MASTER'S THESIS

Master in Public Health Nutrition
November 2017

Breastfeeding as a human right based approach to adequate food

Gifty Adwokyi Arthur

Faculty of Nursing and Health Promotion
Oslo and Akershus University College of Applied Science

Acknowledgements

I would like to thank my supervisor Professor Liv Elin Torheim, for introducing me to the course unit called Nutrition and Human Rights at Oslo and Akershus University College. She has an enormous passion and enthusiasm for the field, which is inspiring.

Sabrina Granheim has been an enormous asset by guiding my steps from a novice within the field to possess a greater in-depth knowledge. She was the reason I wrote the thesis based on the theme breastfeeding in relation to human rights.

I am grateful that Ina Lindau Aasen from the Norwegian Resource Centre for Breastfeeding could take time from her busy schedule to meet me and give helpful advice on key points that needed to be addressed for my discussion.

One of my dearest friends Nils-Erik Aasen Flatø proof read the thesis several times and gave useful comments after each meeting. It was helpful and truly enlightening to have inputs from a male point of view when discussing breastfeeding that is mostly concerned about the female perspective.

My classmate Mia Kopland shared some of the same struggles as me throughout the process of the writing the paper and the encouragement she gave me at the library was heaven sent. The laughs and frustration went hand in hand on certain days but she was optimistic and focused which had a domino effect on me. Anne Lene Løvhaug was also a great contributor during certain crucial points during the writing process.

Furthermore, I would like to thank all the lecturers of Akershus University College for their course units which have broadened my understanding of public health nutrition.

Abstract

Background: The nutritional status is crucial for the mental and physical development of the infant. Breastfeeding has positive short- and long term health outcomes that are beneficial for both the maternal and infant health. The Norwegian health department recommends that infants should be breastfed. The child has a right to adequate health under the human rights framework (ICESCR, 1966).

Objective: The objective of the paper was to find out if breastfeeding was recognized as a human rights issue in the Norwegian context, as well as assess how breastfeeding was promoted, supported and encouraged as a feeding practice under the human rights framework.

Method: The paper had a qualitative approach. Documents were selected through several online searches. An assessment of the documents was performed that used a human right based approach to answer the main objective. Provisions from the human rights instruments related to infant health were identified. National and intergovernmental documents were also gathered to find out how breastfeeding was encouraged, promoted and supported as a feeding practice in Norway. A qualitative content analysis of human rights documents was conducted on selected provisions that explicitly mentioned breastfeeding and adequate food.

Results: Norway has signed and ratified 11 different human right instruments. Breastfeeding was explicitly mentioned in 3 of these instruments; the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of Persons with Disabilities. The Norwegian Health Departments recommends that the infant should be exclusively breastfed for 6 months, aligned with the recommendations by the WHO. Norway has implemented several health initiatives, policies and legislation that support, promote and protect the act of breastfeeding.

Conclusion: Norway has a conducive, facilitative food environment which supports, protects and promotes the act of breastfeeding. Breastfeeding is considered to be a human right of the infant and the mother in Norway.

Keywords: Human Rights Framework, Breastfeeding, Breastmilk Substitute, Norway, Human Right Based Approach, Human Rights Instruments, Right-holder, Duty-bearer

Table of contents

List of tables

List of figures

List of Appendix's

List of Abbreviations

BFHI	Baby Friendly Hospital Initiative
CEDAW	Convention on the Elimination of all kinds of Discrimination Against Women
CRC	Convention on the Rights of the Child
HIC	High income country
HRBA	Human Rights Based Approach

ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
MoBa	The Norwegian Mother and Child Cohort Study will be referred to as The Code
LMICs	Low- and middle-income countries
OHCHR	United Nations Office of the High Commissioner
The Code	The International Code of Marketing of Breastmilk Substitutes shall be referred to as The Code
WHO	World Health Organisation
UDHR	Universal Declaration of Human Rights
UN	United Nations

Definitions

Malnutrition: refers to deficiencies, excesses or imbalances in a person`s intake of energy and/or nutrients (WHO, 2016).

Exclusive breastfeeding: exclusive breastfeeding means giving a baby only breast milk, and no other liquids or solids, not even water. Drops or syrups consisting of vitamins, mineral supplements or medicines are permitted (WHO & UNICEF, 2006).

