same freedom, in a state of dependence according to law. Liberty becomes virtually identical with authority.[29]

[27] I. Berlin, 'Two Concepts of Liberty', in: I. Berlin, *Four Essays on Liberty* (Oxford 1969), p. 2.
[28] I. Berlin, 'Two Concepts of Liberty', p. 8-9.
[29] Idem, p. 18.

The juxtaposition of these two conceptions of liberty seemed to rule out a fertile ground for the fulfillment of both set of rights. However, insisting on the primacy of either one of these conceptions of liberty comes with its own pitfalls. Relying too heavily on the negative conception of liberty can justify inaction, while the noble ideal of self-mastery or self-realization can easily be twisted and abused by dictators and demagogues. Moreover, classic English philosophers recognized that a state of anarchy – the absolute conception of negative liberty – would lead to social chaos and, in the words of Thomas Hobbes, *a war of all against all*.[30] In order to harmonize society and in the interests of other values such as security and equality, it was acknowledged, freedom had to be limited by law.

But how can states be expected to uphold the principle of social justice when this is dependent on the degree of development achieved? The ICESCR acknowledged that each state party had an immediate obligation to take appropriate steps 'individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'[31]

The so-called concept of progressive realization describes an intent to gradually come to a full realization of economic, social and cultural rights. It introduced a flexibility mechanism in the way the international community conceived what could realistically be expected of states in the advancement of economic, social and cultural rights. Any retrogressive measures were to be understood as opposed to this concept and could constitute a violation of the respective right. The concept of progressive realization does not, however, provide any clear instructions or methods what minimum entitlements the right to health encompassed and who is responsible for ensuring the right to health by which states can assure their compliance.

From the 1980s onwards, human rights scholars began to analyze the meaning and implications of economic, social and cultural rights, which, Toebes argued, had remained undeveloped and undefined in comparison with civil and political rights. Courts and policymakers had so far been very reluctant to apply economic, social and cultural rights, as they feared the financial consequences for governments once a socioeconomic right was granted.[32] A further impetus to clarify the normative content of the rights listed in the ICESCR was the creation of the UN Committee on Economic, Social and Cultural Rights (CESCR) in 1986. This body of 18 independent experts was tasked with monitoring the implementation of the

[30] T. Hobbes, *Leviathan*, (Yale 2010), p. 72
[31] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights. Article 2(1)* (New York 1966), p. 3
[32] Toebes, B. a.o., *Health and Human Rights in Europe*, p. 4.

Economic Covenant by its state parties. Mainly through investigating the periodic state reports, exchanging views with its member states and issuing general comments the Committee contributed to an advanced understanding of the nature of economic, social and cultural rights.

A children's right to health

Parallel to the advanced understanding of the nature of economic, social and cultural rights, a decade of discussion came to a close that recognized persons under the age of 18 as autonomous bearers of those rights and capable of exercising them. The Convention on the Rights of the Child (1989) is the only human rights instrument through which the concept of a children's right to health is directly protected in international human rights law.

Children's rights, however, had previously been the subject of discussion by the international community. Declarations on the rights of the child had been adopted by the League of Nations (1924) and by the United Nations (1959).[33] Furthermore, specific regulations regarding children had been included in several human rights treaties. Nevertheless, the government of Poland argued in 1979 that there was 'a need to further strengthen the comprehensive care and well-being of children all over the world.'[34]

Although not entirely opposed to the idea of a convention on children's rights, many diplomats and human rights scholars questioned the necessity and legitimacy of a child-specific convention. Some advocated that children had the same rights as any other human being while others saw children as non-autonomous beings, in need of help and care, not capable of being bearers of rights at all. [35] The advocates and opponents of this convention were largely separated along ideological lines. Thus, while Poland was supported by delegates from the German Democratic Republic, Bulgaria and the Soviet Union, several countries from the Western bloc – the Netherlands, the UK and Sweden – criticized the Polish proposal for its timing, form and content. In 1979, the UN Commission on Human Rights concluded that a treaty-making process would be set into motion by means of an open-ended working group, through which the Polish proposal was extensively amended and expanded.

Both the delegations of Poland and Canada submitted draft articles for a children's right to health. The more extensive proposal of the Canadian delegation was used as a basis for discussion and served as a framework for Articles 24 and 25 on the right to health. [36] In view of

[33] League of Nations, *The Geneva Declaration* (Geneva 1924) and UN General Assembly, *Declaration of the Rights of the Child* (New York 1959).
[34] L.J. LeBlanc, *The Convention on the Rights of the Child. United Nations Lawmaking on Human Rights* (Lincoln 1995), p. 17.
[35] United Nations General Assembly, *Convention on the Rights of the Child. Article 24* (New York 1989), p. 7.
[36] L.J. LeBlanc, *The Convention on the Rights of the Child,* p. 82.

the importance of these articles, I will quote them here in full:

> '1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.'
> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures;
> a) To diminish infant and child mortality;
> b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
> c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;
> d) To ensure appropriate pre- and post-natal health care for mothers;
> e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
> f) To develop preventive health care, guidance for parents and family planning education and services.' [37]

Article 25 included that:

> 'State parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.'[38]

In sum, States had several obligations regarding a children's right to health. They had to take direct measures (to the maximum extent of their resources) to ensure that all abovementioned articles were progressively realized. But critics might wonder if this conception is fundamentally different from any other persons right to health. This question touches upon the fundamental perception of the child in the area of healthcare: in what way is a child different from any other human and does it require other or additional care?

In general, most delegations agreed that a child is not a wholly autonomous being, having not yet reached its full potential and thus requiring supervision and care by others. It was recognized that the primary responsibility for the child rested with the parents or guardians and with the child itself when it became mature enough to take responsibility.[39] The State had to respect the responsibilities, rights, and duties of the parents to provide direction and guidance to

[37] United Nations General Assembly, *Convention on the Rights of the Child. Article 24,* p. 7.
[38] United Nations General Assembly, *Convention on the Rights of the Child. Article 25*, p. 7.
[39] A. Eide and W.B. Eide, *A Commentary on the United Nations Convention on the Rights of the Child. Article 24 The Right to Health* (Leiden 2006), p. 6.

the child while its main responsibility was to provide for health care policies, institutions and measures, both preventive, curative and rehabilitative.[40]

But the CRC was also meant as a convention protecting the child within the context of the family. Children were not to be subjected to the arbitrary authority of their parents or legal guardians. Therefore, the best interest of the child should always be matter of the highest priority – even serving as a legitimate factor for interventionist State action in the family. Any measure that severely curtailed the responsibility of parents in guiding their child, however, was only allowed when it was in the best interests of the child, implemented as a last resort and for the shortest possible amount of time.[41]

The primary responsibility of the parents represents just one side of the equation: the other involves the child's right to participate in decision-making efforts that may be relevant for its health – within the family, the school, healthcare or the community. This guiding principle of the Convention on the Rights of the Child is closely linked to the freedom of expression. Most recently, the UN Committee on the Rights of the Child issued General Comment No. 12 (2009) on the right of the child to be heard. In this comment, it was argued that governments should stimulate a process of exchange and dialogue in which children could openly express their views – free from pressure and manipulation.[42] Children had to be heard in 'a manner consistent with their evolving capacities', which implies an assessment of the capacity of the child to form an autonomous opinion to the greatest extent possible.[43] This designation of the autonomy of a child presents parents, healthcare professionals and teachers with a duty to be willing and capable of listening to children, understanding their point of view and re-assessing their own opinion in light of the child's perspective.

When we compare the section on the right to health in the CRC with the articles on the right to health in the ICESCR, there is an explicit emphasis on the development of preventive (schools, employers or the neighborhood) and primary (general practitioners, community-based) healthcare. Adequate and timely preventive care can often prevent children in an early stage from having to rely on more specialized, expensive care in a later stage. Moreover, the preventive and primary branches of healthcare often bring to light the underlying factors of a child's deteriorating health, such as poverty issues, domestic violence, child abuse or a stressful divorce.

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[40] A. Eide and W.B. Eide, *A Commentary on the United Nations Convention on the Rights of the Child,* p. 6.
[41] Examples of these kind of state interventions in youth care are placing patients under supervision or in an out-of-home care facility.
[42] UNICEF, *Factsheet: the right to participation*, p. 1.
[43] UNICEF and Defence for Children, 'Kinderrechten en jeugdzorg', *in: Jaarbericht Kinderrechten 2014* (Den Haag 2014), p. 26.

In spite of the successful drafting and subsequent ratification of the CRC, there remained some disagreement among the state parties about the appropriate role of the state in the provision of healthcare services. The Soviet Union and other socialist states proposed that healthcare should be provided to children free of charge, while the US put forward a more conservative position, expressing the opinion that the state had an obligation to provide healthcare to children 'only in case of need.'[44] In the next section, we will take a look at several attempts to overcome this rigid Cold War dichotomy and to provide a more useful, operational language on the right to health for states.

1.2 Theoretical conceptions of the right to health

In the 1980s, several human rights scholars tried to prove that economic, social and cultural rights were less different from civil and political rights than previously thought and that the distinction between positive and negative obligations was unfortunate and inappropriate. Just as the right to health implies a state to take measures to ensure the protection of this right, they argued, it also obliges a state to refrain from any measures that will violate the right to health of its citizens. In their eyes, the protection of human rights amounted to a balancing act between the positive and negative conceptions of liberty. This paradigm shift was adopted in the Vienna Declaration and Programme of Action (1993) which declared that all human rights were 'universal, indivisible, interdependent and interrelated.'[45]

Several of these theoretical frameworks and principles provide useful notions when interpreting a States' duties to a children's right to health. They give a balanced categorization of a state's duties to the right to health which is, to a large extent, applicable to the provision of youth care services by states.

Tripartite typology of state obligations

The tripartite typology of state obligations, first introduced by Henry Shue in 1980 and simultaneously developed by Asbjørn Eide, who acted as the UN's Special Rapporteur for Food during the early 1980s, revolves around the tripartite categorization of state obligations to *respect, protect and fulfill* human rights. [46] Eide describes the obligations as follows:

- the obligation to '*respect*' requires states to abstain from violating a right;

[44] L.J. LeBlanc, *The Convention on the Rights of the Child,* p. 84.
[45] UN General Assembly, *Vienna Declaration and Programme of Action* (New York 1993), p. 3.
[46] H, Shue, *Basic Rights: Subsistence, Affluence and U.S. Foreign Policy* (Princeton 1980), p. 52 and A. Eide, *Food as a human right* (Tokyo; United Nations University 1984), p. 251-256.

- the obligation to '*protect*' requires states to prevent third parties from violating that right; and
- the obligation to '*fulfill*' requires the state to take measures to ensure that the right is enjoyed by those within the state's jurisdiction. The obligation to fulfill contains obligations to *facilitate, provide and promote*.[47]

This definition of the obligations imposed upon States by human rights treaties clearly constitutes a paradigm shift from the rigid negative and positive obligations dichotomy. It is argued that, in the same way that States have an immediate obligation to take appropriate steps to ensure the right to health (*fulfill*), they have an obligation to prevent violations of the right to health by third parties (*protect*) and to refrain from measures that deprive anyone of the right to health (*respect*).

Although this human rights-based approach does not refer to States' obligations to the right to health itself, it gives a good impression of the scope of activities that states can potentially undertake to secure a certain right. De Schutter argues that the concept of a tripartite typology was gradually accepted and imported into the UN system, but however useful the concept is as an analytical tool, it remains 'essentially static' and does not answer the question what can reasonably be expected of a state to ensure compliance with a specific right.[48] This framework does not refer to any concrete measures that can be taken by States; a factor that the core obligations to the right to health does provide us with.

Core obligations to the right to health

Four years after its creation, the UN Committee on Economic, Social and Cultural Rights (CESCR) issued General Comment No. 3 in which the experts acknowledged that 'on the basis of the extensive experience, as well as examining States' parties reports the Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party.'[49]

The formulation of a set of minimum core obligations to the right to health would prove a time-consuming process. But after ten years, the Committee issued General Comment No. 14 on the Right to the Highest Attainable Standard of Health. It addressed substantive issues that had arisen in the implementation of the right to health and provided more explicit, operational

[47] A. Eide, *The Right to Adequate Food as a Human Right: Final Report submitted by Asbjørn Eide*, (New York 1987), p. 67-69.
[48] O. de Schutter, 'Economic, Social and Cultural Rights as Human Rights: An Introduction', in: *CRIDHO Working Paper 2013/2* (Leuven 2013), p.7.
[49] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The Nature of States Parties' Obligations* (New York 1990), p. 3.

language on the freedoms and entitlements of the right to health. According to the General Comment, the core obligations of the right to health were:

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- To ensure equitable distribution of all health facilities, goods and services;
- To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.[50]

What catches the eye is that the right to health is interpreted in a broad sense, going beyond healthcare and encompassing the right to food, shelter, housing and sanitation, water and essential drugs. These interrelated categories of the right to health are the so-called *underlying determinants of health*: conditions that shape our individual and group differences in health status.

It is unmistakable that the right to health is dependent on, and contributes to the realization of these underlying determinants of health. Someone's adequate standard of living cannot be guaranteed by the existence of healthcare (services, goods and facilities) alone. Whilst healthcare has proven its curative function, access to safe and clean water and plenty nutritious food offers legion possibilities to prevent sickness and disease from manifesting itself. It is a form of preventive care; crucial to achieving an adequate standard of living for all. Therefore, states have the obligation to continuously seek to improve access to the underlying determinants of health.

What stands out, moreover, is the focus on non-discriminatory accessibility and an equitable distribution of healthcare facilities, goods and services. This presupposes a balancing conception of liberty, since it entitles the state to take measures to ensure a non-discriminatory and equitable nature of healthcare services, facilities and goods. At the same time, it obliges the state to refrain from action that in any way would be discriminatory or seem to increase the inequitable access to healthcare.

At the heart of this equalization measure is the idea that vulnerable and marginalized sections of the population are often the ones requiring healthcare, but do not have the means or capacity to access healthcare services, facilities and goods. Scholars therefore agree that there had

[50] UN Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (New York 2000), p. 15-16.

to be some minimum guarantee of access to health resources for everyone, but that it was not to be understood as an equitable state of health for every person. Due to congenital and hereditary impairments this would be an impossible – or for that matter, unethical – standard to uphold.[51]

AAAQ principles

More geared toward the right to health than the tripartite framework are the AAAQ principles, a set of interrelated and essential elements that encompass the right to health in all its forms and at all levels. These principles were incorporated in the UNCESCR General Comment No. 14, which included obligations related to the availability, accessibility, acceptability and quality of healthcare facilities, services and goods.

Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity. This includes, for example, hospitals, trained health workers, essential medicines, preventive public health strategies and underlying determinants of health;

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination. Health services have to be organized in a way that is responsive to local needs. Accessibility has four overlapping dimensions:

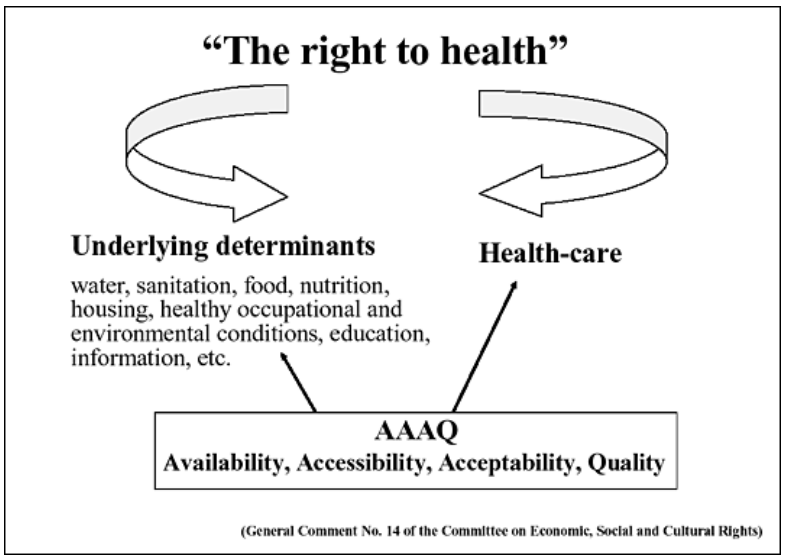
- *Non-discrimination*: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population without discrimination;
- *Physical accessibility*: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities or children;
- *Economic accessibility* (affordability): health facilities, goods and services must be affordable for all;
- *Information accessibility*: accessibility includes the right to seek, receive and impart information and ideas concerning health issues.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally sensitive. Medical treatment has to be explained in an understandable manner and healthcare workers need to be aware of cultural sensitivities;

Quality. Healthcare services must be scientifically and medically appropriate and of good quality.[52]

[51] M. Susser, 'Health as a Human Right: An Epidemiologist's Perspective on the Public Health', in: *American Journal of Public Health,* Vol. 83, No. 3 (Washington 1993), p. 419.
[52] UN Committee on Economic, Social and Cultural Rights*, General Comment No 14*, p. 4-5.

