9TH DR ABRAHAM HORWITZ LECTURER

STRATEGIES FOR REALIZING HUMAN RIGHTS TO FOOD, HEALTH AND CARE FOR INFANTS AND YOUNG CHILDREN IN SUPPORT OF THE MILLENNIUM DEVELOPMENT GOALS

ROLE AND CAPACITY ANALYSIS OF RESPONSIBLE ACTORS IN RELATION TO BREASTFEEDING IN THE MALDIVES

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Introduction

The general theme of the 9th Dr Abraham Horwitz lecture was "National Anti-Hunger Strategies: What can we learn from country-ownership of the fight against hunger and malnutrition?" This paper deals with theory and practice regarding anti-hunger strategies in support of the Millennium Development Goals (MDGs) and the realization of human rights to food, health and care for infants and young children with a focus on breastfeeding. Specifically, it discusses experiences from a role and capacity analysis of responsible actors in relation to breastfeeding from a human rights perspective in the Maldives.

Breastfeeding, MDGs and human rights

Any anti-hunger strategy for infants and young children must include breastfeeding as a critical component. Breastfeeding is in itself, a factor that will contribute to the achievement of the MDGs, as documented by the SCN through its Working Group on Breastfeeding and Complementary Feeding in New York in 2004.[1] The MDGs on the other hand, must be anchored in human rights, as reflected in the preceding Millennium Declaration.[2]

The uniqueness of breastfeeding is that it provides infants and young children with one complete food which ensures health and where care is the mode of delivery. Optimal breastfeeding practices, therefore, contribute to the realization of infants and young children's rights to adequate food [Convention on the Rights of the Child (CRC) Art. 24.2(c), International Covenant of Economic, Social and Cultural Rights (ICESCR) Art. 11.1] and the highest attainable standard of health (CRC Art. 24.1, ICESCR Art. 12.1).[b] At the same time mothers have human rights that can be used to claim conditions that will enable them to breastfeed successfully, such as the right to appropriate post-natal care [CRC Art. 24, Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) Art. 12.2] and the right to paid maternity leave (ICESCR Art. 10, CEDAW Art. 11.2(b)). Figure 1 summarizes these relationships. The specific relevant articles found in these conventions are numerous and comprise the rights of infants and mothers respectively, as well as the obligations of states (see Box 1 on page 65).

Human rights imply corresponding duties

With any human right, there is a corresponding set of duties held by *duty-bearers*. The specific duties are (by necessity) not spelled out in more than very general terms in the human rights conventions, and must therefore be specified on the basis of human rights norms and principles as well as international norms[c] for best practice. Generally, 'human rights norms' encompass the various conventions themselves, as well as the relevant 'general comments', issued by the respective human rights treaty bodies

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[b] Whether infants have an explicit *right to be breastfed* may be a controversial question as such a notion implies that mothers have a *duty to breastfeed*. This is a complex issue that will not be specifically addressed here.

[c] The term norm is here used as the desired standard; an aspiration towards which one should strive. It should not be confused with the concept of norm as typically used by social scientists, i.e. meaning what is common to the social group in question.

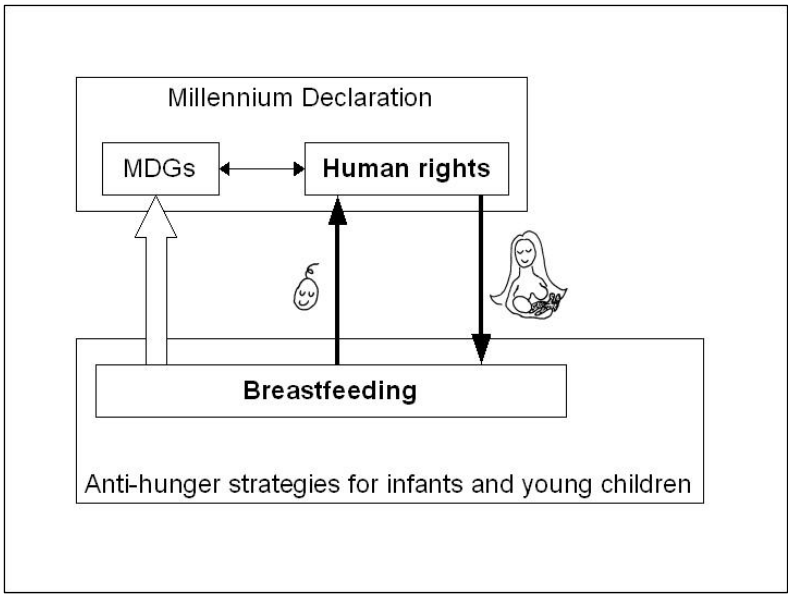

Figure 1: The relationships between breastfeeding, MDGs and human rights.