Breast-milk substitute: any food being marketed or otherwise represented as a partial or total replacement for breast-milk, whether or not suitable for that purpose (UNICEF, 2015).

Human rights issue: a human rights issue is an issue that is based upon the human rights framework

Human right framework: the terms human right instruments and human right documents are collectively mentioned as the human right framework in this thesis

1.0. Introduction

The nutritional status of an individual is important for the mental and physical development throughout the stages of life from infancy till adulthood (Victora et al., 2016; WHO & UNICEF, 2014). The maternal and infant nutritional environments are interlinked and the mother`s diet can directly impact the infant's health (Aaltonen et al., 2011; McFadden et al., 2017; Shah et al., 2012; WHO, 2014). Depending on the mother`s nutritional adequacy the infant can experience either positive or negative health outcome(s) (Ballard & Morrow, 2013; Rollins et al., 2016; Shah et al., 2012). If the mother has an inadequate diet pre- and post-natal as well as during the time of breastfeeding, the infant has an increased risk of adversely affecting their metabolic health (Aaltonen et al., 2011; Ip et al., 2007). The mother's health is also affected by her sub-optimal diet, with a higher risk of complications during pregnancy such as premature birth and pre-eclampsia (Aaltonen et al., 2011; Meltzer, Bransæter, & Haugen, 2014). It is vital to focus on the nutritional status during the first 1000 days[1] for the optimal growth and development of the infant and the overall health of the woman (Shah et al., 2012). Malnutrition during this period could result in infectious diseases, a weakened immune system and death in certain instances of the infant (Victora et al., 2016). There are two forms of malnutrition, undernutrition and overweight (WHO, 2016). Malnutrition is the underlying cause of 2.6 million child deaths each year (Shah et al., 2012). Breastfeeding can be a way of combating malnutrition (undernutrition) and obtaining good health of the child (WHO, 2001, 2002).

The infant is in a precarious situation relating to its own nutrition. The infant is not physically able to procure its own food for consumption, but is reliant on their caregivers to provide them with adequate nutrition. General comment No.12 , The Right to Adequate Food states that "The right to adequate food is realized when every man, woman and child, alone or in a community with others, has physical and economic access at all times to adequate food or means for its procurement" (UN & FAO, 2010). The infant has two options for their food consumption, which are breastmilk or breastmilk substitutes. Both food options can be deemed adequate if administered properly. But the right to adequate food shall "…not be interpreted in a narrow or restrictive sense which equates it with a minimum package of calories, proteins and other specific nutrients" (UN, 1999). The nutritional composition of

[1] "The period from the start of a mother's pregnancy through her child's second birthday". (Shah et al., 2012)

[2] Optimal breastfeeding synonymous to exclusive breastfeeding.

breastmilk contains thousands of bioactive and non-active molecules that is needed for the infant`s optimal development and health (Ballard & Morrow, 2013). And the nutrient profile of breastmilk varies throughout the different developmental stages of the infant, whereby breastmilk substitute has a standardized nutritional composition which cannot be altered during infections due to the fact that it does not contain active nor non-bioactive immunological (Ballard & Morrow, 2013).

The food environment is an important factor to consider that directly affects people's ability to live a healthy life (Helsedepartementet; Swinburn et al., 2015). The conditions which influence a person's food choices are determined by the economic, physical, social, political and cultural surroundings (Swinburn et al., 2015; Vandevijvere, Dominick, Devi, & Swinburn, 2015). If the societal norm promotes breastfeeding as the feeding practice for the infant and the use of breastmilk substitutes are stigmatized, the mothers' choice could be affected by these external determinants: attitudes, beliefs, skills, food/health policies, economic situation and educational background, that form the basis of an individual food environment (Glanz, 2009). The State is responsible for facilitating conducive food environments for all of its citizens, in particular vulnerable groups such as infants, that promotes breastfeeding (CRC, 1989; Helsedepartementet; UN, 1948). But taking into consideration the multi-levelled conditions of a food environment the task of breastfeeding can be intricate (McFadden et al., 2017; Piwoz & Huffman, 2015).