The AAAQ framework is a human rights-based approach to healthcare as it encompasses all essential elements of the right to health. It argues that the availability, accessibility, acceptability and the quality of the healthcare system is critical when it comes to ensuring the right to health for all citizens within a country. Consequentially, any human rights-based decision-making aimed at the healthcare system should contribute to one of these principles. The Committee on Economic, Social and Cultural rights clarified the scope of the right to health and the AAAQ principles by means of a graphic representation.



This definition of the right to health clearly shows that the obligations of States encompass two distinct separate categories: those that relate to healthcare and those that are related to the underlying determinants of health. In both of these areas, States have an obligation to respect, protect and fulfill the overarching AAAQ principles.

The adoption of these overarching principles led to a different conception of the concept of progressive realization. Any measure that would turn out to have a regressive effect on any of the AAAQ principles, would essentially constitute a violation of the concept of progressive realization as it results in a situation where the highest attainable standard of health and required essential care cannot be ensured. Moreover, 'the adoption of any retrogressive measures incompatible with the core obligations under the right to health (…) constitutes a violation of the right to health.'[53] In the case of deliberate retrogressive measures, the State party has 'the burden of proving that they have been introduced after the most careful consideration of all alternatives

[53] UN Committee on Economic, Social and Cultural Rights, *General Comment No 14*, p. 14.

and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources.'[54]

In sum, for a greater part of the post-World War II history, the conception of a right to health has been characterized by bipolar struggles between the two Cold War's two rival superpowers. A new conception of the right to health coincided with the collapse of the Soviet Union. Bridging the gap between the Cold War *laissez-faire* and interventionist dichotomy allowed for a conception of human rights as universal, indivisible, interdependent and interrelated. This holistic perspective led to the three previously discussed theoretical conceptions of States' obligation to human rights and the right to health.

However, what this research presupposes is the municipality as the primary duty-holder of human rights and not the national government. Therefore, what this research needs is a 'localized' human rights-based approach, relevant for municipalities in the context of the decentralization of youth care. In the next chapter, I will evaluate and expand upon the abovementioned theoretical conceptions. Only then can we begin to comprehend what obligations municipalities have regarding a children's right to health and how a human rights-based approach to youth care can be integrated into local policymaking efforts.

[54] Idem, p. 14.

Chapter two. From a human rights-based approach to local policy practice

Introduction.

While the first Chapter describes the origins and implications of a human rights-based approach to healthcare for States, the second Chapter will focus on the question how a human rights-based approach to youth care can be implemented in a local policy-oriented context. In Chapter two, I will tackle two unresolved issues:

- How do the theoretical conceptions of the right to health translate to municipal obligations to the right to health for children?
- How is a human rights-based approach to youth care policy-oriented?

Before I start with addressing the first question, however, it is important to note that I will merely focus on one category of the right to health for children: youth care. Youth care encompasses the working field of many organizations that support and help children and their parents with problems of a psychic, social or pedagogical nature during the upbringing of their children. While the underlying determinants of the right (access to food, water, essential drugs) to health are an integral and vital aspect of the broader category of youth policy and a child's healthy upbringing, it is the youth care aspect of youth policy that is currently being decentralized in the Netherlands.

2.1 Municipal obligations to the right to health

How do the theoretical conceptions of a right to health for States 'translate' to obligations for municipalities? In general, international charters, treaties and conventions that have been signed and ratified by the Dutch State are directly applicable to municipalities.[55] Thus, the ICESCR, CRC, Charter of Fundamental Rights of the EU and affiliated documents such as General Comments are applicable to municipalities. After ratification, every municipality is under an obligation to harmonize its policy and practice with the relevant treaty. Since the right to health is protected by several international treaties, local governments are encouraged to take human rights considerations into account when formulating new health policies. But what elements of the before mentioned theoretical conceptions of the right to health are relevant in a municipal context? And in what way do they present obligations for municipalities?

[55] Artikel 93: Rechtskracht internationale verdragen, in: *Grondwet voor het Koninkrijk der Nederlanden* (2008), *Hoofdstuk. 5: Wetgeving en bestuur, Paragraaf 2: Overige Bepalingen.*

Municipalities have an obligation to guarantee a non-discriminatory and equitable youth care system for all children. Both the core obligations to the right to health and the AAAQ framework include the right to non-discrimination and an equitable distribution of health services, facilities and goods. By national law, Dutch municipalities have an obligation to provide anti-discrimination services (ADV) that handle complaints, investigate allegations and offer advice to victims of discrimination.[56] Integrating the right to non-discrimination with youth care policy, however, would imply an obligation for municipalities to ensure that children of minorities (regardless of sex, ethnicity, religion) and marginalized citizens enjoy, amongst others, the same level of access to health facilities, goods and services as other citizens. Streamlining youth care policy with already formulated anti-discrimination and anti-poverty policies could prove helpful: when inclusive and empowering policies have a measurable effect on minority groups, it is likely that they will experience a higher degree of access to youth care services.

Every municipality has the obligation to ensure an available, accessible, acceptable and qualitatively good youth care system in its community. The AAAQ framework, introduced in General Comment No. 4 (2000), represents the right to health in all its forms and at all levels and offers a legally binding interpretation of the human right to health. The principles imply obligations for municipalities in their own right, but they are to be understood as mutually reinforcing. For example, the accessibility of youth care services requires a non-discriminatory policy, but is also accommodated by able and professional youth care workers that correctly indicate which type of care is necessary per patient. If neighbors, on the basis of a gut feeling, decide which type of care is appropriate in a given situation, it would constitute a deterioration of the accessibility of youth care since the indication would happen at random.[57] Likewise, the quality of specialized youth care workers – apart from a certified, professional education – depends on the possibility to provide for acceptable healthcare: being able to work in a culturally sensitive way with patients opens up several venues to improve the quality of work.

The measures taken at the local level to ensure these categorical obligations will, depending on the local context, vary per municipality. In order to provide for an acceptable measure of the distance and cost for patients, municipalities could for example provide a transport service to health facilities for children and parents whose financial or physical distance to youth care facilities is disproportionately large. For the sake of acceptability, municipalities could offer healthcare workers a cultural sensitivity training to ensure healthcare workers can function in an ethnically diverse environment.

[56] Staten-Generaal van het Koninkrijk der Nederlanden, *Wet gemeentelijke antidiscriminatievoorzieningen* (Den Haag 2009).
[57] Nieuwsuur, 'Geen garantie continuïteit jeugdzorg', in: *Uitzending maandag 22 september 2014*.

AAAQ-AP: Accountability and participation

Two additional human rights-based principles are relevant in a municipal context: *accountability* and *participation*. Axel Hadenius argues that decentralization allows for citizens to 'participate and exert influence', because the political process becomes more tangible and is brought closer to the citizens.[58] By empowering citizens to take an active role in decision-making processes they develop a sense of ownership for a healthcare system that is based on transparency and integrity. Ideally, this would result in a continuous dialogue between health care workers, the municipality and its citizens. Although these principles were not introduced in General Comment No. 4, Toebes argued, they are increasingly referred to in the health and human rights literature as 'important principles underpinning the right to health.'[59]

- **Accountability**. The availability of possibilities to address questions regarding the health sector through monitoring, accountability mechanisms, and remedies;
- **Participation**. Participation of the public in the health-decision making process.

Accountability is a word often used to capture the notion of responsibility and answerability. It takes many different forms, but to provide for non-judicial accountability is an obligation of every democratically-oriented municipality. In most countries, non-judicial accountability is guaranteed through local elections and by the work of the municipal council. But healthcare accountability, as Potts argues, involves a continuous four-phased process of policy implementation, monitoring, assessment and remedy.[60] True accountability requires careful monitoring (by municipal officials, interest groups, individuals and independent parties), transparency, access to information and active popular participation.[61] In that way, it constitutes an interactive process of assessment between the municipality and its citizens, one of the characteristics of a democratic form of government. While municipalities often have formal accountability procedures in place, a recent survey showed that municipalities haven't put a lot of thought into informal complaint mechanisms.[62] From a human rights-based approach this would include instating a local Ombudsman service or a municipal confidant that regularly engages in dialogue with several patient groups, with the specific aim of assessing current policy.

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[58] A. Hadenius, *Decentralisation and Democratic Governance. Experiences from India, Bolivia and South Africa* (Stockholm 2003), p. 1.
[59] B. Toebes, 'Human Rights, Health Sector Abuse and Corruption', in: *Human Rights and Human Welfare Working Papers* (Aberdeen 2011), p. 19.
[60] H. Potts, *Accountability and the right to the highest attainable standard of health* (Essex 2008), p.14.
[61] A. E. Yamin, 'Beyond compassion: The central role of accountability in applying a human rights framework to health', in: *Health and Human rights,* Vol. 10, No. 2 (Harvard 2008), p. 3.
[62] Vereniging van Nederlandse Gemeenten, 'Klagen is een recht maar hoeft lang niet altijd tot een formele procedure te leiden', in: *Expertmeeting Jeugdhulp en Wmo* (Gouda 2014).

Accountability goes hand in hand with civic participation. Participation revolves around the notion of 'the active involvement of individuals, communities or community-based organizations in the design, implementation, management or evaluation of their community health services or systems'.[63] Effective accountability requires participatory mechanisms to be established to allow children and adolescents to participate and actively shape health policy – not as a symbol of tokenism, but of true joint decision-making. Youth participation in policymaking could take a formal character (municipal council and client advisory boards) or an informal character (consultations, focus group research and online discussions).

The human rights-based AAAQ-AP framework offers insight in the categorical obligations for municipalities in the area of youth care to ensure compliance with the right to the highest attainable standard of health. It combines the legal obligations for municipalities to the right to health with principles of good governance.[64] This includes both the principles of non-discrimination and equitability of health care facilities, services and goods. In the next section of this chapter I will address the question in what way a human rights-based approach to youth care is policy oriented.

2.2 A policy oriented approach

The AAAQ-AP framework refers to underlying considerations that inform policymaking efforts in the area of youth care. How can municipalities organize an easily accessible and accountable system of youth care? Can municipalities effectively base local policy on this framework and how does such an approach take shape at the local level?

A human rights-based approach aims to integrate human rights into the plans and processes of a policymaking actor. It seeks to regulate the relationship between government and citizen through the notions of duty-bearer and rights-holder, and their corresponding duties and rights, and sets the abilities to meet obligations and claim rights as the target of good governance.[65] In doing so, human rights principles are not merely understood as vague and lofty ideals but as a policy instrument that goes beyond the classical violation/non-violation dichotomy. A human rights-based approach offers a safeguard against arbitrary policy choices, keeps people at the center of policy considerations and allows local governments to discuss, learn and reflect upon their progress.

To assess whether and how a human rights-based approach can inform and guide a youth

[63] F. Bustreo en P. Hunt, *Women's and Children's Health: Evidence of Impact of Human Rights* (WHO 2013), p. 70.
[64] Committee on the Rights of the Child, 'The right of the child to be heard', in: *General Comment No. 12* (Geneva 2009) and Rijksoverheid, Rechten in de zorg. Patiëntenrecht en cliëntenrecht.
[65] The Danish Institute for Human Rights, The AAAQ Framework and the Right to Water. International indicators for availability, accessibility, acceptability and quality (Copenhagen 2014), p. 17.

care policy process (including decision making and policy formulation, implementation, and evaluation) I will take a look at those instances in which Dutch municipalities have based their policy considerations on human rights principles.'[66] While few municipalities would object to the idea that these principles underpin their policy-making efforts in the area of youth care – as a normative framework – it is rare for municipalities to actually refer to human rights frameworks or international human rights treaties in their policy papers or during implementation of policy.

The homecoming of human rights

Barbara Oomen contends that those cities that do apply international human rights standards in addressing urban issues comprise a group of 'modest forerunners' in the global movement of cities. These cities are known in the academic literature as human rights cities.[67] And although human rights have been increasingly recognized as a framework for action by Dutch municipalities, there still exists a persistent 'awareness gap' on the role of local authorities in ensuring human rights.[68] How do human rights 'translate' to the local level and what is the theoretical grounding of human rights implementation by municipalities?

In general, there is a gap in human rights research that focuses on the empirical study of human rights implementation at the domestic level of developed nations.[69] No extensive body of literature exists that explains the theoretical grounding of human rights implementation in local policy practice in developed countries. Human rights, however, have strongly manifested themselves in the Netherlands since the 1960s.[70] Several treatises seem to suggest that human rights were regarded as an ideology exclusively for export and not for domestic consumption: human rights implementation was merely necessary in Third World Countries where the rule of law had not yet been established and serious human rights violations occurred.[71]

But in the last couple of years, the Netherlands has witnessed several institutions and initiatives taking a turn towards a firmer anchoring of human rights in local policy practice. A first and meaningful step towards this goal was taken with the establishment of the Netherlands Institute for Human Rights (2012), an institution that seeks to explain, monitor, protect and

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[66] S. Becker, and A. Bryman, 'Policy research', in S. Becker, A. Bryman, A, *Understanding Research for Social Policy and Practice: Themes, Methods and Approaches* (Bristol 2004), p. 1.
[67] E. v.d. Berg and B. Oomen, 'Towards a Decentralization of Human Rights: The Rise of Human Rights Cities', in: T. van Lindert and D. Lettinga, *The Future of Human Rights in an Urban World. Exploring Opportunities, Threats and Challenges* (Amsterdam 2014), p. 15.
[68] A. Accardo, J. Grimheden and K. Starl, 'The case for human rights at the local level: a clever obligation?' *European Yearbook on Human Rights* (Graz 2012), Neuer Wissenschaftlicher Verlag – NWV, p. 33.
[69] P. Schmidt and S. Halliday, *Human Rights Brought Home. Socio-legal Perspectives on Human Rights in the National Context* (Oregon 2004), p. 3.
[70] P.A.M. Malcontent, *Op kruistocht in de Derde Wereld: de reacties van de Nederlandse regering op ernstige en stelselmatige schendingen van fundamentele mensenrechten in ontwikkelingslanden, 1973-1981* (Utrecht 1998), p. 46.
[71] B. Oomen, *Rights for Others: The Slow Home-Coming of Human Rights in the Netherlands* (Cambridge 2013), p. 12.

promote respect for human rights in practice, policy and legislation.[72] In 2013, following countries such as Spain, Finland and Sweden, the Dutch government published its first National Human Rights Action Plan in which the role of municipalities in securing fundamental human rights was acknowledged and confirmed.[73] Apart from these standard-setting and pioneering initiatives, several municipalities, human rights scholars and NGOs joined their forces in a Local Human Rights Network that regularly meets to discuss and exchange knowledge and experiences of human rights implementation on a local level.[74] Finally, in 2014 a multiparty initiative was launched (consisting of senators and parliamentarians combined with human rights workers and experts) that seeks to establish a structural involvement of political representatives with local implementation of human rights.[75]

It is important to note that this 'homecoming' of human rights is not purely an endogenous development, but also attests to the successful advocacy of civil society initiatives and international organizations. One of such actors, the Congress of Local and Regional Authorities of the Council of Europe (the Congress) has credibly committed itself to the promotion of human rights implementation at the local level. The Congress is the political forum for local and regional policymakers within the Council of Europe, consisting of delegations from 47 member states in which local and regional mayors, councilors and presidents participate. Its members stated in the 'Child in the City' report (2008) that the implementation of the rights of the child (as codified in the CRC) could most concretely be undertaken at the local level.[76] Since its adoption of Resolution 296 (2010) on the role of local and regional authorities in the implementation of human rights[77], the Congress has credibly committed itself to the promotion of human rights implementation at the local level. In a report dating from its 26th session (March 2014), the Congress offers several best practices of implementation of human rights at the local level, categorized according to the obligations of municipalities to *respect, protect and fulfill* human rights.[78]

These best practices offer valuable examples of the ways in which human rights can be implemented in the area of youth care. First, regarding the responsibility of municipalities to *respect* the right to health, the Congress advises municipalities to establish an Ombudsman that

[72] United Nations. Office of the High Commissioner for Human Rights, OHCHR and NHRIs.
[73] Ministerie van Binnenlandse Zaken en Koninkrijksrelaties, *Nationaal Actieplan Mensenrechten. Bescherming en bevordering van mensenrechten op nationaal niveau* (Den Haag 2013), p. 14.
[74] Netwerk Mensenrechten Lokaal. 'Wat is het Netwerk?', Netwerk Mensenrechten Lokaal.
[75] E. v.d. Berg, and B. Oomen, *Mensenrechten en lokaal beleid. Handreiking voor beleidsmakers* (Den Haag 2014), p. 11.
[76] Congress of Local and Regional Authorities of the Council of Europe, *Child in the City* (Strasbourg 2008), p. 4.
[77] Since the adoption of resolution 296 (2010), the Congress has adopted reports on 'Developing indicators to raise awareness of human rights at local and regional level (2011) and on 'Best practices of implementation of human rights at local and regional level in member states of the Council of Europe and other countries' (2014).
[78] L. O. Molin, 'Best practices of implementation of human rights at local and regional level in member states of the Council of Europe and other countries', in: *Monitoring Committee* (Strasbourg 2014), p. 7-13.

assesses municipal decisions and policies in the light of international human rights principles. Municipalities could, in the area of youth care, opt for a specialized care Ombudsman that scrutinizes youth policy by making use of the AAAQ-AP framework. An Ombudsman office gives visibility to local authorities' important role in human rights protection. Moreover, it serves as a focal point for human rights-oriented work in a variety of sectors and functions as an independent and authoritative accountability mechanism.[79] Several Dutch municipalities are considering to introduce a care Ombudsman in a local or regional context.[80] Another way to ensure respect for the right to health includes analyzing all youth care services from an AAAQ-AP perspective (by means of a survey or otherwise) and act in order to eliminate barriers of any kind.