Elements of capacity

1. Motivation and acceptance of duty
2. Authority
3. Access to and control of resources
   - Economic
   - Human
   - Organizational
4. Capability to communicate
5. Capability for rational decision-making and learning

Box 2: Elements of capacity as suggested by SCN.

to clarify the content of certain articles in those conventions.[d]

For breastfeeding, there exist a number of international norms and 'model plans'. The most comprehensive one is the Global Strategy on Infant and Young Child Feeding[3] from 2003 ('the Global Strategy') which endorses previous standards such as the International Code of Marketing of Breast-milk Substitutes[4] ('the WHO Code'), the Innocenti Declaration,[5] the International Labor Organization (ILO) Maternity Protection Convention,[6] and the Baby-Friendly Hospital Initiative[7] (BFHI) which is based on the Ten Steps to Successful Breastfeeding. The Global Strategy is human rights-based (para. 3); it spells out the specific obligations and responsibilities of a range of actors in society (paras. 35-48) and requests that States allocate responsibilities among them (para. 37).

Methodology

The research project

The research used a methodology developed within UNICEF[8] and suggested by the SCN through its Working Group on Nutrition, Ethics and Human Rights at the 28th Annual Session of the SCN in Nairobi in 2001 for monitoring the realisation of the rights to food, health and care.[9] The methodology has been further developed within UNICEF in various publications by Urban Jonsson and others,[10,11] as part of a human rights-based approach to development programming. It provides a theoretical framework in terms of a 'role and capacity analysis'—which has to be specifically operationalized for different situations.

The first part of the research was to develop specific indicators based on the framework, second to field-test these indicators in a case study carried out in relation to a review of hospitals declared Baby-Friendly in the Maldives. The field-test, in turn, contributed to a refinement of the indicators (Figure 2, next page). The indicators are normative, meaning that they were formulated to indicate the ideal situation, through a combination of human rights principles and international norms for breastfeeding policy and practice. In the case study, these normative indicators were compared to the situation in reality measured by performance, in order to identify gaps.

The focus of this paper is on experiences using this particular methodology, and particularly how it was operationalized to yield indicators. For this one particular finding, low rates of exclusive breastfeeding among mothers of newborns (51% of the newborns in the study sample had already received food or drink other than breastmilk) was pursued to illustrate how the analysis can enhance understanding of the reasons for failure to meet duties. The paper does not attempt to give a full picture of the breastfeeding situation in the Maldives.

Role and capacity analysis

Who are the duty-bearer(s) in a given situation? Through a role analysis responsible actors or duty-

[d] In the case of CEDAW (Convention on the Elimination of all forms of Discrimination Against Women) the term used is 'general recommendations'.

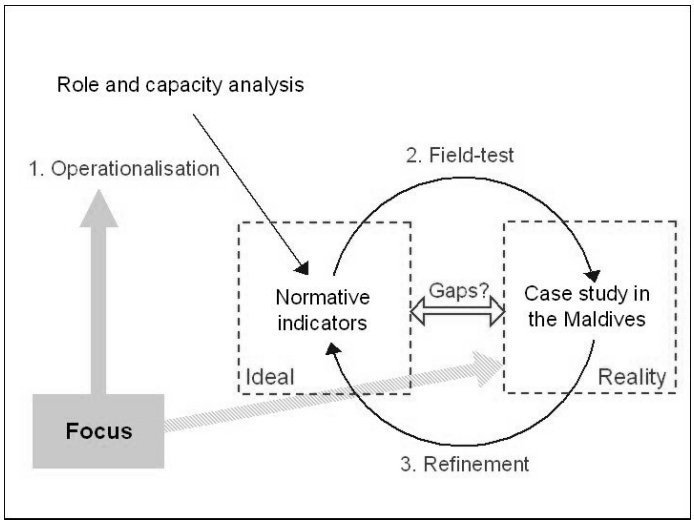

Figure 2: Overview of the research project.