Several national and international health initiatives have been established throughout the years to increase the initiation, prevalence and duration of breastfeeding (WHO, 1981; WHO & UNICEF, 2003, 2009). Norway has implemented different health initiatives that encourages breastfeeding as a feeding practice for the infant. The Baby-Friendly Hospital Initiative (BFHI) which is a global initiative that aims to protect, promote and support breastfeeding was launched in the spring of 1993 in Norway (Hansen et al., 2012). Over 90% of infants born in Norway are conceived at designated Baby-Friendly birthing units (Hansen et al., 2012; WHO & UNICEF, 2009). The hospitals and health facilities that are under the BFHI have an obligation to comply with all the provisions under the International Code of Marketing of Breast-milk Substitute (The Code) (WHO, 1981). The aim of the Code "… is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (WHO, 1981). There are few provisions of the Code implemented into

Norwegian law (WHO, UNICEF, & IBFAN, 2016), but there is a voluntary agreement between the Norwegian Health Department and food industry in Norway. The industry is also regulated by the food and drug regulation in Norway (Lovdata, 2008).

It is recommended that all children should be breastfed (Piwoz & Huffman, 2015; WHO, 2014; WHO & UNICEF, 2014), but in many parts of the world there is a decline in the rate of breastfeeding (Rollins et al., 2016). Globally less than 35% of children are exclusively breastfed during the first 4 months (WHO & UNICEF, 2003), in Norway 70% of infants are exclusively breastfeed during the first 3 months (SSB, 2003). In general, breastfeeding rates are lower in high-income countries than in low- and middle income countries (LMICs) (Rollins et al., 2016; Victora et al., 2016). But Norway which is a high-income country (HIC) has breastfeeding initiation at 99% (Lande et al., 2003). Infants in LMICs that are breastfed are 6 times more likely to survive during their infancy than children that are not breastfed (Rollins et al., 2016; Shah et al., 2012). More than 800 000 child deaths are due to suboptimal breastfeeding practices (Piwoz & Huffman, 2015; Sankar et al., 2015). If optimal breastfeeding[2] was practiced 1000000 child deaths could be prevented each year (Sankar et al., 2015; Shah et al., 2012). Breastfeeding also increases the survival rate of infants under the age of 5 (Piwoz & Huffman, 2015; Save the children, 2015).

The most effective nutrition specific intervention to improve the health of the infants is breastfeeding (McFadden et al., 2017). Also, the act of breastfeeding could prevent 20 000 annual deaths due to breast cancer in women, and might also protect the woman against ovarian cancer and type 2 diabetes (Victora et al., 2016). Even though the health benefits of breastfeeding are greater in developing countries, infants in high-income countries such as Norway also benefit from being breastfed (Heymann, Raub, & Earle, 2013; NTNU, 2010). Infants that are breastfed in HICs have a reduced risk of developing acute otitis media, non-specific gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma, obesity, type 1 &2 diabetes and childhood leukaemia (Ip et al., 2007). Almost all mothers are biologically capable of breastfeeding their infants, except for a few that have a medical condition(s) which hinders or limits the ability to breastfeed (Rollins et al., 2016; WHO, 2002, 2009). The infant may also have a condition(s) which makes breastmilk an unsuitable option for their nutrition (WHO, 2009). Under these circumstances breastmilk substitute is recommended (WHO & UNICEF, 2009).

The infants right to adequate food is stated in various health documents in Norway as well as the human right framework (CRC, 1989; ICESCR, 1966). The State has certain obligations under the framework to respect, protect, and fulfil the rights of their citizens (UN, Undated), in particular "Motherhood and childhood are entitled to special care and assistance" (CRC, 1989; IJRC, Undated; UN, 1948). The thesis has a focus on breastmilk as a source of adequate food. The relationship between breastfeeding and the human rights framework shall be discussed throughout the paper, by assessing how and if breastfeeding is promoted, supported and protected as a human rights issue in Norway.

2.0. Theoretical Background

2.1. The Norwegian Constitution and Human rights

The Norwegian Constitution was adopted and signed on the 17th of May 1841 at Eidsvoll (Stortinget, Undated). The Constitution was based on three principles; the sovereignty of the people, the separation of powers and human rights. The Constitution has been revised several times and human rights principles have been added during these alterations. The Act (No. 30 of 1999) to strengthen the position of human rights in Norwegian law (Human Rights Act) incorporated several human rights treaties into Norwegian law, which included the European Councils Convention for the Protection of Human Rights and Fundamental Freedoms, its protocols Nos. 4, 6 and 7; the International Covenants on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and the two optional Protocols to the International Covenant on Civil and Political Rights (ILO, 1999). The Act states that "The provisions of the conventions and protocols mentioned in section 2 shall take precedence over any other legislative provisions that conflict with them" which include the Convention on the Rights of the Child (ILO, 1999). The latest revision on the 13th of May 2014, added several additional human rights articles which were enshrined into the Norwegian Constitution.