Secondly, the Congress asserts that municipalities have an obligation to *protect* the right to health for children and make sure that the right to health for children is not deliberately violated by any third party. This includes instances where a child's health is directly influenced by situational factors or instances where children are prevented (by their parents or other parties) to access any form of healthcare. The obligation to protect requires an activist, timely and interventionist stance on the part of municipalities: when situations that endanger a child's right to health are discovered in an early phase, aggravated situations can be prevented. Such is the case with preventive action in the area of domestic violence or mounting tensions in the context of an impending divorce between parents.

Often, however, the seclusion of the home makes it hard to assess what is happening behind the 'front door.' Integrated, community-based youth care that cooperates on a structural basis with educational facilities and the neighborhood can play a crucial 'early warning' element in preventing deterioration of children's health. Strengthening the connection between the neighborhood, schools and youth care providers (but also with police and the prosecution authority) enables for timely action and for youth care facilities that are readily available and easily accessible for children and their families. The report offers an example of this working method in the region of Umeå in Sweden, which is a cooperative project between the municipality of Umeå, Västerbotten County Council, Umeå University, the Swedish Police, the Swedish Board of Prosecution Authority and the National Board of Forensic Medicine.[81]

Municipalities can facilitate and establish the parameters of such an experiment to

[79] L.O. Molin, 'Best Practices of implementation of human rights at local and regional level in member states of the Council of Europe and other countries', p. 5.
[80] 'Assen krijgt ombudsman voor de zorg', in: *RTV Drenthe* (24 oktober 2014) and 'PvdA Arnhem wil ombudsman voor zorg en jeugd', in: *De Gelderlander* (27 oktober 2014).
[81] Molin, 'Best Practices of implementation of human rights at local and regional level in member states of the Council of Europe and other countries', p. 9.

conflate the community-based youth care with the neighborhood and the educational infrastructure. But organizing this process in an efficient way might not be as easy as it seems and might differ per neighborhood. Municipalities would have to draw up an inventory of what help the respective neighborhood could offer with regards to youth care, what is expected of the schools in the neighborhood and what the community-based youth care team can do.[82] The municipality of Utrecht began an experiment in 2012 with two 'Youth & Family' neighborhood teams. These teams (made up of several youth care professionals that specialize in generalist approaches in child welfare) are available, visible and can be found on schools and in the neighborhood. Working with this approach has resulted in an increased quality of the youth care work in those neighborhoods and has drastically lowered the costs that has been associated with them.[83]

Finally, concerning the obligation to *fulfill* the right to health for all children, the report vies for inclusive policies where minorities are involved. Municipalities can ensure that there is a person in every community-based youth care team that is a member of a minority, has worked with minorities before or they can train someone to be able to work more effectively with religious or ethnic minorities. In many neighborhood teams Christian organizations such as Abrona or the Leger des Heils (the Dutch arm of the Salvation Army) are represented, but no outspoken Muslim organizations or otherwise affiliated are included. Religious and ethnic diversity – how limited it might be – would allow the team members to learn from each other how to deal with situations in a culturally sensitive context, which increases the acceptability and quality of the provided youth care services.

Municipalities have an obligation to ensure that the access to youth care services is guaranteed for all children. Fulfilling this duty also implies taking care of the weakest and most vulnerable children in society whose rights are not adequately entrenched in national law: undocumented immigrant children. UNICEF and Defence for Children have criticized the new Youth Law for its discriminatory nature towards children with different resident status. For these children, the term for deciding which youth care services are required is limited to six months, additional motivational grounds are required to place them with foster parents and any provided youth care service cannot continue after the child has reached the age of 18.[84] These stipulations are in violation with Article 2 of the CRC which states that:

'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's

[82] Nederlands Jeugdinstituut, Wijkteam en onderwijs , in: *Dossier Wijkteams* (29 oktober 2014).
[83] Nederlands Jeugdinstituut, *Praktijkvoorbeeld. Buurtteams Jeugd & Gezin – Utrecht* (Utrecht 2013), p. 3-4.
[84] Defence for Children and UNICEF Nederland, *Jaarbericht Kinderrechten 2014* (Den Haag 2014), p. 25.

race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.'[85]

The decision of several Dutch municipalities to provide shelter to illegal residents, recently backed by a decision of the ECSR[86], demonstrates that municipalities do not shun defying national policy and emphasizing their own local autonomy in implementing human rights standards. Municipalities have an obligation to keep track of illegal immigrants and ensure that all children, even illegal residents under 18, gain access to the new youth care system in a non-discriminatory way.

Human rights implementation in Dutch municipalities

The examples given by the Congress demonstrate that the municipal obligations to a child's right to health can be framed in a policy-oriented way, but do municipalities actually implement human rights in local policy practice? One academic, policy-oriented contribution that tried to capture the rationale behind local human rights implementation in the Netherlands was the project titled '*Human Rights and the City'*. During this three-year project, Oomen and van den Berg, two human rights scholars, aimed to show which Dutch cities make use of human rights, why they do it and how they do it. By looking at several cases in Dutch human rights cities – most notably Utrecht, Den Haag and Middelburg – they concluded that human rights are important in three ways in local policy practice: as a juridical framework justifying policy, as a moral foundation for policy and as principles for good governance.[87]

First, human rights are norms which have been codified in international human rights treaties and imply certain legal obligations for municipalities. The systematic of these human rights declarations and treaties has inspired several cities to formulate declarations of their own to commit themselves to respecting, protecting and fulfilling human rights in their city. One striking example is the European Charter for the Safeguarding of Human Rights in the City (2000) which has been signed by 350 European cities.[88] Numerous cities have also formulated their own local human rights action plan, tailored to local needs, including human rights benchmarks and monitoring tools. The global organization for municipalities, United Cities and Local Governments (UCLG), has published a guiding charter for cities that wish to form their own human rights action plan.[89]

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[85] United Nations General Assembly, *Article 2 of the Convention on the Rights of the Child.* (New York 1990), p. 1.
[86] European Committee of Social Rights, *European Federation of National Organisations working with the Homeless (FEANTSA) v. the Netherlands* (November 2014).
[87] E. v.d. Berg and B. Oomen, *Mensenrechten en lokaal beleid. Handreiking voor beleidsmakers* (Den Haag 2014), p. 15-16.
[88] V.d. Berg and Oomen, *Mensenrechten en lokaal beleid,* p. 15.
[89] United Cities and Local Governments, 'Global Charter-Agenda for Human Rights in the City' (Florence 2011).

Secondly, human rights can function as a normative framework that provides policymakers with a discourse that points to human rights principles such as equal treatment and non-discrimination as guidelines for policy formulation. The Dutch municipality of The Hague has explicitly based its youth policy on the Convention on the Rights of the Child.[90] Here, the right to participation of the child gained shape by giving the youth a voice through the advocacy of several Youth Ambassadors. Participation tools include the setting up of a local youth council, a youth inspection team (in the area of youth care) or organizing a thematic debate.[91] Moreover, the municipality of Middelburg has adopted the attainment of human rights, as formulated in the UN Convention on the Rights of Persons with Disabilities (CRPD), as ambitions in their policy statement on social support.[92] In their support for human rights as a normative framework, the municipality of Utrecht has sought to unite as many urban partners in a Human Rights Coalition that seeks to promote human rights awareness through organizing human rights events.[93]

Thirdly, human rights can provide local policymakers with principles of good governance, such as transparency, accountability and civil participation. One way to assure that policy is in accordance with principles of good governance is to closely scrutinize any policy measure and remove any obstacles. In 2013, the municipal council of The Hague instructed a law firm to conduct a human-rights impact assessment (HRIA) of the national austerity measures on social support services. It concluded that the foreseen (but by then reversed) austerity measures were in contradiction with the international human rights norms of the progressive realization of rights. Apart from conducting HRIAs, the Dutch organizations Stichting Alexander and the Verwey-Jonker Instituut have developed several other human rights-based policy tools for monitoring, assessing and improving youth care policy. These policy tools allow for an assessment of policy from a human rights-based approach before, during and in the aftermath of a policy process.[94]

A participative method of decision-making is an essential part of a human rights-based approach. Regarding the decentralization of youth care, optimizing local youth participation is therefore of vital importance to municipalities in the coming period. Municipalities that have optimized local youth participation live up to the right of access to information and the right to participation – two vital components of the right to health – as codified in the CRC and in patients' rights.[95] Are children and adolescents involved in an early stage of policymaking? And

[90] Gemeente Den Haag, *Programma Jeugd en Gezin 2011-2014* (Den Haag 2011), p. 7.
[91] Stichting Alexander en Verwey-Jonker Instituut, 'Toolkit Jeugdparticipatie', in: *Be Involved* (2011).
[92] Gemeente Middelburg, *Welzijn, ondersteuning en zorg in Middelburg: ambities binnen de WMO* (Middelburg 2011), p. 6-7.
[93] Local Human Rights in Utrecht, Start van Lokale Mensenrechtencoalitie (Utrecht 2013).
[94] Verwey-Jonker Instituut en de Gemeente Utrecht, *Van vraag naar verbetering. PAja! Utrecht: jongeren keuren de opvang* (Utrecht 2014) and Be Involved. Instrumenten jeugdparticipatie gemeenten.
[95] UN Committee on the Rights of the Child, *General Comment No. 12: The right of the child to be heard* (New York 2009) and Rijksoverheid, Patiëntenrecht en cliëntenrecht in de zorg.

do they get actual influence in the decision-making process?

The human rights ambitions of municipalities can be adopted in several ways. Oomen and van den Berg point to the advantages of institutionalizing these ambitions in order to secure the continuity of a human rights-based approach. In that way, municipalities can ensure that credible commitment does not diminish or is dependent on the activism of one committed policymaker. As we have seen, several municipalities turn to declarations, policy papers or treaties to voice their human rights ambitions, but human rights can also be highlighted in the municipal budget or in municipal regulations. Finally, some cities in Europe – Graz and Barcelona – go even further and appoint a human rights advisor, council or municipal department to oversee human rights implementation in their municipality.[96]

Applying human rights to local governments activities: the example of a child's right to health

In short, a human rights-based approach can guide and shape local policy practice in several, distinct ways. The best practices put forward by the Congress of the Council of Europe present a possible course of action for municipalities to respect, protect and fulfill a children's right to health. Oomen and van den Berg have convincingly shown how several Dutch municipalities have applied a human rights-based approach in their community. When these local policy examples are combined with the AAAQ-AP framework, we can draw up a schematic overview of the ways in which municipalities can apply a children's right to health in a local policy context.

	Content	Principles	Examples of policy measures
Availability	**Are public youth care facilities, services and goods readily available throughout the municipality?**	• Do municipalities, youth care providers and schools provide timely and complete accounts of their responsibility? • Is the youth care system non-discriminatory? Is it (meant to be) provided on an equal basis to all? • Does the youth care chain as a whole respect, protect and fulfill the right to health for children?	• Inform children and parents of organizations' role and duties in the youth care system by means of a brochure, leaflets or during special events, such as Universal Children's Day. • Firmly anchor the principles of human rights in the fabric of the city by subscribing to a human rights declaration, adopting a local human rights action plan or

[96] V.d. Berg and Oomen, *Mensenrechten en lokaal beleid,* p. 16.

			referring to them in a policy paper.
Accessibility	**Are public youth care facilities, services and goods physically and financially accessible to the entire population?**	• Are all minority groups able to access youth care? • Is the distance and cost associated with traveling to a youth care center acceptable for all citizens within the municipality? • Are youth care workers sufficiently qualified in order to adequately indicate which type of care is necessary?	• Empower and reach out to those minority groups that are incapable of accessing youth care by themselves (Roma, first-generation and illegal immigrants). • Instate a local transport service for children and parents whose financial or physical distance to youth care facilities is disproportionately large. • Prevent community-based youth care services to be indicated by amateurs or semi-educated local residents.
Acceptability	**Does the municipal youth care policy promote the best interests of the child?**	• Do youth care workers allow for children to be heard and participate to decide what is in their best interest? • Do the process and content of youth care work take into account the cultural diversity of the patient? • Is sensitive information shared on a confidential basis between youth care providers?	• Progressively inform and involve a child (as it gets older) in the process of youth care work. • Provide municipal workers with human rights education and cultural awareness training. • Set up a secure IT-infrastructure and adopt a protocol for the sharing of confidential information between youth care providers.
Quality	**Do youth care facilities, workers and services function according to scientific and medical standards?**	• Are youth care workers professionally trained? Are their methods based on sound scientific and medical research? • Are all obstacles removed that impede upon the quality of community-based youth care? • Is the process and content of youth care work up-to-date and does it correspond to patients' evolving wishes?	• Ensure that community-based youth care workers are certified professionals that work on the basis of scientific and medical standards. • Structurally scrutinize youth care policy and remove any obstacles that impede upon its quality. • Organize a participatory project where local youth monitor and assess the youth care process themselves.

Accountability	**Is youth care accountability guaranteed by a monitoring and assessment process between the municipality and its citizens?**	• Are accountability mechanisms accessible to all children and parents throughout the municipality? • Do participatory accountability mechanisms allow for children to be heard and influence policy decision-making? • Do the accountability mechanisms ensure an impartial and professional process of assessment?	• Establish a (youth) care Ombudsman that independently addresses complaints, scrutinizes youth care policy and conducts research on the basis of human rights principles. • Establish a local youth council where all children can voice their concerns and ideas, thereby influencing decision-making.
Participation	**Are children actively involved in the design, implementation, management and evaluation of the youth care system?**	• Are children/parents or teachers able to participate without any financial or physical barriers? • Do participation mechanisms take the cultural diversity of the municipality into account? • Is youth participation ensured throughout the whole process chain of youth care work?	• Refer to the principle of youth participation into policymaking efforts and papers. • Strengthen and facilitate youth organizations to be a focal point of youth participation, new ideas and initiatives. • Establish a Youth Ambassador Network that represents local youth and advises the municipality on issues of youth care.

In sum, the AAAQ-AP framework offers a human rights-based conception of the municipal obligations to the right to health for children. It is deduced from universal human rights and principles of good governance, incorporating six essential elements that prescribe principles that local youth care policy should encompass.

The Congress of Local and Regional Authorities has presented several examples of local policy measures to respect, protect and fulfill human rights implementation. Moreover, van den Berg and Oomen have convincingly shown how several Dutch municipalities take human rights considerations into account when formulating social policy.

But how can the AAAQ-AP framework inform and guide municipal policymaking during the decentralization of youth care? To be able to answer that question, I will first have to address the decentralization of youth care itself. What is the content and dynamic of this decentralization? And what are the main risks and challenges associated with devolving the responsibilities to municipalities?

Chapter three. Youth care decentralization: risks and challenges

Introduction.

Only by understanding the content, dynamics and associated risks and challenges of the decentralization, can local policymakers and youth care workers craft a durable social welfare landscape in which human rights principles are integrated in local policymaking. Thus, any assessment of the ways in which a human rights-based framework can guide local policymaking during the decentralization of youth care, should take the content and dynamic process of such a transition into account.

The first section of this chapter will elaborate on the current decentralization of youth care in the Netherlands: which type of youth care is being decentralized and who gets what responsibilities in the new youth care system? How do municipalities cope with this new set of responsibilities? In the second part of this chapter, I will explain what approach underlies the current transformation of youth care and how this thinking has shaped the system of youth care throughout the years. Finally, I will address the question what risks and challenges are associated with the territorial-based working method in a decentralized youth care system.