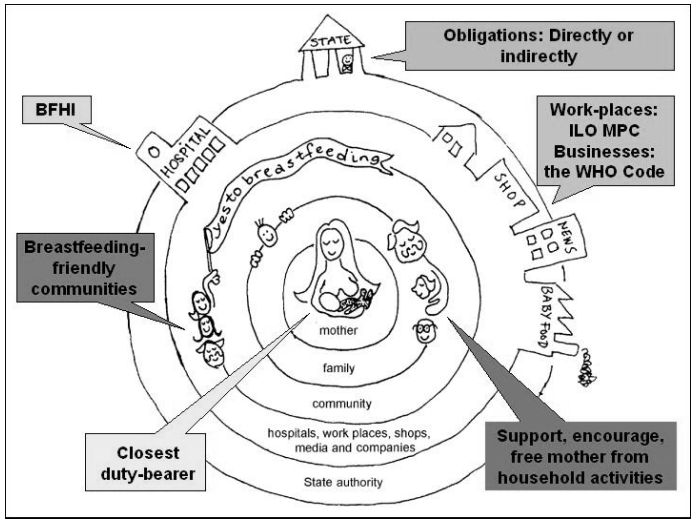

Figure 3: Role analysis of duty-bearers (adapted from Kents' 'rings of responsibilities')[21]

bearers at various levels are identified. After identifying who they are, it is necessary to determine their particular obligations and responsibilities, and assess their performance in meeting them.

For breastfeeding, a range of responsible actors can be identified (Figure 3). The mother is the closest duty-bearer to her infant. She needs active support from her surroundings to practise optimal breastfeeding. The husband and the family thus have responsibilities to support and encourage the mother by building her confidence and freeing her from household chores. Communities have responsibilities to create breastfeeding-friendly communities, such as those in the Gambia as described by Semega-Janneh in the 2nd Dr Abraham Horwitz Lecture in Oslo in 1998.[12] Work-places are responsible for ensuring that working mothers receive paid maternity leave in line with the ILO Maternity Protection Convention. Businesses, shops and media have responsibilities to adhere to the WHO Code. Health care services have responsibilities to protect, promote and support breastfeeding, for example through implementing the BFHI. The state authority is obliged to implement measures towards the enjoyment of the rights, either directly, by working through public institutions such as governmental hospitals, or indirectly, by strengthening opportunities for non-state actors such as work places and communities.

In the Maldives case study, duty-bearers at three levels were considered: the mothers, the hospitals and the State.

A major assumption of the methodology is that failure to meet duties at any of these levels may not necessarily be due to unwillingness on the part of the duty-bearers, but rather to a lack of capacity to do so. A capacity analysis seeks to investigate why duty-bearers are not fulfilling their duties. Specifically, we are interested in identifying and assessing the gaps in capacity which hinder them.

The framework proposed by the SCN examines the following five elements of capacity: (1) being motivated to implement measures towards the enjoyment of the right and accepting the duty to do so, (2) having authority to take action, (3) having access to and control of the necessary economic, human and organisational resources, (4) possessing capabilities to communicate, and (5) possessing capabilities to make rational decisions and to learn from experience (Box 2, previous page).

Conceptual framework

Many of the readers will recognise the upper part of the conceptual framework presented in Figure 4 which is based on the UNICEF framework for understanding the causes of malnutrition.[13] Here it is depicted in its normative version, pointing to optimal breastfeeding practices as an underlying condition for good nutrition among infants and young children.

For analysis at the basic level, the original UNICEF conceptual framework focuses on the presence or non-presence of relevant resources as well as the economic, political and ideological factors that influence their control and management. In the case of breastfeeding, factors at the basic level would, for example, be the existence of breastfeeding policies and whether or not maternity services are baby-friendly.

In a human rights-approach, it mandatory to apply certain principles such as participation and accountability. Participation requires the identification of specific duty-bearers who have an obligation

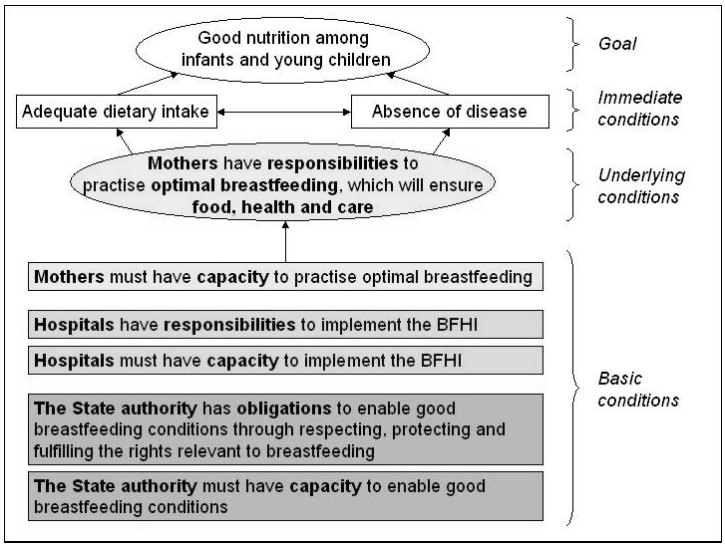

Figure 4: Conceptual framework for the role and capacity of three sets of duty-bearers.

or a responsibility vis-à-vis right-holders to perform in accordance with certain principles and standards (role analysis). Holding them accountable for this must be seen in light of their capacity to meet duties (capacity analysis).