Human rights have a vital role in how Norway is governed. Article 92 of the Constitution states that, "The authorities of the State shall respect and ensure human rights as they are expressed in this Constitution and in the treaties concerning human rights that are binding for Norway" (Stortinget, Undated). Due to the predominant presence of human rights in the Norwegian Constitution, the thesis will be based on fundamental human rights of the infant.

2.2.0. Human Rights Framework

2.2.1. The Universal Declaration of Human Rights

Human rights are inherent to all human beings (UN, 1948). The rights are to be viewed as fundamental human rights to all people regardless of economic, social, political or religious status. The Universal Declaration of Human Rights (UDHR) states that "all human beings are born free and equal in dignity and rights" (UN, 2015). The human rights can be viewed as a set of principles which are interdependent, interrelated and indivisible. The UDHR together with the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and its two optional protocols are termed as The International Bill of Human Rights (OHCHR, Undated).

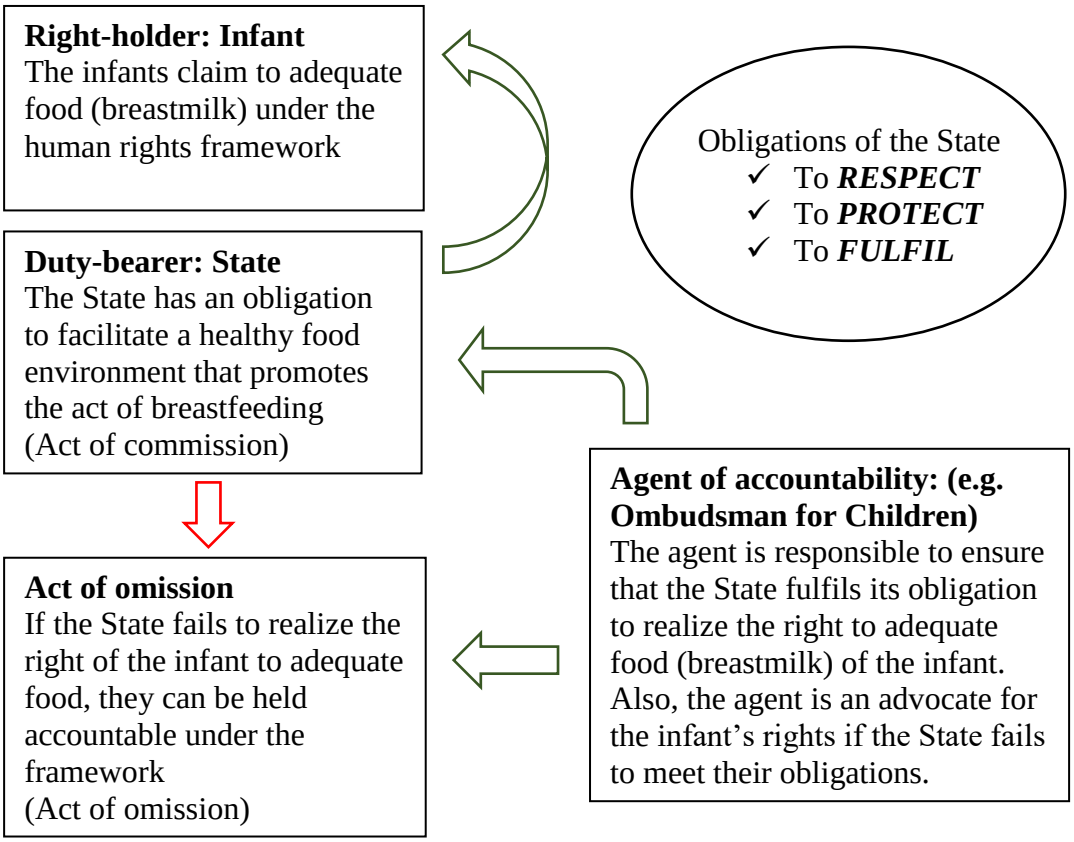
The right to food was first mentioned in the UDHR Article 25 (1) "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services..." (UN, 1948). The mother and child are explicitly mentioned under the same declaration as a group that needs to be prioritized (UN, 1948). However, "In all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration" (CRC, 1989).