3.1 The decentralization of youth care services in the Netherlands

Decentralization is defined in general terms as 'the transfer of authority or dispersal of power, in public planning, management and decision-making from the national level to subnational levels, or more generally from higher to lower levels of government.[97] Decentralization in the health sector takes on many different forms but the notion of a decentralization policy is, Krishna Regmi argues, to 'develop a new type of health-care organization that would allocate some degree of 'spaces' to local authorities or local government to assess, analyze and then plan and deliver (action) appropriate health-care services, keeping people at the center of their policies.'[98]

Since January 1st 2015, Dutch municipalities are administratively and financially responsible for all youth care services. These include universal services (child care and regular schools), preventive services (parenting support and Youth and Family Centres) and specialized services (youth mental health care and child protection). In effect, this enormous transition will affect an estimated total amount of 100,000 children that fall under this wide array of social services.[99] The bulk of these responsibilities was previously carried out by several national ministries and provincial governments, but the current youth care system was found to have a

[97] A. Mills ao., *Health System Decentralization. Concepts, issues and country experience* (Geneva 1990), p. 11.
[98] K. Regmi, *Decentralizing Health Services: A Global Perspective* (New York 2014), p.5.
[99] G. Herderscheê, 'Geen flauw idee wie straks welke zorg krijgt', in: *De Volkskrant* (17 november 2014), p. 11.

number of structural flaws that required a restructuring of the system: it was – financially and administratively – imbalanced, too fragmented and the use of medication and expenditures kept on rising.[100] The drastic restructuring of the youth care system aims to make these services more efficient, coherent and cost-effective by bringing the cash flows and the social services under the responsibility of one party that is situated close to the service-users.[101]

What is the vision behind this idea of a more efficient, coherent and cost-effective localized youth care? How are municipalities supposed to accomplish this feat? Several policy papers make mention of the fact that the decentralization of youth care is not merely a transition, but also includes a transformation in the *modus operandi* of youth care professionals. Youth care workers are expected to deliver tailor-made youth care services in an integral and multidisciplinary way of working. In order to do this, youth care professionals have to cooperate and share sensitive information to ensure that families with multiple problems are assisted by one youth care professional, instead of several. Moreover, the preventive branch of youth care has to be strengthened, making use of the social networks of children and their parents, allowing space for participation, civil initiatives and informal care.

What complicates this transition and transformation, however, is the short time frame and the austerity measures that accompany it. The Netherlands Institute for Social Research has calculated that a sum of 3.5 billion euros is involved in the decentralization of youth care and that one seventh of the total amount is cut by austerity measures (0.5 billion euros). This puts a heavy burden on municipalities, because they have to guarantee the continuity and quality of future youth care services.

But are these worries grounded in reality? Municipalities themselves have eagerly started working on the coming transition and numerous municipalities have experimented and shown great progress in setting up and organizing a local youth care infrastructure. Lots of municipalities have chosen to 'decentralize' youth care to the level of the neighborhood and establish neighborhood teams, consisted of different youth care professionals that cooperate together to deliver tailor-made youth care to inhabitants.[102]

These multidisciplinary neighborhood teams have, for lots of municipalities, become the central aspect of their entire local youth care infrastructure and symbolize the new and foreseen transformation of working in the youth care sector which emphasizes a preventive, community-

[100] N. Bosscher, *The decentralisation and transformation of the Dutch youth care system*, p. 4.
[101] Het Ministerie van Volksgezondheid, Welzijn en Sport, het Ministerie van Veiligheid en Justitie en de Vereniging van Nederlandse Gemeenten, 'Factsheet Jeugdwet. Naar goede jeugdhulp die bij ons past', in: *Stelselwijziging Jeugd* (Juni 2014), p. 2.
[102] S. Kooistra en C. Vos, 'Gemeenten vernieuwen hun zorg. Veel plaatsen tuigen 'integrale wijkteams' op om extra taken te combineren met bezuinigen', in: *De Volkskrant* (21 november 2014), p. 1.

based and integral style of working.[103] The municipalities of Eindhoven, Enschede, Leeuwarden, Utrecht and Zaanstad all participate in a project by the Dutch Association of Municipalities which investigates the design, implementation and management of their neighborhood teams. Other municipalities, for example in the Holland Rijnland region, cooperate together on the transition and transformation of youth care policy. They have instated specialized youth care teams – the Integral Youth- and Family Teams (YFT) – which are made up of an alloy of youth care workers which are closely tied to basic services such as schools, day care providers, general practitioners and the youth healthcare (JGZ).[104]

A provisional evaluation of these teams seems to suggest generally favorable outcomes. Parents, schools and general practitioners indicated that the YFTs are readily available and easily accessible due to their visibility in the neighborhood. Moreover, due to the de-bureaucratization, the teams can act timely and quickly activate other centers of expertise if necessary. Within a week, a significant portion of children and families had had their first exploratory conversation with one of the youth care professionals and laid the foundations for a family plan. However, as promising as this evidence of the neighborhood team as a local service provider might seem, it is by no means an indicator for other municipal experiences with neighborhood teams.

3.2 Theoretical foundations of decentralization: the neighborhood approach

The decentralization of social services is based on the idea that a territorial approach stimulates social cohesion, participation and civil ownership of the healthcare system. In his essay *Een wijkgerichte aanpak,* former senator Jos van der Lans argues that the decentralization of social services – apart from the need for national austerity measures – was mainly rooted in the conviction that the Dutch welfare state had to be organized differently to maintain its durability.[105] Modern society, with its social entrepreneurship and bottom-up initiatives, he argues, requires a healthcare system that is geared to citizens' social networks, municipalities and their daily activities.

In many municipalities, the neighborhood has become the arena in which the ideals of the decentralization are expected to take hold. Neighborhood teams are presented as the ultimate solution for the panacea of problems that the current healthcare system has to cope with. But where does this belief in the transformative power of the neighborhood come from? Is it based on a realistic representation of the neighborhood? The idea of the neighborhood as the pivotal

[103] N. de Boer en J. van der Lans, *Burgerkracht in de wijk. Sociale wijkteams en de lokalisering van de verzorgingsstaat* (Den Haag 2013), p. 5.
[104] Centrum voor jeugd en gezin, *Tussenevaluatie. Proeftuinen Jeugd- en Gezinsteams Holland Rijnland* (Holland Rijnland 2014), p. 31-32.
[105] J. van der Lans, *Een wijkgerichte aanpak: HET FUNDAMENT (*Amsterdam 2014), p. 5.

social territorial collective in which the social welfare state can reinvent itself is rooted in the neighborhood approach. The history of the neighborhood approach can roughly be divided into three distinct phases and Van der Lans argues that the current decentralizations might constitute a fourth phase in this development.

The first phase: 1945-1960

The origins of the neighborhood approach can be traced back to the urban reconstruction of the city of Rotterdam in the post-Second World War era. Since the city had been bombarded heavily, new ideas on urban development had surfaced amongst which the neighborhood approach figured prominently. In a classic study, *De stad der toekomst, de toekomst der stad* (1947), the municipality of Rotterdam developed the neighborhood approach to serve 'as a buffer against the dangers of modern urban life such as anonymity and immoral amusement.'[106] Central to the neighborhood approach was the building of a better society by focusing on the most important socially constructed community: the neighborhood. Proponents of this view argued that ongoing centralization of power had led to bureaucracy and a diminished confidence of civilians in democracy, because the perceived distance between centers of power and people had become disproportionately large. In order to increase the contact between the government and its citizens, they argued that every neighborhood should have certain facilities: schools, churches, sports associations, but also a polyclinic, a consultation service, social workers and all kinds of helpdesks to prevent citizens from having to travel to the city hall.[107]

This neighborhood approach of the 1950s seems to echo certain elements of the decentralized welfare cities that are currently coming into existence. But apart from the idea that social services have to be provided locally, there are stark differences between the conception of the neighborhood then and now. In the 1950s, a romantic vision of the neighborhood dominated public perception. The neighborhood, with its tight social bonds and friendly character, was framed as the basis for a healthy and decent life and a defensive bulwark against the negative influences of the big city. Criticism on this view came from sociologist Van Doorn (1955) in which he attacked the prospect of the neighborhood as a framework for integration. He argued that the study by the municipality of Rotterdam presented an utopian view of 'the neighborhood', as a uniform object that was placed against a dystopian view of 'the city' as a place where massive

[106] Van der Lans, *Een wijkgerichte aanpak,* p. 8.
[107] W.F. Geyl, 'Wij en de Wijkgedachte', in: *Plannen en Voorlichting* (Utrecht 1949), p. 19.

building blocks would transform people into individualistic nomads without any feeling of social responsibility.[108]

The second phase: 1960-1980

Notwithstanding this overly romantic representation of the neighborhood, the idea of the neighborhood as the place where the welfare state could be reconstructed seemed to strike a chord with policymakers during the coming decades. In the 1960s, large-scale urban renewal projects were undertaken that were focused on improving the quality of living by modernizing the accommodations in several cities. In 1968, Minister Wim Schut of Housing, Spatial Planning and the Environment presented a prospective study for urban development in which 1.900.000 houses were scheduled for complete modernization, demolition or emergency adjustments.[109] Moreover, 125.000 accommodations were built on a yearly basis to solve the housing shortage.

Virulent protesting and social activism had led to a high degree of participation by inhabitants in decision-making. They, however, mostly earned low-income wages and did not want to live in expensive newly built houses in other neighborhoods. During subsequent consultations, they demanded modernization and affordable accommodation within their own neighborhoods. In the end, a compromise was reached under the credo *Bouwen voor de buurt* (*building for the neighborhood*), a program that was aimed at fighting social and economic inequality by modernizing accommodations and allowing people to stay in their neighborhoods.[110] It resulted in the building of relatively small subsidized accommodations (social housing) instead of the planned larger family homes, but ensured that the character of existing neighborhoods was preserved.

The inhabitants of these neighborhoods succeeded in extracting many neighborhood welfare services and excelled in community work.[111] This work, inspired by the theories of Murray Ross on community organization and the activism of Jo Boer (director of the foundation *Opbouw Drenthe*), attempted to further the adjustment of individuals and families to the society and the adjustment of society to the individual and the family.[112] It stressed the importance of a

[108] J.A.A van Doorn, 'Wijk en Stad: reële integratiekaders?' (1955) in: *Staalkaart der Nederlandse Sociologie* (Assen 1970) p. 232.
[109] D. Schuiling, 'Stadsvernieuwing door de jaren heen', in: *Rooilijn. Tijdschrift van de Universiteit van Amsterdam* 40 (3) (Amsterdam 2007), p. 159.
[110] L. Fels, *Bouwen voor de Buurt. De stadsvernieuwingswoningen van toen in de buurt van nu* (Amsterdam 2007), p. 3.
[111] J. van der Lans, *Een wijkgerichte aanpak*, p. 8.
[112] B. Peper, *Vorming van welzijnsbeleid. Evolutie en evaluatie van het opbouwwerk* (Meppel 1973), p. 201.

healthy family situation and formed the link between a local general welfare policy and individual social work.[113]

The third phase: 1980 - 2000

At the end of the 1980s a shift occurred in the thinking about the neighborhood approach. Previously, the neighborhood approach was aimed at maintaining social bonds in the neighborhood. But in contrast to the first and the second period, the third phase was aimed at constructing a neighborhood rather than maintaining it. Labor immigration from Southern Europe (and later Turkey and Morocco) had turned more and more neighborhoods into a heterogeneous, cultural melting pot, rather then – what was previously thought – a unified social collective. Under the heading of social innovation, neighborhoods had to be organized in a different manner. Inhabitants had to be brought together to enter into a dialogue aimed at preventing segregation, bridging the much-feared cultural divide.[114]

In general, the national government together with the municipalities, housing cooperatives and other organizations became more focused on the inhabitants of the neighborhood during this period, rather than the neighborhood itself. It was thought that merely changing the physical lay-out of the neighborhood wouldn't suffice to improve the health and social standing of inhabitants. An integral approach (setting social, economic and physical goals for a neighborhood) would deliver the best results in improving the livability of these neighborhoods. This idea came to be known as social renewal and would inspire urban renewal projects by the Lubbers-Kok administration (1989-1994), the Urban Policy I and II programs (1995-2003) and the forty *Vogelaarwijken* program (2007-2009).[115]

This paradigm shift in thinking about neighborhoods was made possible by a national sense of urgency starting to surface in the 1980s. Since the Oil Crisis in the 1970s the Netherlands had suffered from an economic recession. The national debt and the annual government deficit had shot upwards and the number of unemployed people was rising. Moreover, the international military build-up of nuclear arsenals by the United States and the Soviet Union only contributed to the sense of uncertainty and crisis. In the midst of this geopolitical and economic crisis Dutch policymakers became increasingly conscious about the need to reorganize the social welfare state. Several sociologists, such as van Doorn and C.J.M.

[113] M. C. Dozy, *Het is altijd het beroep van de toekomst geweest. De beroepsontwikkeling van het opbouwwerk* (Leiden 2008), p. 97.
[114] J. van der Lans, *Een wijkgerichte aanpak, p.9.*
[115] Ibidem.

Schuyt, had criticized the welfare state because it had become unaffordable, over-institutionalized and bureaucratic.[116]

Neoliberalism was on the rise in the 1980s as Thatcherism and Reaganomics introduced economic policies of a free market economic system with minimal government intervention. By the 1980s, even the Dutch political establishment argued that the welfare system had to be reorganized to allow for more free market processes and less interventionism by the government. Minister of Welfare, Health and Culture Elco Brinkman presented his idea of the 'caring society'(*zorgzame samenleving*) in 1982, combining his confessional beliefs about caring with modern ideas about market regulation.'[117] The old supply-based, heavily subsidized system of healthcare had to be replaced by a competitive system of supply and demand. This idea propagated a *laissez faire* attitude by the government in social policy, giving back collective social responsibilities to citizens and restoring their self-sufficiency by stimulating civil participation – on the basis of mutual solidarity – in order to decrease their dependency on the state.[118]

But how could citizens be given social responsibilities if youth services were not provided at a regional or – for that matter – a local level? The reorientation of social welfare policy in the 1980s coincided with an upsurge in the attention for the decentralization of youth policy. Ever since the *Knelpuntennota* (1974) and the final report by the Working Group on Youth Welfare (1976) argued that the youth welfare policy could best be executed by respectively local authorities and 'care regions, under supervision of the provinces'[119], the decentralization of youth policy had been a hot-debated issue.[120]

The sector of welfare policy was decentralized to the 714 Dutch municipalities in 1987 by the Welfare Act. By this Act, municipalities became responsible for the basic care (universal services) for children: education, day-care facilities and social participation of children. Due to their far-reaching responsibility, social welfare organizations became known as the 'breeding grounds' for the next generation.[121] They became respected local partners for the development of local social policy and increasingly strengthened their position in the area of a youth-focused neighborhood approach.[122]

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116 J.A.A. van Doorn and C.J.M. Schuyt, *De stagnerende verzorgingsstaat* (Amsterdam 1982), p. 12.
117 I. de Haan and J.W. Duyvendak, *In het hart van de verzorgingsstaat. Het ministerie van Maatschappelijk Werk en zijn opvolgers (CRM, WVC, VWS), 1952-2002* (Amsterdam 2002), p. 181.
118 I. de Haan and J.W. Duyvendak, *In het hart van de verzorgingsstaat,* p. 185.
119 Gemengde interdepartementale werkgroep jeugdwelzijnsbeleid, *Jeugdwelzijn. Op weg naar samenhangend beleid* (Den Haag 1976), p. 90-91.
120 N. de Boer and J.W. Duyvendak, 'Welzijn', in: P. Meurs and E. Schrijvers, *Wetenschappelijke Raad voor het Regeringsbeleid. Maatschappelijke dienstverlening, een onderzoek naar vijf sectoren* (Amsterdam 2004), p. 26.
121 N. de Boer and J.W. Duyvendak, 'Welzijn', p. 32.
122 R. Kwekkeboom, T. Roes & V. Veldheer, *De werkelijkheid van de welzijnswet* (Den Haag 2002), p. 137.

In contrast to the decentralization of welfare policy to the local level, youth care policy was decentralized to the provincial- or regional level (in the case of Amsterdam, Rotterdam and The Hague) by the Act on Youth Services (1989). This Act was in line with the previous decision by the government to embrace the conclusions that the Interdepartmental Working Groups on Youth Care Policy (IWG-YCP) had presented in 1984, which stated that youth care could best be provided 'as close to a child's home, for the shortest amount of time and in the least intensive form as possible.'[123] The core of this regional youth care infrastructure would be formed by youth protection and psychiatric care organizations that had to coordinate their actions in regional co-operations. These co-operations were to serve as the basis for multidisciplinary Advisory Youth Teams that would provide advice and services in complex and problematic situations. Moreover, Care and Advice Teams – consisting of teachers, youth care professionals, social workers, police and other professionals – had to be operational within every school to preventively identify and address problems with children.