The approach by which one focuses on performance in meeting duties and capacity to do so can be applied in the normative version of the conceptual framework, i.e. for identifying the conditions for optimal breastfeeding practices, the framework thereby becoming a tool for establishing a viable norm. In this way one may say that the ideal conditions at the basic level in the normative framework are when the identified duty-bearers can and are satisfactorily carrying out their duties. The human rights approach thus adds two dimensions to the normative nutrition framework by going beyond the question "*are there* certain factors in place at the basic level?" (i.e. presence of, for example, policies, programmes, etc.), to "*are the duty-bearers taking action* to ensure that such factors are present?" (i.e. duty-bearers' role) and "*can the duty-bearers* take such action?" (i.e. duty-bearers' capacity), thereby highlighting a critical human rights principle, namely accountability, for nutrition analysis. Also, this approach points to the concept of nested responsibilities as it becomes clear that the performance and capacity of duty-bearers at one level depends on the performance and capacity of duty-bearers at more distant levels. The conceptual framework for the role and capacity of three sets of duty-bearers is depicted in Figure 4.[e]

The next step is to further operationalize each of the elements in order to create meaningful indicators. In the case study, the framework in Figure 4 served as a guide for developing normative indicators for the ideal performance and capacity of the three sets of duty-bearers, resulting in six sets of indicators:

- the *performance* of mothers in meeting their responsibilities to practise optimal breastfeeding, and
- their *capacity* to do so
- the *performance* of hospitals in meeting their responsibilities to implement the BFHI, and
- their *capacity* to do so
- the *performance* of the State authority in meeting its obligations to respect, protect and fulfil the rights relevant to breastfeeding, and
- its *capacity* to do so.

The total number of indicators developed in the study amounts to almost 250 and cannot be presented here. The next section shows a brief overview of the areas investigated under each of the six sets, illustrated by some selected examples from the case-study in the Maldives.

[e] Figure 4 shows the nested responsibilities for only three sets of duty-bearers. The entire claim-duty pattern would of course be a more complex web.

Case-study

BACKGROUND INFORMATION

The Republic of Maldives is a small island nation in the South Indian Sea with a population of 275 000 scattered over 199 of some 1200 islands. Although graduated from status of least developed country in 2004, the Maldives is extremely vulnerable, geographically and economically, to shocks such as that of the tsunami last December. Malnutrition is rife, with underweight, wasting and stunting rates among children underfive years of 30, 13, and 25% respectively[15]—which are comparable to those of Sub-Saharan Africa. The breastfeeding rate of 97% is among the highest in the world, however, it does not reflect the degree of optimal practices and only 11% of mothers reported breastfeeding exclusively for six months in 2001. The Maldives is a country in transition which is increasingly adopting a Western lifestyle in many respects. The Department of Public Health (DPH) has expressed concern that formula feeding is starting to replace breastfeeding.[16] Regarding human rights, the Maldives ratified the CRC in 1991 and acceded to the CEDAW in 1993.

SAMPLING

The findings presented in the examples below are based on interviews in maternity wards of six hospitals: 58 mothers of infants younger than 25 days of whom 49 were non-special care babies; 59 staff members of whom 14 were doctors (1 Maldivian and 13 expatriates); 45 nurses (32 Maldivians and 13 expatriates). At the State level, data was obtained from official documents, observations and discussions with governmental employees.

INDICATORS AND EXAMPLES

Indicators at the mother level

Performance

The CRC states that a mother has, as a parent, the "…*primary responsibility for the up-bringing and development of the child*…" where "…*the best interest of the child* …" will be the basic concern (Art. 18.1). She has in that respect, both "…*responsibilities, rights and duties*…" (Art. 5).

Mothers' performance in meeting their responsibilities to ensure their children good nutrition through optimal breastfeeding can be measured against the various aspects of such practices, that is: whether or not breastfeeding is initiated early so the baby may benefit from colostrum, whether or not the infant is breastfed exclusively for six months with continued breastfeeding for two years or beyond, and whether or not breastfeeding is unrestricted—with regard to frequency and duration of feeds.