In sum, these two institutional changes – the decentralization of welfare policy to the municipalities and the decentralization of youth care policy to the provinces – were the culmination of a reorientation of the social welfare state in the 1980s that was inspired by the principles of social responsibility and less governmental interventionism. It led to the first turn towards decentralization of social policy in the Netherlands, a process that continues with the current decentralizations of youth care, social support and appropriate education.

A fourth phase: 2005 - ?

However, it would take until the decentralization of the Social Support Act in 2007 (WMO), before local authorities would directly become responsible for youth care services. Up until then, the provincial Bureaus for Youth Care (*Bureau Jeugdzorg*) had been the organizations that functioned as a portal to all forms of youth care. The first Bureau had opened its doors in 1996 and eventually every province and three major urban regions (Amsterdam, Rotterdam and The Hague) would house a Bureau, bringing the total number in the Netherlands to fifteen. The development of these Bureaus, however, proved to be a time-consuming process fraught with difficulties and uncertainties. Van Lieshout argues that the national government provided little to no guidance in the setting up of these organizations and there existed no agreed-upon national framework as to what the duties and responsibilities for the Bureaus for Youth Care should

[123] K. Waaldijk, 'Helpen samenwerken en regeren. Over de eindrapporten van de interdepartementale werkgroepen jeugdhulpverlening', in: *Jeugd en samenleving,* 14, nr. 10 (Den Haag 1984), p. 655.

encompass.[124] The Bureaus often had their own agenda and priorities which led to a fragmented youth care structure in the Netherlands. This fragmentation ultimately blocked the successful functioning of the envisioned regional co-operations and multidisciplinary Advisory Youth Teams.

In 2005, the national government decided to harmonize the function of the existing Bureaus in the Youth Care Act: the Bureaus' responsibility to provide health care services was severely limited. From then on, they would mainly perform a central coordinating role in setting indications and medical diagnosis. By this time, however, the Bureaus for Youth Care had become a tainted symbol of the fragmentation, bureaucracy and ineffectiveness of the youth care system.[125] Its standing in the eyes of the public perception had been negatively influenced by several scandals that were extensively covered by the media.[126] Especially the case of Savanna (2004), a 3 year-old that was underfed and physically abused by her mother which led to her eventual death, laid bare the shortcomings of the responsible Bureau for Youth Care.[127] The incident caused public shock, a massive outcry for investigations into the matter and changes in the youth care system that would prevent a recurrence of such a situation.

Evaluations and prospective studies confirmed the image of the Bureaus for Youth Care and in 2010 the demissionary Balkenende-IV administration advised its successor to decentralize youth care policy completely to the municipalities.[128] Crucial to the adoption of this view by the Rutte-I administration was the activism of Jet Bussemaker – then State Secretary for Health, Welfare and Sport – who captured the spirit of social innovation in her program titled *Welzijn Nieuwe Stijl* (New Style Social Work).[129] In this program, she presented a combination of eight principles that offered a framework which indicated how social policy and social work should develop.[130] The inspiration for this influential program originated from a few notable, neighborhood-based experiments in 2007-2008 by Ella Vogelaar, then Minister of Integration and Housing. These experiments aimed to provide social services to citizens as close as possible to their home by using so-called multidisciplinary 'frontline teams'.[131] The working methods of

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[124] M. van Lieshout, '1994 Bureau Jeugdzorg. Van provincie naar gemeenten, in: Canon jeugdzorg Nederland (versie 21 februari 2014).
[125] T. Kuijenhoven and W.J. Kortleven, 'Inquiries into Fatal Child Abuse in the Netherlands: A Source of Improvement?', in: *British Journal of Social Work* 40(4) (Rotterdam 2010), p. 2.
[126] Among these were several child abuse incidents. In 2002, six children – after suffering from severe domestic violence – died in a fire accident in Roermond that was lit by their own father. And in 2005 two children were murdered by the partner of their mother who had physically abused her and the children.
[127] De Volkskrant, *Savanna (3) stelselmatig mishandeld* (8 december 2004).
[128] Demissionary Balkenende IV administration, *Perspectief voor jeugd en gezin* (Den Haag 2010).
[129] J. Bussemaker, 'De dood of de gladiolen', in: *Maatwerk. Vakblad voor maatschappelijk werk*, 11(5) (oktober 2010).
[130] M. Kluft, 'Are yóu the new professional? Translating the vision on social work to the new professional's action', in: *Journal of Social Intervention: Theory and Practice*, 21(1), p. 2.
[131] H. Weggemans en L. Weijberg, 'Dringen(d) achter de voordeur – Het Enschedese model van wijkcoaches met mandaat', in: *Sociaal Bestek*, 3 (2009), p.4.

these frontline teams would subsequently serve as an example for the many neighborhood teams. In sum, during this fourth phase of the neighborhood approach, the youth care system was entirely decentralized to the local level and became an integral part of the neighborhood approach.

3.3 Risks of a neighborhood-based working method

In general, decentralization literature that focuses on health service decentralization offers no clear-cut answer relating to associated risks and challenges. It holds that decentralization poses risks and challenges, but also offers chances for improvement of healthcare service delivery closer to its citizens.[132] Among the possible risks identified by scholars are the inequitable distribution of resources, challenges related to insufficient human resource capacity and negative outcomes between the association of health sector reforms, privatization and health outcomes.[133]

What stands out in the current representation of the neighborhood is its instrumental value: the neighborhood is seen as an organizational space in which professionals and credibly committed civilians can effectively cooperate to improve the health of other citizens. In this sense, it differs from the historical romantic view of the neighborhood in the 1950s as the basis for a healthy and decent life. But modern ambitions still emphasize the role of the neighborhood as a framework for integration where social bonds are tight and civil participation is mobilized. How realistic is this territorial approach? And what are the risks involved from a human rights-based perspective? The question that Jacques van Doorn asked in 1955 is still relevant: is the neighborhood a real framework for integration? In short, is it a realistic landing strip for the decentralization of youth care?

Duyvendak argued in 1999 that the neighborhood approach is plagued by several myths that present us with a distorted image of the neighborhood. First, Duyvendak questions the possibility of a neighborhood approach to connect to the social environment of inhabitants in a meaningful and sustainable way. In his opinion, modern civilians do not primarily identify themselves with their neighborhood and have a radius of action that increasingly exceeds the boundaries of the neighborhood. Apart from these legitimate reservations, however, the current decentralization of youth care is focused on strengthening the preventive character of the system. It is therefore of vital importance that youth care professionals keep in touch with the social environment of the child, because it allows for timely preventive care measures through the early

[132] K. Regmi, *Decentralizing Health Services: A Global Perspective*, p. 10-12.
[133] Idem, p. 12.

signaling of problems. Moreover, any treatment or rehabilitation of children in society will require the support and cooperation of their surroundings.[134]

So how can neighborhood teams achieve a meaningful dialogue with the social environment of children? The human rights-based principles state that youth care has to be available and accessible to children and families. Thus, neighborhood teams have to present themselves as a visible actor in those places that the local youth frequently visits and is involved in activities. That way, municipalities can guarantee that youth care is integrated within the daily routine of children, easily accessible and readily available. This should not be limited to visibility within the neighborhood itself, but also include schools, sports organizations and religious institutions. Neighborhood teams will thus have to keep in touch with an extensive network of social partners.

Secondly, there is no such thing as 'the' neighborhood approach since every neighborhood is composed of unique elements and has its own issues. In short, the compartmentalization that decentralization is meant to combat continues at the local level. However, the current decentralization is more than a transition: it is combined with a transformation. Youth care workers will have to adopt an integral method of working to overcome the compartmentalization to ensure that families are assisted by one youth care professional; a process which localization has made more tangible. In order for this process to succeed, Duyvendak argues, the several social partners in one neighborhood team have to standardize and harmonize the scope and goals of such a working method. What are the goals and benchmarks of their team? And how will they manage and evaluate this process? This harmonization is crucial for the accessibility and quality of the youth care system.[135]

Not surprisingly, the lay-out and goals of each neighborhood team will vary per municipality as they are geared to local issues. But does this difference between municipalities and neighborhoods pose a risk from a human rights-based approach? Nelleke Vedelaar, alderwoman of Zwolle, argued that these differences are merely the result of local tailor-made youth care and, as such, do not endanger the fulfillment of a children's right to health at the local level.[136] Serious worries from a human rights-based perspective start to arise when municipalities suffer from a lack of financial resources or expertise in neighborhood teams which renders them unable to organize their youth care system effectively. Especially for smaller municipalities these problems would seem more urgent (due to a lack of personnel and ways to generate income) and could

[134] J.W. Duyvendak, 'Zeven mythen over de wijkaanpak', in: J.W. Duyvendak en R. Hortulanus, *De gedroomde wijk: methoden, mythen en misvattingen in de nieuwe wijkaanpak* (Utrecht 1999), p. 9.
[135] J.W. Duyvendak, 'Zeven mythen over de wijkaanpak', p. 3-4.
[136] N. Vedelaar, 'De sociale wijk- en jeugdteams: toegangspoort of poortwachter?', in: *VNG Taskforce Mensenrechten en Decentralisaties* (4 juli 2014).

have far-reaching consequences for any of the human rights-based principles of a child's right to health.[137]

In order to secure a minimum standard of youth care in every municipality, the national government – being responsible for the municipal fund – is working towards an objective and proportionate distribution of financial means among all municipalities. These financial equalization measures will allow a fair distribution of funds to guarantee a children's right to health by preventing disproportionate differences between municipalities to come into existence. In order for this model to be successful, however, it will require municipal monitoring and reporting procedures that keep track of the local context of families and children that are receiving youth care such as relocation, divorce and custody.

Thirdly, Duyvendak argues that the neighborhood approach inherently encompasses a false conviction that the neighborhood – as the place where problems first surface and become recognizable – is the place where these problems should be addressed. So how realistic is this accreditation of the neighborhood? Underlying causes of youth care issues (such as financial debt, substance addiction or psychosocial disorders) often have deep psychological or socio-economic roots which cannot easily be solved within the neighborhood. Reintegration trajectories require a professional approach that goes beyond the neighborhood, integrating it with broader urban plans (the national Urban Policy programs) and as part of a dialogue with public and private partners.[138]

In cases of highly specialized youth care, a regional approach is required due to the advantages of economies of scale. This involves domestic violence, child abuse and child protection.[139] Experiments with the regional organization of these sectors has a long history: pilot-projects of 'RAAK'[140] (2000), the coming into existence of a regional hotline (AMHK) for domestic violence and child abuse and – more recently – a regional expertise center (LECK) have integrated these sectors of specialized youth care in the region.[141] But how can municipalities and local youth care workers ensure that these specialized, more expensive forms of youth care are connected to the local infrastructure? Will local youth care workers refer children to these expensive facilities or will they rather opt for a cheaper possibility? And how can such a decision integrate the rights and responsibilities of the involved actors?

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[137] Centraal Planbureau (CPB), *Decentralisaties in het sociaal domein* (Den Haag 2013), p. 18.
[138] J.W. Duyvendak, 'Zeven mythen over de wijkaanpak', p. 4-5.
[139] Centraal Planbureau, *Decentralisaties in het sociaal domein*, p. 19.
[140] H. Baartman, '40 jaar kindermishandeling: een terugblik', in: *Rede bij gelegenheid van de herdenking van het 40-jarig bestaan van de Vereniging tegen Kindermishandeling* (Leiden 2010), p. 4.
[141] M. Effting, 'Mishandeld? Dat is niet zomaar duidelijk', in: *De Volkskrant* (Editie woensdag 10 december 2014), p. 14.

Finally, decentralization does not breed civil participation. Duyvendak contends that many inhabitants will not automatically harbor any feeling of social responsibility toward their neighbors or will simply have no time to take care of their friends or family. This is a problematic situation, since the decentralization of youth care is accompanied by an increasing emphasis on informal care, dependency on social networks and civil participation. The municipalities and neighborhood teams will have to cooperate to facilitate civil participation and mobilize credibly committed civilians in the neighborhood. This can be realized by facilitating and funding a neighborhood council that organizes local activities or by launching an online municipal portal which can be used by people to start up civil society initiatives and help each other with social services. This way, the neighborhood is as it were 'created'.

In sum, there are a number of pitfalls associated with a neighborhood-based working method. First, municipalities have to strengthen the preventive character of the local youth care infrastructure by ensuring the availability and accessibility of neighborhood teams in the local community. Neighborhood teams will have to establish a meaningful cooperation and dialogue with schools, sports associations and religious organizations to remain visible and receive timely feedback and indications of the situation of a child or family. Secondly, municipal funds have to be distributed proportionately to make sure that every municipality has the means to guarantee a child's right to health. This distributional system will require some form of municipal monitoring and reporting procedures to keep track of local developments that influence the distribution of these funds. Thirdly, highly specialized care – such as domestic violence, child abuse or child protection – has to be organized regionally. But how can this be done in an integral way that integrates the rights and responsibilities of the actors? Finally, municipalities and neighborhood teams will have to find ways to mobilize credibly committed civilians. Only by doing so can citizens rely upon their social environment to take care of them or their children.

But are these challenges a reason to discount a neighborhood approach altogether? Recently, the URBAN40 research was published which concluded that a neighborhood-based working method can indeed, under certain circumstances, lead to an improved health situation for inhabitants.[142] Nevertheless, Dutch municipalities have to find innovative ways to cope with these challenges. In the fourth chapter, I will try to answer the question how the earlier mentioned human rights principles can inform local policymaking in the area of youth care to counter these challenges. To illustrate how this can be done, I will look at several cases of youth care policy in Swedish municipalities in which a human rights-based approach is applied to deal with the abovementioned challenges.

[142] RIVM, Universiteit Maastricht en het Amsterdam Medisch Centrum, *URBAN40. Een betere wijk, een betere gezondheid?* (Den Haag 2013).

Chapter four. Sweden: a human rights-based approach in youth care

Introduction.

In Sweden, the government has moved to decentralize control of healthcare systems over the last fifteen years. Swedish municipalities are responsible for providing social services in the area of youth care and possess a considerable degree of autonomy and independent powers to set their own tax rates in order to finance and shape local youth care policy.[143] In several national human rights action plans, the Swedish government acknowledged that the provision of these social services touched upon the protection of social, economic and cultural rights within the country. The Swedish government encouraged municipalities to integrate a human rights based approach within their local policy practice to secure the right to the highest attainable standard of health.[144]

In this Chapter, I will first give a short overview of the youth care system in Sweden: what is the role of Swedish municipalities in the youth care system and what characterizes the localized Swedish service provision? In the second part of this chapter, I will elaborate on three youth care initiatives by Swedish municipalities that integrate a human rights-based approach. Finally, I will analyze these three cases and argue what lessons could be learned from these practical examples by Dutch municipalities. Do these examples counter the challenges, mentioned in the previous chapter, faced by Dutch municipalities? And what lessons can be learned from this by Dutch municipalities?

4.1 Youth care in Sweden

Youth care in Sweden is, as in the Netherlands, focused on the successful support, treatment and (re)integration of persons from the age of 0 to 18 in society. In 2010, 28.300 Swedish children were affected by youth care measures, whether this involved family therapy, the assignment of a guardian to a family or more structural (institutional) treatment programs.[145]

Swedish youth care actors

The responsibility for the provision of social services in Sweden is shared between the national government and municipalities. On a national level, the Ministry of Integration and Emancipation and the Ministry of Health and Social Affairs both have certain responsibilities in the area of welfare policy. In general, the national government actively facilitates and supports

[143] R. Saltman, 'After decades of decentralisation, the state now has a growing role in Nordic health systems', in: *Eurohealth. European Observatory on Health Systems and Policies, Vol. 18(3)*, (Brussels 2012), p. 1.
[144] Swedish Government, *A National Action Plan for Human Rights. 2006-2009* (Stockholm 2005), p. 65-66
[145] Nederlands Jeugdinstituut, *Jeugdzorg in Europa versie 2.0* (Utrecht 2012), p. 53.

the local youth care infrastructure and is responsible for monitoring and evaluating the system. The Ministry of Integration and Emancipation coordinates all national youth policy attempts aimed at securing a reasonable level of welfare for all persons between the age of 13-25 and ensures that they have the possibility to participate in- and influence their direct social environment and society. The Ministry of Health and Social Affairs is responsible for social services, children's rights, public health and medical care.[146]

The national ministries are supported by national agencies that actively develop new youth care strategies on an operational level and advise the ministries and youth services that provide youth care. They are closely attached to the ministries and are regarded as a meaningful addition to the Swedish youth care system.[147] First, the *Socialstyrelsen* is a national agency that oversees the equitable access to youth care throughout the country and ensures that all Swedish citizens are in a reasonably healthy state. It is responsible for the functioning of social services within municipalities and develops strategies to ensure their proper functioning. Secondly, the *Ungdomsstyrelsen* develops publications on the living standards of children in Sweden and monitors the follow-up on the formulated goals within the framework of national youth policy. The agency supports Swedish municipalities in the provision of their youth care services by granting subsidies to NGOs and youth organizations. Thirdly, the *Statens institutionsstyrelse* is responsible for the development and evaluation of treatment procedures, it supports municipalities with diagnostics and administers several treatment facilities itself.

These supervisory national agencies have, compared to the Dutch healthcare inspectorates, far-reaching monitoring and controlling functions. While the Dutch Health Care Inspectorate (IGZ) and the Youth Care Inspectorate (IJZ) merely monitor the primary process of social service provision within municipalities (focusing on general quality indicators as codified in national law), the *Socialstyrelsen* additionally monitor the differences in service provision between Swedish municipalities. This monitoring process is to function as a protective framework which prevents disproportionate inequalities in service provision to occur.

However, besides far-reaching national competencies in the area of youth care, the Swedish design of youth care services largely depends on decision-making within the municipality itself. Anna Meeuwissen argues that the 'Scandinavian model', with municipalities acting as organizers and providers of social services is unique by international standards.[148]

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[146] T. Berg en C. Vink, *Jeugdzorg in Europa. Lessen over strategieën en zorgsystemen uit Engeland, Duitsland, Noorwegen en Zweden* (Utrecht 2009), p. 35-38.
[147] G. Brummelkamp, 'Approaches towards children at risk. A cross national analysis', in: *Business and Policy Research* (Zoetermeer 2005), p. 21.
[148] A. Meeuwisse, R. Scaramuzzino and H. Swärd, 'Everyday realities and visionary ideals among social workers in the Nordic countries: A matter of specialization and work tasks?', in: *Nordic Social Work Research*, Vol. 1 (1), (Lund 2011), p. 1.

Common national guidelines do exist – in the form of national legislation, healthcare strategies and monitoring responsibilities by national agencies – but municipalities themselves can decide how to interpret and implement national regulations. [149] Sweden has one of the most decentralized youth care systems in Europe in which municipalities themselves shape their local welfare policy and youth care service provision.[150] Municipalities are responsible for a large range of youth care services: universal services, preventive support, access to youth care and voluntary or forced interventions which are often carried out by municipal social workers. In sum, the Swedish youth care system is strongly decentralized, characterized by municipalities acting as organizers and providers of social services (although private youth care also exists) and financed primarily through municipal taxes. The system is based on autonomous municipal decision-making although national government agencies do have extensive monitoring and evaluative powers.

Working method of youth care in Sweden

The Swedish orientation to locally provide for social services originates from a holistic attitude of the municipality towards the necessities of its inhabitants. Social, economic and physical indicators are seen as inextricably linked to each other and to problematic situations with children and within families. Thus, these problems cannot be addressed by singling out and merely addressing one of these factors, but by targeting them within the framework of a local welfare policy that is inherently integral in outlook; it addresses various problems that are associated with children at risk: substance addiction, poverty, unemployment, domestic violence or marital breakdown.[151]

Social workers are considered to personify the typically Nordic local social service provision. In most Swedish municipalities, these university-educated healthcare professionals are employed within the public administration, but they can be employed by NGOs or the private sector. They are often specialized individuals (in areas ranging from children, adolescents and families to disabilities or employment and integration), although a study by Bergmark and Lundström shows that the number of non-specialized social workers is significantly higher in smaller municipalities.[152] Municipal social workers often function within their own specialized unit which represents an institutionalized, organizational division based on groups of clients or

[149] The Social Services Act (SoL) and the Care of Young Persons Act (LVU) describe all the responsibilities of the government in the provision of social services to children and adolescents.
[150] T. Berg-le Clercq, N. Bosscher e.a., *Generalistisch werken rondom jeugd en gezin in de Scandinavische landen* (Utrecht 2013), p. 29.
[151] T. Berg, N. Bosscher e.a., *Generalistisch werken rondom jeugd en gezin in de Scandinavische landen*, p. 28
[152] A. Bergmark and T. Lundström, 'Unitarian ideals and professional diversity in social work practice – the case of Sweden', in: *European Journal of Social Work* 10, no. 1 (London 2007), p. 68.

type of problems.[153] On the one hand, a certain degree of specialization might positively influence the quality of the provided social services. A single generalist could, for example, not hope to understand and address all issues in a multi-problem family. On the other hand, the development of a sustainable relationship between service user and provider is seriously hampered by the organizational and functional specialization. The fragmented support of families and children by different service providers or healthcare professionals leads to a decreased continuity for children and families.

Youth care-oriented social workers offer multiple services to children, adolescents and their parents, working from municipal facilities. Similar to the Dutch youth worker in a neighborhood team, the Swedish social worker offers support to schools and sports associations, draws up a family plan in which the social network of the child is taken into account and offers tailor-made youth care. One example of a municipal facility in which Swedish social workers offer youth-oriented services are the so-called *familjcentraler* or family centers. These centers – staffed by doctors, nurses, social workers, psychologists and midwives – offer a place for youth care professionals to cooperate and for families with children to meet and seek counsel and help.[154] The centers offer preventive care in the form of various free health-promoting activities (playing, cooking, gardening) for parents and children and social workers inform parents and children about the available municipal social services.[155]

Systemic differences between youth care systems in Sweden and the Netherlands

The envisioned youth care system in the Netherlands differs from the Swedish youth care system in several important ways. First, Dutch municipalities do not function as the providers of social services, but merely facilitate and support healthcare professionals during their work. The provision of services is often, as it were, decentralized to neighborhood teams in which healthcare professionals decide what support a child needs, by whom and in what manner. Secondly, Dutch youth care workers that are part of a neighborhood team are, in general, not employed directly by the municipality but by private providers, community service providers or other foundations. Thirdly, Swedish municipalities provide the vast majority of universal services for children themselves, such as daycare and schools. These services are respectively provided by private partners and school boards in the Netherlands while the municipality has an exclusively monitoring role to fulfill. This makes it relatively easy for Swedish municipalities to initiate and

[153] A. Meeuwisse, R. Scaramuzzino and H. Swärd, 'Everyday realities and visionary ideals among social workers in the Nordic countries, p. 9.
[154] M. Kekkonen, M. Montonen and R. Viitala, *Family centre in the Nordic countries – a meeting point for children and families* (Copenhagen 2012), p. 17.
[155] T. Berg-le Clercq en C. Vink, *Generalistisch werken rondom jeugd en gezin in de Scandinavische landen*, p. 30.

coordinate outreaching and preventive youth care strategies based at universal services, because they do not have to enter into a time-consuming process of consultation with several partners. Finally, Dutch municipalities remain largely dependent on the distribution of national funds for their service provision.[156] Swedish municipalities can, on the contrary, set their own tax rates and generate the bulk of their annual budget themselves (around 70%) which gives them a certain degree of financial autonomy. In sum, the function of Dutch and Swedish municipalities in the local service provision system is fundamentally different.

These differences bear witness to what Esping-Andersen has dubbed 'welfare-state variations'.[157] He argues that the Swedish healthcare system owes allegiance to a predominantly social democratic historical development while the development of the Dutch healthcare system has also been influenced by liberal and corporatist values. As a result, the Swedish youth care system is strongly state-centered, civilians are publically insured and the government is directly responsible for service provision. In the Netherlands, the decentralization of youth care is characterized by a retreating national government, allowing privately-employed youth care professionals to work without excessive interference of the state.[158]

When looking at local Swedish youth care methods that integrate children's rights, it is important to keep these systemic differences in mind. Both Dutch and Swedish policymakers have an obligation to ensure that their youth care systems function in accordance with the rights that are enshrined in the Convention on the Rights of the Child. But the procedures and methods through which these rights are secured at the local level depend on the political and administrative design of the youth care system in a given country. Therefore, any human rights-based method that is applied in a Swedish municipality might be harder to implement in a Dutch municipality. It might require adaptation or a long process of consultation before it can be implemented in a local context within the Netherlands.

[156] The Dutch national government distributes the Municipal Fund on a yearly basis which makes up 63% of the total annual budget of municipalities, of which 25% constitute earmarked funds.
[157] G. Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton 1990*)*, p. 25.
[158] Interview with Pink Hilverdink and Tijne Berg-le Clercq at the Netherlands Youth Institute in Utrecht (January 8th 2015).

4.2 Human rights-based approaches in Swedish youth care provision

Since the ratification of the UN Convention on the Rights of the Child (CRC) in 1990, a national strategy has applied that focused on implementing this convention in the national Swedish context. In 2010, the Riksdag approved a new strategy to strengthen the rights of the child that expresses fundamental requirements at state and municipal level to ensure that the rights of the child are continually safeguarded. This *strategi för att stärka barnets rättigheter i Sverige* calls upon decision-makers and professionals to increase their knowledge of the rights of children and to 'put this knowledge into practice in relevant activities.'[159] In the context of these national undertakings, several initiatives were started that offer interesting views when trying to anchor children's rights in the local youth care system.

Focusing on a cross-country analysis will allow for a highly contextualized analysis between countries of reference that share three important characteristics. First, both the Netherlands and Sweden share similar 'universalist' welfare policies in which the state averts a relatively high figure of public spending to securing basic social and economic rights for its citizens.[160] Secondly, both countries have decentralized extensive responsibilities in the domain of youth care to municipalities, which demonstrates that local authorities are the primary duty holders in securing access to these basic healthcare services. Thirdly, the Netherlands and Sweden are both outspoken defenders of human rights implementation at the local level.[161] By empirically constructing several cases in Swedish municipalities this venture offers practical, cross-country examples of the ways in which municipalities in the Netherlands can integrate a HRBA to youth care in their policymaking efforts.

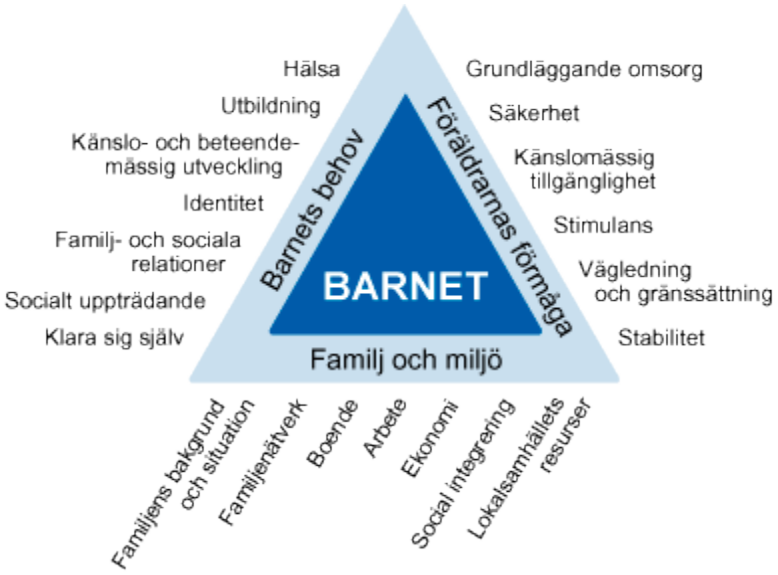
Children's Needs in Focus (BBIC: Barns Behov I Centrum)

The BBIC project was a Swedish project by the National Board of Health and Welfare for seven years (1999-2005), together with seven local authorities. It was aimed at implementing children's rights in child welfare and offers a children's rights-based instrument to map and decide what social services children are in need of. The method was based on the English assessment system Integrated Children's System (ICS) and exists of structured questionnaires and theoretical guidelines – modelled after the CRC and Swedish national law – to assess the needs of children and adolescents and what interventions are required to best protect the child.[162] As such, it is a

[159] The Ministry of Health and Social Affairs, *Strategy to strengthen the rights of the child in Sweden* (Stockholm 2011), p. 3.
[160] G. Esping-Andersen, *The Three Worlds of Welfare Capitalism,* p. 27.
[161] Both countries have implemented national human rights action plans and repeatedly acknowledged the importance of municipalities in protecting human rights.
[162] J. Höglund, 'An introduction to assessment system for children at risk in Sweden', in: *Annual Report of Center for Research and Development on Community Issues*, vol 1. (Osaka 2012), p. 93.

human rights-based working method, specifically designed for youth care workers. *Socialstyrelsen* argued in its final report that the BBIC framework 'provides a structure for systematically collecting information and documenting children's and young people's needs of services.'[163] Almost all Swedish municipalities use this framework during their preliminary assessments when social workers decide whether professional support for a child is necessary. These assessments largely consist of conversations between the municipal social worker and the parent(s), the child or adolescent in question and any other relevant partner (school, police or the hospital).[164]

Central to the BBIC method is the perspective of the child. Youth care workers have to establish 'what needs the child has and to what extent parents ensure that the needs of the child are met.'[165] In order to do so, children are asked to share their views on their personal needs, their parents, the family as a social unit and its surroundings. One of the theoretical guidelines to support youth care professionals in this process is the BBIC triangle.



As this illustration shows, the best interests of the child (*Barnet*) are presented as the central focus. The triangle is divided into three distinct categories: the needs of the child (*Barnets behov*), capabilities of the parents (*Föräldrarnas förmåga*) and family and social environment (*Familj och miljö*).[166] As such, the situation of the child is approached from an integral outlook and the social network of the family is taken into account. Questions can include for example whether

[163] Socialstyrelsen, *Child welfare in a state of change – Final report from the BBIC project* (Stockholm 2005), p. 3.
[164] T. Berg, N. Bosscher e.a., *Generalistisch werken rondom jeugd en gezin in de Scandinavische Landen*, p. 31-32.
[165] Socialstyrelsen, *Child welfare in a state of change – Final report from the BBIC project,* p. 4.
[166] J. Bergman, *Barns Behov i Centrum (BBIC): Uniformity: An unreachable goal?*(Lund 2010), p. 16.

substance addiction or unemployment influences parents' capability to provide for the child. The assessment, management and evaluation of the preliminary process and subsequent service provision is executed in close cooperation with the child and the parents, to ensure their participation and co-ownership throughout the process.

The objective of the BBIC project was to 'develop a national uniform system within child welfare that could be offered to local authorities throughout the country.'[167] Critique had been voiced about the considerable variation that existed between municipalities when working with children in need of protection and support. However, Julie Bergman argues – based on the earlier work of Michael Lipsky[168] – that the BBIC method did not result into uniformity, which would effectively minimalize social workers' local autonomy.[169] Social workers found the administrative tasks too arduous and selectively applied the BBIC questionnaires, resulting in local variations. It is important to point out that the BBIC system does not function as a panacea for all problems, but the method does offer a common language for youth care workers to ensure that the best interests of the child are the primary consideration when deciding what social services are required.

Could such a children's rights-based policy example prove valuable in a Dutch municipal context? And is there a need for such an instrument? During an interview at the Netherlands Youth Institute, Tijne Berg-le Clerq stated that many Dutch youth care workers currently use the self-sufficiency matrix to decide whether a family is in need of any social support.[170] But the matrix is a broad *family*-oriented instrument which does not focus on a child's needs from a child's perspective. Many youth care workers in the Netherlands do not have a specific child-oriented instrument at their disposal to map the needs of the child, which would greatly help to anchor the rights of the child in the local youth care infrastructure. The BBIC allows for a child to participate in the process of youth care, to express its own views and for them to be heard which makes the youth care system accountable to the evolving needs of the child. This strongly resembles the formulated goals by the Dutch government and the Association of Netherlands Municipalities known as the *Jeugdbakens* which includes 'the provision of support aimed at dialogue with explicit attention given to the perception of the child.'[171] Moreover, the BBIC method incorporates several of the human rights principles (AAAQ-AP) that constitute a child's right to health. By allowing a child to directly participate in the design and management of its

[167] Socialstyrelsen, *Child welfare in a state of change – Final report from the BBIC project,* p. 4.
[168] M. Lipsky, *Street-Level Bureaucracy; Dilemmas of the Individual in Public Services* (New York 1980).
[169] J. Bergman, *Barns Behov i Centrum (BBIC): Uniformity: An unreachable goal?*, p. 30.
[170] Interview with Pink Hilverdink and Tijne Berg-le Clercq at the Netherlands Youth Institute in Utrecht (January 8th 2015).
[171] Vereniging van Nederlandse Gemeenten en de Rijksoverheid, *Stelselwijziging Jeugd. Jeugdbakens. Bakens voor de transformatie van het jeugdbeleid* (Den Haag 2014), p. 9.

social services, the child becomes co-owner of its own approach whereby the accountability and the acceptability of the chosen social support is increased.