Capacity

A mother's *capacity* to meet her responsibilities to ensure her child good nutrition through optimal breastfeeding practices, should been seen in light of her

1. *motivation* to breastfeed and her feeling of a responsibility to nourish her baby in the best possible way (motivation, for example, will be based on *inter alia* knowledge about the benefits of and recommendations for breastfeeding);
2. *authority* to make her own decisions about breastfeeding (e.g. that she is not separated from her infant and that she does not have to follow strict feeding schedules);
3. *economic, human and organizational resources* to practise optimal breastfeeding (e.g. time in the form of paid maternity leave for working mothers, skills and confidence, and a supportive network);
4. *capability to communicate* and seek help about problems that may arise (e.g. communication with professionals and with peers, freedom of opinion, expression and information,[f] and participation[g] in the planning and implementation of her health care); and,
5. *capability for rational decision-making and learning from experience* (which presupposes that her decisions are made on correct and non-misleading information).

[f] See Universal Declaration of Human Rights Art. 19, International Covenant on Civil and Political Rights (ICCPR) Art. 19, International Convention on the Elimination of Racial Discrimination Art. 5(d)(viii), CRC Arts. 13, 17 and 24.2(e).

[g] See ICCPR Art. 25, CEDAW Art. 7, CRC Art. 12. Participation in health and nutrition issues has also been emphasised in the Alma Ata declaration from the International Conference on Primary Health Care in 1978 which declares that "…*people have the right and duty to participate individually and collectively in the planning and implementation of their health care*…" as well as in the General Comments No. 12 (on the right to adequate food) and No. 14 (on the right to the highest attainable standard of health) to the ICESCR.

Examples

In the case-study in the Maldives as many as 51% of the non-special care babies in the study sample had, despite their young age, already received food or drink other than breast-milk. One may question whether their mothers were motivated to breastfeed exclusively. *Motivation*, however, will depend i.a. on their knowledge about the recommendations for and benefits of breastfeeding. Among these mothers, 55% knew that exclusive breastfeeding is recommended for six months but only 31% planned to follow it. Further, only 14% could mention more than one benefit of breastfeeding. Both these findings indicate poor knowledge.

If we look at what these babies received and by whom, it becomes clear however that the mothers may not have had the authority to breastfeed exclusively. Of the non-special care babies, 24, 22 and 11% had received *Shaahade*,[h] vitamin or mineral supplements, and glucose or dextrose water, respectively. The Shaahade was given by the family whereas the vitamin or mineral supplements were prescribed by doctors and the glucose or dextrose water was given by nurses. In addition it was reported that grandmothers liked to give the baby something to eat or drink, so they could later tell the child that they fed them when they were young. These actors constitute the mothers' *organizational resources* and should normally support optimal breastfeeding and hence in principle exclusive breastfeeding for the first six months. The remainder of this analysis will look at factors at the hospital level and specifically why the health workers gave the newborns supplements and sweetened water.

INDICATORS AT THE HOSPITAL LEVEL

Performance

According to the CRC (Art. 24) and the CEDAW (Art. 12.2), mothers have the right to "… *appropriate*…" post-natal care. The BFHI is widely recognized as the norm for how hospitals should protect, promote and support breastfeeding. In that respect, a WHO publication from 1998 went so far as to declare that "… *there is no excuse for maternity services not to have implemented the Ten Steps*…."[17] From the combination of these two points it follows that hospitals indeed do have a duty to become baby-friendly. Their performance can therefore be measured against the Global Criteria for the BFHI which sets standards on how the hospitals should comply with the Ten Steps, and on how they should protect mothers from marketing of breast-milk substitutes.

Capacity

Whether or not hospitals comply with the Global Criteria for BFHI depends on their capacity to do so. This capacity must be seen in light of:

1. *motivation* of hospital management and all staff to implement the Ten Steps and the *acceptance of duty* to do so (which is, for example, manifested in the existence, quality and use of hospital breastfeeding policies);
2. *authority* of the hospital to plan and initiate interventions to better adhere to the Ten Steps as well as the authority of individual staff members to support mothers to breastfeed (restrictions on how hospitals may promote breastfeeding can for example come from local traditions that are non-consonant with the Ten Steps; within the hospital, staff members in lower positions may feel that they do not have authority to contradict instructions given by staff in higher positions—even when these instructions do not comply with the Ten Steps);
3. *economic, human and organisational resources* available to the hospital (such as budget for salaries and for material, trained and experienced personnel, and internal and external organisational structures);
4. *capability of hospital staff to communicate* (with the central level, amongst themselves, and listening to mothers' views); and,
5. *capability to make rational decisions and to learn from experience* (on the basis of sound and regular monitoring and evaluation).

Examples

In light of the above aspects of capacity, one reason why health workers in the Maldives gave the newborns supplements and sweetened water might be that only 22% of staff members interviewed had received appropriate training, this in turn reflects a lack of adequate human resources in these hospitals. In this case, it is crucial that those who are trained should be given authority to make decisions. In

[h] Shaahade is a religious rital where the newborn is given a little prayer in his or her mouth. The prayer is usually written in a thin layer of honey on a piece of cotton. It is a one time ceremony.

the Maldives, a high proportion of doctors and nursing supervisors are expatriates on short-term contracts who do not receive any special in-service training. They should nevertheless follow the hospital breastfeeding policy, integrate it and *accept it as their duty*. The breastfeeding policies in these hospitals varied considerably in quality, however. Further, not more than 42% of the staff members reported having received an orientation about it, an indication of inadequate *communication*. The poor policies and orientation routines might be a sign of a sub-optimal *motivation* to implement the Baby-Friendly Hospital Initiative.

The hospital breastfeeding policy should be based on the Ten Steps; Step 6 reads that "…new-borns should be given no food or drink other than breast-milk—unless medically indicated". Here one may raise the question of whether or not vitamin supplements and sweetened water really are medically indicated in the first days of life. In practice, the interpretation of what is "medically indicated" becomes a subjective decision by the individual paediatrician or other health worker with similar authority. In the Maldives, conflicts on this issue were frequent.

In all six hospitals, there was a total ban on bottles and artificial teats. Yet it was reported that such products were frequently used in paediatric wards where older infants were admitted.. It is not hard to imagine the difficulty in refusing a sick child his or her bottle despite the ban. In such a situation, rational decision-making may favour a happy child rather than a crying child.

One of the hospitals' organisational resources, the DPH, has been concerned with maintaining standards in the baby-friendly hospitals. The responses from the State are dealt with in the next section.

INDICATORS AT THE STATE LEVEL

Performance

A State that has ratified and which, therefore, is a party to a human rights convention is obliged under international law to implement measures toward the enjoyment of these rights. The level of obligation will vary according to different situations. Common human rights language interprets State obligations as the obligations to *respect*, *protect* and *fulfil* a given right, fulfil through *facilitation* or where necessary through *provision*. This categorisation of State obligations has been adopted by the UN Committee on Economic, Social and Cultural Rights in its General Comments No. 12 on the right to adequate food[18] and No. 14 on the right to the highest attainable standard of health.[i, 19]

For breastfeeding specifically, this would mean that the State is, at the first level, obliged to *respect* existing good breastfeeding practices. At the next level, it is obliged to *protect* breastfeeding mothers from interfering third parties—such as aggressive marketing behaviour from infant formula companies. Further it is obliged to *facilitate* good breastfeeding conditions and environments, for example, through establishing policies or implementing programmes. For especially needy infants, such as prematures, the State may even have to *provide* alternatives of comparable quality such as mother's milk from human milk banks.

Capacity

The extent to which the State meets its obligations to fulfil the rights relevant to breastfeeding depends on its capacity to do so, which must be seen in light of its:

1. *motivation* to respect, protect and fulfil the rights relevant to breastfeeding and *acceptance of duty* to do so (which will be reflected in national legislation, policies and programmes on breastfeeding);
2. *authority* to make decisions which concern breastfeeding (i.e. that the State authority has delegated responsibility and political mandates to relevant institutions);
3. *economic, human and organisational resources* to implement its obligations (such as budgets for implementation of policies and programmes, availability of experienced and skilled staff, and arrangements for technical or economic support);
4. *capability to communicate* (internally within the State's own structures; externally with collaborating actors and, most importantly, with mothers themselves who are the problem-owners through establishing feedback mechanisms and ensuring their participation in decision-making); and,

[i] General Comment No. 14 on the right to the highest attainable standard of health includes a third subdivision of *promotion* under the obligation to *fulfil* (in addition to *facilitation* and *provision*). In this work, breastfeeding promotion is considered as one way in which the State may facilitate for optimal breastfeeding through providing information.

5. *capability for rational decision-making and learning from experience* (i.e. monitoring and evaluation of breastfeeding practices, policies and programmes).

Examples

In the Maldives, the DPH has responded to the problem of inadequate policies and has developed a standardized, comprehensive hospital breastfeeding policy of fifteen steps. This policy covers all the Ten Steps, but also includes some elements specific to the situation in the Maldives (e.g. that training should also be provided to expatriate staff). The Global Criteria for BFHI do not require hospital breastfeeding policies to be identical to the Ten Steps. The DPH was nevertheless discouraged from introducing this policy in the baby-friendly hospitals by one of their organizational resources, the nutrition section of the UNICEF headquarters at the time. This was based on fears that it could reduce the impact of the Ten Steps. Without the author taking a stand on this issue, one might question whether endorsement of the added elements might have contributed to a sense of country-ownership to the BFHI.