Keeping the systemic differences between the Swedish and Dutch youth care systems in mind, the BBIC could only be implemented if social workers would assign enough value to such a specific child-oriented instrument. As we have seen, Dutch youth care workers are not directly employed by the municipality itself so any method could only be implemented after careful deliberation between the municipality and the social service providers. The potential value of the method is that it can function as a supportive framework, stimulating youth care workers to focus on the child's perspective when working with children and, in doing so, minimizing the risk of overemphasizing systemic considerations (financial costs, bureaucratic procedures). At most, this method could contribute to a moderate harmonization of working methods between municipalities and decrease the risk of disproportionate deviations.

Young Speakers – A method for listening to children

In 2011, the Ombudsman for Children in Sweden published a report on a method for listening to children: Young Speakers. Originally developed by the ChangeFactory in Norway (an organization with professional experience of listening to children in vulnerable situations), the Ombudsman used this method while reporting on the experiences of children with regard to social care for children and young people. As the report shows, the 'fundamental thought behind Young Speakers is that children are experts on their own situation and on that basis they can share experiences and views.'[172] In the words of Ombudsman Fredrik Malmberg, the method illustrates 'what is reasonable in the requirements of the CRC when it comes to children being able to speak out, be listened to, and be met with respect.'[173] It does so by offering a methodological support that consists of six steps which includes informing and getting into contact with children during an information meeting and two work meetings. The method is aimed at professionals that work with children – directly or indirectly – and is best suited to meeting children in a group, for example in a classroom or in a sports team.

Different from the BBIC method, Young Speakers does not exclusively address youth care professionals, but includes people working for other social services in municipalities (schools, culture and leisure), for a county council or for a regional- or state authority. It offers a methodology that 'creates conditions for children and young people to shape and talk about their

[172] The Ombudsman for Children in Sweden, *Young Speakers – a method for listening to children* (Stockholm 2011), p. 4.
[173] The Ombudsman for Children in Sweden, *Young Speakers,* p. 20.

experiences' on any given subject.[174] As such, it empowers professionals working with children (teachers, general practitioners or sports coaches) and gives them the tools to engage a meaningful dialogue with children.

From a youth care perspective, it is important that these professionals have the capabilities to signal and know how to cope with a situation in which a child requires professional support. Teachers and sports coaches are professionals that come into contact with children on a daily or weekly basis and find themselves in an ideal situation to alert the municipal youth care worker as soon as they have any reservations involving the condition of a certain child. Young Speakers could, based on a children's rights perspective, contribute to making youth care more readily available and easier accessible by empowering professionals working at universal services. If applied correctly, it can improve the protection of a child's right to health within a municipality by discussing youth care-related subjects, such as addiction, poverty or the family.

This Swedish method is part of the broader children's rights-based strategy formulated by the government in which 'decision-makers and relevant professional groups must be knowledgeable about the rights of the child and put this knowledge into practice in relevant activities.'[175] Pink Hilverdink of the Netherlands Youth Institute argued that it is fairly common for Swedish teachers to receive training on how to recognize children at risk. Swedish teachers often cooperate with social workers on specific cases to be able to offer a child the support it needs in the classroom. Through this collaboration, actors in different areas of activity that concern children are able to strengthen the rights of the child.[176]

As we have seen in the third chapter, neighborhood teams in the Netherlands are tasked with achieving a meaningful dialogue with the social environment of children. This problem is complicated because municipalities in the Netherlands, in contrary to Swedish municipalities, have less extensive authorities regarding universal services. Dutch schools are governed by school boards whereas Swedish municipalities are directly responsible for providing education to children. Therefore, the structural and universal cooperation between schools and the municipality on youth care issues is not as self-explanatory in the Netherlands as it is in Sweden. Allowing youth care workers to train teachers and other professionals working with children could strengthen the preventive and outreaching character of the youth care system in the Netherlands (making it more readily available and easier accessible), but this process would have to be based on mutual agreements between the municipality and other involved partners. Such a process will strengthen the connection between universal services and the neighborhood teams.

[174] Idem, p. 5.
[175] The Ministry of Health and Social Affairs, *Strategy to strengthen the rights of the child in Sweden*, p. 3.
[176] Interview with Pink Hilverdink and Tijne Berg-le Clercq at the Netherlands Youth Institute in Utrecht (January 8th 2015).

The contact person- or family

One of the possible interventions by Swedish social services into the lives of families that are in need of support are so-called 'contact-persons.' The Social Services Act (SoL) obligates municipalities to have a couple of contact persons or families available for being assigned to a child or family in need. The contact persons or families are no youth care professionals, but function as paraprofessional support in cooperation with a professional youth care worker. They are evaluated and approved of in advance by the social service providers and receive a monetary compensation for their work. A contact person often relieves a family of its burdens by helping children with their homework, discussing problems with them or taking the child to a cinema or a museum. The contact person is not a child-specific instrument, however, as contact persons often support families with their financial administration or help out with other chores. Contact families are families that welcome a child into their homes on a monthly basis, during summer or offer a place for temporary shelter when the situation at home is no longer considered safe.[177]

Everyone has the right to file for support from a contact person, but the social worker decides whether a child or family is in need of such an intervention. The assignment of a contact person to a child under the age of 15 requires the consent of its legal guardians (mostly their parents). For children above the age of 15, a contact person can only be assigned when the adolescent 'personally asks for it or agrees with the procedure.'[178] Throughout the entire process, the contact person closely collaborates with the social worker, the parents of the child and has regular contact with the child or adolescent.[179]

In contrast to the BBIC and Young Speakers method, this intervention is not directly designed to incorporate the rights of children mentioned in the CRC, but it allows for a child to be heard and to continue exercising its rights (right to development and education) by receiving the attention it needs without being negatively influenced by issues within its family. [180] Moreover, Swedish families can recommend friends or befriended couples to the social worker (when deciding who should function as a contact person for the child), hereby mobilizing their social network and increasing the acceptability of the approach.[181] In sum, the method combines essential principles of the child's right to health with broader interrelated children's rights as mentioned in the CRC. Some Dutch youth care organizations (amongst these Spirit and

[177] T. Berg en C. Vink, *Jeugdzorg in Europa. Lessen over strategieën en zorgsystemen uit Engeland, Duitsland, Noorwegen en Zweden*, p. 41.
[178] Ibid.
[179] Interview with Pink Hilverdink and Tijne Berg-le Clercq at the Netherlands Youth Institute in Utrecht (January 8th 2015).
[180] The right to development, the right to be heard and the right to education are respectively codified in Article 6, 12 and 28 of the Convention on the Rights of the Child
[181] T. Berg en C. Vink, *Jeugdzorg in Europa. Lessen over strategieën en zorgsystemen uit Engeland, Duitsland, Noorwegen en Zweden*, p. 41.

Humanitas) have applied a comparable method in which citizens are connected to a family in need of support, but this practice is not implemented as widely as in Sweden nor does it allow for the social network of a particular family to be mobilized.[182]

The decentralization of youth care in the Netherlands is characterized by an increasing emphasis on civil participation, informal care and self-sufficiency. But as we have seen, it is up to Dutch municipalities and neighborhood teams to actively facilitate and support civil participation and the mobilization of social networks. The 'contact person' method could help to stimulate civil participation in the youth care system (on a voluntary basis) and facilitate a mobilization of the social network of families. It can do so by linking together those people in a municipality that want to help out other families in trouble and families that are in need of (paraprofessional) assistance. Recently, a research by the Swedish government acknowledged the popularity of this intervention amongst users, volunteer families and professionals but recommended that the method should be reinforced with knowledge-based components to increase the effectiveness of the Contact Family Program (CFP).[183]

In sum, the Children's Needs in Focus (BBIC), Young Speakers and the contact person or family are three human rights-based interventions that are applied by Swedish municipalities and professionals working with children. They incorporate children's rights as mentioned within the CRC and contribute to a child's right to health by making the youth care system more readily available, easier accessible and more acceptable. By allowing children to shape and voice their own opinions and needs, professionals can engage in a true dialogue that serves the best interests of the child.

These three methods demonstrate how children's rights can concretely be integrated in local youth care decision-making. Human rights can serve as a policy instrument and offer a common language for youth care decision-makers when working with children and families that are in need of support. These methods can serve as an inspiration to Dutch policymakers as they could effectively counter several challenges that are associated with the youth care decentralization in the Netherlands.

[182] Interview with Pink Hilverdink and Tijne Berg-le Clercq at the Netherlands Youth Institute in Utrecht (January 8th 2015).
[183] L. Brännström, B. Vinnerljung and A. Hjern, ´Long-term outcomes of Sweden's Contact Family Program for children', in: *Child Abuse & Neglect 37* (2013), p. 413.

Conclusion. Integrating a human rights-based approach in local youth care policy

This thesis centered on the integration of a human rights-based approach in local youth care policymaking efforts. I indicated that the decentralization of youth care in the Netherlands presents Dutch municipalities with unprecedented challenges. From a human rights perspective, every Dutch municipality is obligated to progressively realize a child's right to health. Moreover, it is of vital importance that every decision taken towards vulnerable children takes the best interests of the child as its primary consideration. But serious doubts have been voiced about municipalities' abilities to do so, as the decentralization is accompanied by severe austerity measures and municipalities are experimenting with relatively new working methods.

Departing from my assumption that a human rights-based approach to youth care could offer local policymakers guidance during the decentralization of youth care, I analyzed the international codification of a child's right to health throughout the post-World War II history. Since the Second World War, the right to health has increasingly been anchored within international and European law, although there has existed substantial disagreement among state parties about the appropriate role of the state in the provision of healthcare services. Only during the 1980s did human rights scholars begin to clarify the meaning and scope of the right to health and the obligations this implied upon states. A pivotal moment in this development was the publication of General Comment No. 4 (2000) by the UN Committee on Economic, Social and Cultural Rights (CESCR), which offered a legally binding interpretation of the human right to health. In this comment, the UN presented the AAAQ-framework (availability, accessibility, acceptability and quality): a set of interrelated and essential healthcare elements that encompassed the right to health in all its forms at all levels. It advocated that states had to progressively realize each of these human rights-based principles in healthcare – in conformity with other interrelated human rights – in order to comply with the right to health.

This human rights-based framework can serve as an inspiration for local policymakers: not solely as a framework to scrutinize current youth care policies, but as a structure for new youth care policies to be based upon. These four principles, combined with the principles of accountability and participation (AAAQ-AP), underpin a child's right to health at the local level. Thus, any human rights-based policy measure or decision aimed at the youth care system should contribute to, amongst others, a more readily available or easier accessible local youth care service provision.

In addition, the thesis has shown that explicit children's rights-based instruments can credibly counter the risks of a neighborhood-based working method. In the third Chapter, I

analyzed the theoretical foundations of decentralization and the pitfalls of implementing a neighborhood-based working method. These ranged from youth care workers failing to establish a meaningful dialogue with the social environment of children (schools or sports clubs) and being incapable of stimulating civil participation or mobilizing social networks to showing reluctance to refer a child to a more expensive regionally organized specialized facility.

Three Swedish children's rights-based youth interventions offer promising results to counter these challenges. First, the Children's Needs In Focus (BBIC) is a child-specific instrument used by local Swedish youth care workers that aims to establish what professional support a child needs. It provides a working structure which, if successfully applied in the Netherlands, could offer an instrument to map the needs of children in an accountable and participatory manner. Moreover, it can standardize and harmonize the working methods of neighborhood teams in different municipalities when working with children at risk. Secondly, Young Speakers is a children's rights-based method that gives professionals the tools to engage in a meaningful dialogue with children. It allows for children to be heard and to form their own opinion on various matters. This method can potentially make the youth care system more readily available and easier accessible by helping teachers or sports coaches to identify risks earlier. That way, it contributes to strengthening the connection between universal services and primary social services such as neighborhood teams. Finally, Swedish youth care workers can assign a contact person or contact family to temporarily help out a child or a family that is in need of support. Employing such a youth care intervention can help to stimulate civil participation by allowing children or families to recommend their friends or befriended couples to function as voluntary paraprofessionals. That way, children can continue exercising their right to development and education in an acceptable and accountable manner, without suffering from issues within their family.

So how can a policy oriented human rights-based approach to youth care guide Dutch municipalities during the decentralization? A human rights-based approach can guide Dutch municipalities in several ways. First, human rights-based frameworks or child-specific instruments – such as the AAAQ-AP framework, BBIC and Young Speakers – can ensure that municipal decision-making, either concerning the entire youth care infrastructure or regarding one specific child, takes as its starting point the best interests of the child. In that way, children's rights can offer a common language for professionals when working with children in vulnerable situations, standardizing and harmonizing the working methods that are applied within different municipalities. Finally, children's rights-based policy instruments can concretely address municipal challenges by, for instance, contributing to strengthening the connection between

universal services and primary social services and helping to mobilize the social networks of inhabitants.

By applying a cross-country comparison, I have analyzed the Swedish youth care system and three municipal youth care interventions that were specifically based on children's rights. The weakness of such an approach is, however, that the systemic differences between both youth care systems obstruct any assertions considering the fruitful implementation of these methods in the youth care system in the Netherlands. Therefore, a task for further research lies in the concrete translation of children's rights into a child-specific instrument that is suited for implementation in the local context within the Netherlands. It would be interesting to see what aspects should be highlighted, what problems emerge and how such an instrument is applied by professionals.

Bibliography

Academic literature

A

Aasen, H.S., Halvorsen R. ao., *Human Rights, Dignity and Autonomy in Healthcare and Social Services: Nordic Perspectives* (Antwerp 2009).

Accardo, A., Grimheden, J. and Starl K., 'The case for human rights at the local level: a clever obligation?', in: *European Yearbook on Human Rights* (Graz 2012).

Alen, A., *A Commentary on the United Nations Convention on the Rights of the Child* (Leiden 2007).

B

Baartman, H. '40 jaar kindermishandeling: een terugblik', in: *Rede bij gelegenheid van de herdenking van het 40-jarig bestaan van de Vereniging tegen Kindermishandeling* (Leiden 2010).

Becker, S. and Bryman, A., 'Policy research', in Becker, S. and Bryman, A., *Understanding Research for Social Policy and Practice: Themes, Methods and Approaches* (Bristol 2004).

Berg, E. v.d. and Oomen, B., 'Towards a Decentralization of Human Rights: The Rise of Human Rights Cities', in: van Lindert, T. and Lettinga, D., *The Future of Human Rights in an Urban World. Exploring Opportunities, Threats and Challenges* (Amsterdam 2014).

Berg, E. v.d. and Oomen B., *Mensenrechten en lokaal beleid. Handreiking voor beleidsmakers* (Den Haag 2014).

Bergman, J., *Barns Behov i Centrum (BBIC): Uniformity: An unreachable goal?* (Lund 2010).

Bergmark, A. and Lundström, T., 'Unitarian ideals and professional diversity in social work practice – the case of Sweden', in: *European Journal of Social Work* 10, no. 1 (London 2007).

Berlin, I., 'Two Concepts of Liberty', in: Berlin, I., *Four Essays on Liberty* (Oxford 1969).

Boer, de N. and Duyvendak, J.W., 'Welzijn', in: Meurs, P. and Schrijvers, E., *Wetenschappelijke Raad voor het Regeringsbeleid. Maatschappelijke dienstverlening, een onderzoek naar vijf sectoren* (Amsterdam 2004).

Boer, de N. and Lans, van der J., *Burgerkracht in de wijk. Sociale wijkteams en de lokalisering van de verzorgingsstaat* (Den Haag 2013).

Brännström L., Vinnerljung B. and Hjern, A., 'Long-term outcomes of Sweden's Contact Family Program for children', in: *Child Abuse & Neglect 37* (2013), p. 413.

Brems, E., de Beco, G. and Vandenhole, W., *National human rights institutions and economic, social and cultural rights* (Cambridge 2013).

Brummelkamp, G., 'Approaches towards children at risk. A cross national analysis', in: *Business and Policy Research* (Zoetermeer 2005).

Bustreo, F. and Hunt, P., *Women's and Children's Health: Evidence of Impact of Human Rights* (WHO 2013).

C
Carey, S.C., Gibney, M. and Poe, S.C., *The Politics of Human Rights: the Quest for Dignity* (Cambridge 2010).

Clarijs, R., 'De olifant in de kamer van het Nederlandse jeugdbeleid. De dreigende beleidsklucht van de transitie jeugdzorg', in: *Jeugdbeleid*, nr. 3 (2012).

D
De Vet, K.J., 'Commentaar: Systeemverantwoordelijkheid', in: *VNG Magazine* 12 (June 20th 2014).

Doorn, van J.A.A., 'Wijk en Stad: reële integratiekaders?' (1955) in: *Staalkaart der Nederlandse Sociologie* (Assen 1970).

Doorn, van J.A.A. and Schuyt, C.J.M., *De stagnerende verzorgingsstaat* (Amsterdam 1982).

Dozy, M.C., *Het is altijd het beroep van de toekomst geweest. De beroepsontwikkeling van het opbouwwerk* (Leiden 2008).

Duyvendak, J.W., 'Zeven mythen over de wijkaanpak', in: J.W. Duyvendak en R. Hortulanus, *De gedroomde wijk: methoden, mythen en misvattingen in de nieuwe wijkaanpak* (Utrecht 1999).

E
Eide, A., *Food as a human right* (Tokyo; United Nations University 1984).

Eide, A., *The Right to Adequate Food as a Human Right: Final Report submitted by Asbjørn Eide* (New York 1987).

Eide, A. and Eide, W.B., *A Commentary on the United Nations Convention on the Rights of the Child. Article 24: The Right to Health* (Leiden 2006).

Esping-Andersen, G., *The Three Worlds of Welfare Capitalism* (Princeton 1990).

F
Fels, L., *Bouwen voor de Buurt. De stadsvernieuwingswoningen van toen in de buurt van nu* (Amsterdam 2007).

G
Geyl, W.F., 'Wij en de Wijkgedachte', in: *Plannen en Voorlichting* (Utrecht 1949).

H
Haan, de I. and Duyvendak, J.W., *In het hart van de verzorgingsstaat. Het ministerie van Maatschappelijk Werk en zijn opvolgers (CRM, WVC, VWS), 1952-2002* (Amsterdam 2002).

Hadenius, A., *Decentralisation and Democratic Governance. Experiences from India, Bolivia and South Africa* (Stockholm 2003).

Hendriks, A.C., 'Gelijke toegang tot zorg – van ideaal naar recht', in: *Tijdschrift voor Gezondheidsrecht. Speciaal nummer/2001.*

Hobbes, T., *Leviathan or The Matter, Forme and Power of a Common Wealth Ecclesiasticall and Civil* (Yale 2010).

Höglund, J., 'An introduction to assessment system for children at risk in Sweden', in: *Annual Report of Center for Research and Development on Community Issues*, vol 1. (Osaka 2012).

Hunt, P. and Backman, G., 'Health systems and the right to the highest attainable standard of health', in: *Backman, G and others, Health systems and the right to health: an assessment of 194 countries* (The Lancet 2008).

J

Jägers, N., 'Mensenrechten in tijden van economische crisis. Het belang van een mensenrechtenperspectief in tijden van bezuiniging en decentralisatie', in: *Lezing op het Ministerie van Binnenlandse Zaken* (The Hague 2013).

K

Kekkonen M., Montonen M. and Viitala R., *Family centres in the Nordic countries – a meeting point for children and families* (Copenhagen 2012)

Kluft, M., 'Are yóu the new professional? Translating the vision on social work to the new professional's action', in: *Journal of Social Intervention: Theory and Practice*, 21(1).

Kuijenhoven, T. and Kortleven, W.J., 'Inquiries into Fatal Child Abuse in the Netherlands: A Source of Improvement?', in: *British Journal of Social Work* 40(4) (Rotterdam 2010).

Kwekkeboom, K., Roes, T. and Veldheer, V., *De werkelijkheid van de welzijnswet* (The Hague 2002).

L

LeBlanc, L.J., *The convention on the rights of the child: United Nations lawmaking on human rights* (Lincoln 1995).

London, L., 'What is a human rights-based approach to health and does it matter?', in: *Health and Human Rights Journal*, Vol. 10 (1), (London 2008).

Lipsky, M., *Street-Level Bureaucracy; Dilemmas of the Individual in Public Services* (New York 1980).

M

Malcontent, P.A.M., *Op kruistocht in de Derde Wereld: de reacties van de Nederlandse regering op ernstige en stelselmatige schendingen van fundamentele mensenrechtenin ontwikkelingslanden, 1973-1981* (Utrecht 1998).

Meeuwisse A., Scaramuzzino R. and Swärd H., 'Everyday realities and visionary ideals among social workers in the Nordic countries: A matter of specialization and work tasks?', in: *Nordic Social Work Research*, Vol. 1 (1), (Lund 2011).

Mills, A. ao., *Health System Decentralization. Concepts, issues and country experience* (Geneva 1990).

O
Oomen, B. and Vrolijk, M., *Inspiratie voor Mensenrechteneducatie. Democratisch Burgerschap en Mensenrechten in het (burgerschaps)onderwijs* (Leiden 2010).

Oomen, B., 'Small places: the home-coming of human rights', in: *Inaugural lecture prof. dr. Barbara Oomen* (Middelburg 2011).
Oomen, B., *Rights for Others: The Slow Home-Coming of Human Rights in the Netherlands* (Cambridge 2013).

P
Peper, B., *Vorming van welzijnsbeleid. Evolutie en evaluatie van het opbouwwerk* (Meppel 1973).

Potts, H., *Accountability and the right to the highest attainable standard of health* (Essex 2008).

R
Regmi, K., *Decentralizing Health Services: A Global Perspective* (New York 2014).

RIVM, Universiteit Maastricht en het Amsterdam Medisch Centrum, *URBAN40. Een betere wijk, een betere gezondheid?* (Den Haag 2013).

S
Saltman, B.R. ao., *Nordic Health Care Systems. Recent Reforms and Current Policy Challenges* (New York 2009).

Saltman, B.R. ao., 'Consolidating national authority in Nordic health systems', in: *Eurohealth. Quarterly of the European Observatory on Health Systems and Policies* (London 2013).

Schmidt, P. and Halliday, S., *Human Rights Brought Home. Socio-legal Perspectives on Human Rights in the National Context* (Oregon 2004).

Schuiling, D., 'Stadsvernieuwing door de jaren heen', in: *Rooilijn. Tijdschrift van de Universiteit van Amsterdam* 40 (3) (Amsterdam 2007).

Schutter, O. de, 'Economic, Social and Cultural Rights as Human Rights: An Introduction', in: *CRIDHO Working Paper 2013/2* (Leuven 2013).

Shue, H., *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (Princeton 1980).

Steiner, H.J. & Alston, P., *International Human Rights in Context. Law, Politics, Morals* (Oxford 2007).

Susser, M., 'Health as a Human Right: An Epidemiologist's Perspective on the Public Health', in: *American Journal of Public Health,* Vol. 83, No. 3 (Washington 1993).

T
Toebes, B., 'Towards an Improved Understanding of the International Human Right to Health', in: *Human Rights Quarterly* 21.3 (1999).

Toebes, B., 'Human Rights, Health Sector Abuse and Corruption', in: *Human Rights and Human Welfare Working Papers* (Aberdeen 2011).

Toebes, B. ao., *Health and Human Rights in Europe* (Antwerp 2012).

U
University College Roosevelt, *Human Rights Cities: Motivations, Mechanisms, Implications. A case study of European HRCs* (Utrecht 2013).

W
Waaldijk, K., 'Helpen samenwerken en regeren. Over de eindrapporten van de interdepartementale werkgroepen jeugdhulpverlening', in: *Jeugd en samenleving,* 14, nr. 10 (The Hague 1984).

Weggemans, H. and Weijberg, L., 'Dringen(d) achter de voordeur – Het Enschedese model van wijkcoaches met mandaat', in: *Sociaal Bestek*, 3 (2009).

Y
Yamin, A.E., 'Beyond compassion: The central role of accountability in applying a human rights framework to health', in: *Health and Human rights,* Vol. 10, No. 2 (Harvard 2008).

Policy papers

A
Amnesty International and the Association of Netherlands Municipalities, 'Goed bezig. De betekenis van mensenrechten voor gemeenten', in: *Handreiking* (The Hague 2012).

Angman, I. and Gustafsson, M. *Combating child abuse and neglect in Sweden* (Regionförbundet Örebro 2011).

B
Bussemaker, J., 'De dood of de gladiolen', in: *Maatwerk. Vakblad voor maatschappelijk werk*, 11(5) (October 2010).

C
Centraal Planbureau (CPB), *Decentralisaties in het sociaal domein* (Den Haag 2013).

Centrum voor jeugd en gezin, *Tussenevaluatie. Proeftuinen Jeugd- en Gezinsteams Holland Rijnland* (Holland Rijnland 2014).

D
Danish Institute for Human Rights, *The AAAQ Framework and the Right to Water. International indicators for availability, accessibility, acceptability and quality* (Copenhagen 2014).

Defence for Children and United Nations Children's Fund Nederland, *Jaarbericht Kinderrechten 2014* (The Hague 2014).

Demissionary Balkenende IV administration, *Perspectief voor jeugd en gezin* (The Hague 2010).

E
Eerste Kamer der Staten-Generaal, Kamerstuk 33684 / vergaderjaar 2013-2014, 'Dossier Jeugdwet', in: Verslag van een gesprek met deskundigen (February 20th 2014).

European Commission and the Council of Europe, *Country sheet on youth policy in Sweden* (Brussels 2014).

European Committee of Social Rights, *European Federation of National Organisations working with the Homeless (FEANTSA) v. the Netherlands* (November 2014).

European Committee of the Regions and the European Union Agency for Fundamental Rights, *Making rights real. A guide for local and regional authorities* (Brussels 2013).

G

Gemeente Den Haag, *Programma Jeugd en Gezin 2011-2014* (The Hague 2011).

Gemeente Middelburg, *Welzijn, ondersteuning en zorg in Middelburg: ambities binnen de WMO* (Middelburg 2011).

Gemengde interdepartementale werkgroep jeugdwelzijnsbeleid, *Jeugdwelzijn. Op weg naar samenhangend beleid* (The Hague 1976).

Government of the Kingdom of Sweden, *A National Human Rights Action Plan 2002-2004* (Stockholm 2001).

Government of the Kingdom of Sweden, *A National Human Rights Action Plan 2006-2009* (Stockholm 2005).

Grondwet voor het Koninkrijk der Nederlanden (2008), 'Artikel 93: Rechtskracht internationale verdragen', in: *Hoofdstuk. 5: Wetgeving en bestuur, Paragraaf 2: Overige Bepalingen.*

I

International Health Conference, *Constitution of the World Health Organization* (New York 1946).

L

Lans, van der J., *Een wijkgerichte aanpak: HET FUNDAMENT (*Amsterdam 2014).

League of Nations, *Geneva Declaration of the Rights of the Child* (Geneva 1924).

M

Ministerie van Binnenlandse Zaken en Koninkrijksrelaties, *Nationaal Actieplan Mensenrechten. Bescherming en bevordering van mensenrechten op nationaal niveau* (The Hague 2013).

Ministerie van Volksgezondheid, Welzijn en Sport, het Ministerie van Veiligheid en Justitie en de Vereniging van Nederlandse Gemeenten, 'Factsheet Jeugdwet. Naar goede jeugdhulp die bij ons past', in: *Stelselwijziging Jeugd* (The Hague 2014).

Ministry of Health and Social Affairs, *Strategy to strengthen the rights of the child in Sweden* (Stockholm 2011).

Molin, L.O., 'Best practices of implementation of human rights at local and regional level in member states of the Council of Europe and other countries', in: *Monitoring Committee* (Strasbourg 2014).

N

Nederlands Jeugdinstituut, *Praktijkvoorbeeld. Buurtteams Jeugd & Gezin – Utrecht* (Utrecht 2013).

Nederlands Jeugdinstituut, *Jeugdzorg in Europa versie 2.0* (Utrecht 2012).

Nederlands Jeugdinstituut, *Jeugdzorg in Europa. Lessen over strategieën en zorgsystemen uit Engeland, Duitsland, Noorwegen en Zweden* (Utrecht 2009).

Nederlands Jeugdinstituut, *Generalistisch werken rondom jeugd en gezin in de Scandinavische landen* (Utrecht 2013).
Nederlands Jeugdinstituut, *Transformeren met beleid. Maatschappelijke resultaten, kwaliteitsindicatoren en ombouwscenario's transitie jeugdzorg* (Utrecht 2013).

Nederlands Jeugdinstituut: *The decentralization and transformation of the Dutch youth care system* (Utrecht 2014).

O
Ombudsman for Children in Sweden, *Young Speakers – a method for listening to children* (Stockholm 2011).

S
Socialstyrelsen, *Child welfare in a state of change – Final report from the BBIC project* (Stockholm 2005).

Staten-Generaal van het Koninkrijk der Nederlanden, *Wet gemeentelijke antidiscriminatievoorzieningen* (The Hague 2009).

T
Tweede Kamer der Staten-Generaal, Kamerstuk 31839 nr. 410/vergaderjaar 2013-2014, 'Jeugdzorg', in: Brief van de staatssecretarissen van volksgezondheid, welzijn en sport en van veiligheid en justitie aan de voorzitter van de Tweede Kamer der Staten-Generaal (August 28th 2014).

U
United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The Nature of States Parties' Obligations* (New York 1990).

United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (New York 2000).

United Nations Committee on the Rights of the Child, *General Comment No. 12: The right of the child to be heard* (Geneva 2009).

United Nations General Assembly, *Universal Declaration of Human Rights* (Paris 1948).

United Nations General Assembly, *Declaration of the Rights of the Child* (New York 1959).

United Nations General Assembly, *International Covenant on Economic, Social and Cultural Rights* (New York 1966).

United Nations General Assembly, *Convention on the Rights of the Child* (New York 1989).

United Nations General Assembly, *Vienna Declaration and Programme of Action* (New York 1993).

V
Vereniging van Nederlandse Gemeenten en de Rijksoverheid, *Stelselwijziging Jeugd. Jeugdbakens. Bakens voor de transformatie van het jeugdbeleid* (Den Haag 2014).

W
Verwey-Jonker Instituut en de Gemeente Utrecht, *Van vraag naar verbetering. PAja! Utrecht: jongeren keuren de opvang* (Utrecht 2014).

Media

Auteur onbekend, 'PvdA Arnhem wil ombudsman voor zorg en jeugd', in: *De Gelderlander* (October 27th 2014).

Auteur onbekend, 'Savanna (3) stelselmatig mishandeld', in: *De Volkskrant* (December 8th 2004).

Effting, M., 'Mishandeld? Dat is niet zomaar duidelijk', in: *De Volkskrant* (Editie woensdag 10 december 2014).

Herderscheê, G., 'Geen flauw idee wie straks welke zorg krijgt', in: *De Volkskrant* (November 17th 2014).

Kooistra, S. en Vos, C., 'Gemeenten vernieuwen hun zorg. Veel plaatsen tuigen 'integrale wijkteams' op om extra taken te combineren met bezuinigen', in: *De Volkskrant* (November 21st 2014).

Nieuwsuur, 'Geen garantie continuïteit jeugdzorg', in: *Broadcasting Monday September 22nd 2014*.
RTV Drenthe, 'Assen krijgt ombudsman voor de zorg' (October 24th 2014).

Websites

Lieshout, van M., '1994 Bureau Jeugdzorg. Van provincie naar gemeenten, in: Canon jeugdzorg Nederland (Last edited on February 21st 2014).

Local Human Rights in Utrecht, Start van Lokale Mensenrechtencoalitie (Utrecht 2013).

Muiznieks, N., Human Rights Comment: Maintain universal access to healthcare, (August 17th 2014).

Nederlands Jeugdinstituut, Wijkteam en onderwijs , in: *Dossier Wijkteams* (October 29th 2014).

Netwerk Mensenrechten Lokaal. 'Wat is het Netwerk?', Netwerk Mensenrechten Lokaal.

Rijksoverheid, Decentralisatie van overheidstaken naar gemeenten' (September 23rd, 2014).

Rijksoverheid, Rechten in de zorg. Patiëntenrecht en cliëntenrecht.

Stichting Alexander en Verwey-Jonker Instituut, 'Toolkit Jeugdparticipatie', in: *Be Involved* (2011).

United Cities and Local Governments, 'Global Charter-Agenda for Human Rights in the City' (Florence 2011).

United Nations Children's Fund, *The convention on the rights of the child. Participation rights: having an active voice* (August 2014).

United Nations Office of the High Commissioner for Human Rights, OHCHR and NHRIs.

Interviews and meetings

Decentralisation Day for municipal officials, members of the municipal council and aldermen ('s-Hertogenbosch 2014).

Interview with Pink Hilverdink and Tijne Berg-le Clerq at the Netherlands Youth Institute (Utrecht January 8th, 2015).

Vereniging van Nederlandse Gemeenten, 'Klagen is een recht maar hoeft lang niet altijd tot een formele procedure te leiden', in: *Expertmeeting Jeugdhulp en Wmo* (Gouda 2014).

Vereniging van Nederlandse Gemeenten, *VNG Taskforce mensenrechten en decentralisaties* (The Hague 2014).

Zonneveld, J. *Decentralisation. An integrated approach*, presentation provided by Integrated Services at Ministry of the Interior (The Hague 2014).