An internal organizational resource at the national level would be a continuing training programme on breastfeeding support for health workers. Generally speaking, the Maldives faces a lack of human resources as there are no universities or colleges offering postgraduate programmes. In this case however, there are several certified trainers for appropriate courses, thus the human resources are present, yet courses are not held regularly. This might be ascribed to a lack of economic resources at the national level, and perhaps also to a lack of motivation as "mothers breastfeed anyway". Some of the challenges particular to the Maldives in providing training to all hospital staff are: high turn-over rates of staff requiring that courses are conducted often, frequent rotations among different wards requiring training of a large proportion of the total staff, a geography of scattered and sometimes inaccessible islands resulting in high transportation costs and difficulties in conducting training programs for more than one unit at a time, and small-sized individual units making it difficult to release staff members for participation in courses.

Reflections on the utilization of the role and capacity analysis

SIGNIFICANCE IN THE PARTICULAR CASE STUDY

Role and capacity analysis clearly brought out the multiple responsibilities of a range of duty-bearers for optimal breastfeeding. The example from the Maldives, though limited in scope, illustrates how this responsibility does not rest with mothers alone. An analysis of their capacity reveals that their breastfeeding success is highly dependant on the performance of other duty-bearers, whether close or distant. This is, for example, reflected in the preamble to the CEDAW, which states that "… upbringing of children requires a sharing of responsibility between men and women and society as a whole."

Although the hospitals surveyed in this study had committed themselves to implement the BFHI, they did not have capacity for achieving full implementation. In developing countries, such as the Maldives, the State authority may have only limited capacity to provide technical or financial support, particularly in terms of economic and human resources. Under international human rights law, however, State Parties to the CRC may request or indicate their need for technical advice or assistance to UNICEF or other competent bodies through the Committee on the Rights of the Child (CRC Art. 45(b)) and, therefore, have an authority in the form of a mandate to request assistance.

GENERAL USEFULNESS OF THE ANALYSIS

The role and capacity analysis is complex, yet not complicated. It is logically structured and well suited for this country setting. An evaluation based on the Global Criteria for BFHI is in itself a thorough and time-consuming process. The additional time and resources needed for the analysis at the hospital level were therefore marginal.

It must be emphasized, however, that the limitations to this particular example are fourfold. Firstly, it only examines duty-bearers at three levels. As indicated earlier many other actors could play an important role in supporting mothers in optimal breastfeeding. Secondly, it only focuses on mothers giving birth in the largest hospitals; the situation might be quite different on other islands. Thirdly, the example, although complex, only considers one of the aforementioned four aspects of optimal breastfeeding. Finally, the findings are only valid for the very first days after birth. Later in the breastfeeding period, interventions and programmes other than BFHI may be more important for creating enabling breastfeeding environments.

When monitoring the realization of nutrition-relevant human rights more broadly, the role and capac-

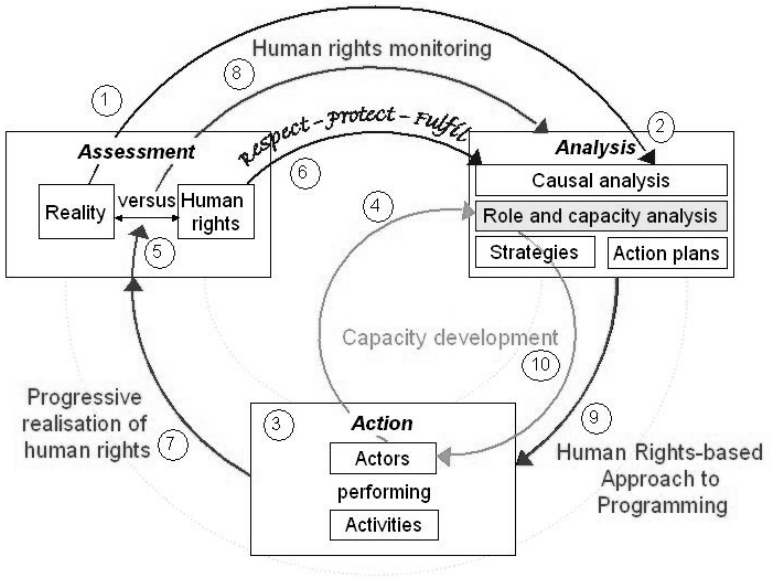

Figure 5: Role of the role and capacity analysis

ity of actors at other levels must be taken into account (e.g. families, communities, health clinics, work places, businesses and media). This might demand more time and resources not always available. The role and capacity analysis can nevertheless be applied to selected topics or actors on an opportunistic and strategic basis. For those who wish to utilize this methodology, it is recommended to have flexibility in data collection, both in sampling as well as in information gathering. The approach using questionnaires in the present study proved unnecessarily time-consuming and precluded gathering of information on related issues that may have come up.

Finally, this study looked at the underlying factors of failure to meet duties, this in terms of sub-optimal capacity. The role and capacity analysis could also serve to study 'best practices', identifying those capacities that appear effective in different settings. An inventory of such studies would be particularly useful for the further refinement and scaling-up[i] of a human rights-based approach to programming (HRBAP).

Conclusion: Potential inherent in role and capacity analysis

So, what conclusions can be drawn from this study? Has the analysis provided useful and has it showed its potential? Given the restrictions mentioned above, the answer is yes. Not only was it helpful to explore capacity in a structured manner, it also allowed for more openness during interviews, in cases of poor performance—perhaps because the duty-bearers felt that they were not being judged, but rather given the opportunity to speak out about their challenges, difficulties and their own unfulfilled rights.

Applying a role and capacity analysis could in fact encourage a series of activities, ensuring *local* ownership and commitment from a broad range of actors under the ultimate sponsorship and encouragement of the State authority. Through identifying duty-bearers and spelling out their roles and responsibilities, accountability is encouraged.

Accountability and ownership will also be nurtured through involving duty-bearers in the decision-making process. The analysis fits well into the greater picture of programming and policy-making, and specifically the so-called triple-A cycle of assessment, analysis and action.

This cycle usually involves an assessment of a real problem (Figure 5, step 1), followed by an analysis of its causes (step 2). This should lead to specific actions to correct the problem. Action on the other hand, always involves actors who are performing activities (step 3). A thorough analysis should, therefore, include a role and capacity analysis (step 4), to ensure that action plans are realistic. This could encourage specific actors to acknowledge their roles and responsibilities and programme planners to

[i] Scaling-up should here be understood in the broad sense: quantitatively (e.g. geographical expansion), functionally (e.g. introduction of new activities), politically (e.g. moving towards empowerment and change in the socio-political-economic environment), or organisationally (e.g. creating new external links with other development actors).[20]

ensure that their capacities are developed and supported so they indeed may meet their duties. Action should always aim to move the situation in reality towards one in which human rights are realised (step 5).

Even where specific problems are not yet identified, ratification of human rights conventions should encourage the formulation of national strategies and measures to respect, protect and fulfil these rights (step 6). The operationalisation of such strategies would clearly benefit from a thorough role and capacity analysis.

Although 'human rights' here are placed within the sphere of 'assessment', in contrast to the situation in 'reality', they are part of each step of the triple A cycle: action should lead to progressive realization of rights (step 7); an assessment of the reality in relation to human rights is a first step in the process of human rights monitoring (step 8); and, an analysis which includes a role and capacity analysis is a central step in HRBAP (step 9).[10]

Overall, whether in programming or policy-making, one must identify specific actors (be they right-holders or duty-bearers), together with their specific roles and capacities to perform those roles. Action must aim at strengthening and developing their capacities to claim rights and meet duties (step 10). Thus when we choose to talk about capacity development rather than 'competence building' and 'provision of resources' we should consider capacity in the broad sense as suggested by SCN. For example, as seen in the Maldives case study, training of health workers had limited impact when those who were trained were not given sufficient authority.

Box 1: Human rights relevant to breastfeeding

Infants have the right to...

- the highest attainable standard of physical and mental health (ICESCR 12.1, CRC 24.1)
- adequate nutritious food (ICESCR 11.1, CRC 24.2(c))
- physical, mental, spiritual, moral and social development (CRC 27.1)

Mothers have the right to...

- health care services and appropriate post-natal care (CEDAW 12.2, CRC 24)
- education and support in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding (CRC 24.2(e))
- appropriate assistance in their child-rearing responsibilities (CRC 18)
- adequate nutrition during pregnancy and lactation (CEDAW 12.2)
- paid maternity leave or other equivalent, including job protection (ICESCR 10, CEDAW 11.2(b))
- safeguarding of the function of reproduction in working conditions (CEDAW 11.1(f))
- decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights (CEDAW 16.1(e))

States Parties are obliged to...

- ensure to the maximum extent possible the survival and development of the child (CRC 6.2)
- take appropriate measures to diminish infant and child mortality (CRC 24.2(a))
- combat disease and malnutrition, including within the framework of primary health care (CRC 24.2(c))
- 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 breastfeeding (CRC 24.2(e))
- ensure provision of health care to all children (CRC 24.2(b)) and institutions, services and facilities which conform with appropriate standards (CRC 3.3)

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