2.2.2. Right-holders, duty-bearers and agent of accountability

The human rights framework deals with three main terms which are right-holders, duty-bearers and agent(s) of accountability (Oshaug, Eide, & Eide, 1994). The right-holder(s) can claim their rights under the human rights framework and the duty-bearer is obligated to fulfil the fundamental human rights of the individual(s) (Eide & Kracht, 2005). The right-holder can either be an individual or a group of people. The fundamental human right is realized when an individual(s) can enjoy their freedoms without limitations. If the duty-bearer fails to fulfil their obligations to realize the right of the individual(s), they are considered accountable under the human rights framework. The agent(s) of accountability is responsible to have an oversight over the duty-bearer(s) actions, in case the State fails to fulfil its obligations (Eide & Kracht, 2007). Their role is to advocate for the right of the individual(s), especially when measures are insufficient. The State is the duty-bearer with subsequent obligations to fulfil the fundamental human rights that are under international human right law (Eide & Kracht, 2007; Oshaug et al., 1994). The State is also obliged to submit periodic reports on the progress that has been made to achieve the various rights mentioned in the different human right instruments to the United Nations (UN) (CRC, 1989). It is important to note that not all

human rights instruments are legally binding, but some treaties namely conventions and covenants are legally binding agreements between parties (IJRC, Undated).

Fig. 1 Breastfeeding as source of adequate food: Relationship between right-holder, duty bearer and agent of accountability



The figure is adapted from: Parties to a human rights system (Oshaug et al., 1994).

2.3 A Human Rights Based Approach to Development

The Human Right Based Approach to development (HRBA) puts human rights as an objective of development by integrating different human rights principles into the development process (Filmer-Wilson E, 2005). The UN recognized the relationship between human rights and development with the adoption of the Declaration on the Right to Development by the General Assembly in 1986 (Filmer-Wilson E, 2005; UN, 1986a). In 2003, an agreement amongst UN agencies was made about a Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming (WHO, Undated). The purpose was to ensure that a human right based approach was central in all global and regional programming processes.

Based on research conducted on maternal and child health and/or nutrition, the thesis will use breastfeeding as an example of achieving adequate food by identifying the implications and values of breastfeeding as a human rights-based approach. How the human right based approach to development is relevant to the right to adequate food in Norway will be discussed.

3.1. Main objective

The main objective of the thesis was to assess to what extent breastfeeding was recognized as a human rights issue in the Norwegian context.

3.2.0 Themes and research questions

The main objective was categorized under two themes;

1. Human Rights Framework
2. Policy level and implementation in Norway

The research questions were as followed;

3.2.1. Human Right Framework

1. Which human rights instruments have Norway signed and ratified?
    a. Does Norway have any obligations to protect, promote and support breastfeeding under the human rights framework?
2. Which human rights instruments has a reference to breastfeeding?
    a. Is breastfeeding mentioned as an explicit right for the infant?

3.2.2. Policy level and implementation in Norway

Norwegian policies and laws on breastfeeding

1. What are the recommendations for breastfeeding in Norway?
    a. Are the recommendations aligned with WHO?
2. What laws and policies have been adopted/implemented in Norway that promotes breastfeeding?
3. To what extent do Norwegian policies and laws on breastfeeding recognize breastfeeding as a human rights issue?

3.0. Method

This chapter will describe the research method used for collection of data, research strategy and content analysis. Human rights instruments are a pivotal part of the thesis, but national and intergovernmental documents that had a focus on maternal and infant health, with a special emphasis on breastfeeding were included. The paper aimed to lay out the various provisions that could support jurisdictional decision makers to promote breastfeeding as the most optimal source of adequate food for infants and compel policy makers to use the human rights framework as a tool to scale up efforts in the development and implementation of nutrition specific policies that secures the right to food for infants.

3.1. Research design and method

The most appropriate method for exploring people's behaviour and actions was through a qualitative approach (Silverman, 2006). The method enabled the researcher to find the reason(s) for the failure or success of the given intervention, by identifying barriers and examining practices that were social and/or institutional (Starks & Trinidad, 2007). The research form allowed the researcher to have a broader look at the functions of government, health institutions and health initiatives implemented that could affect the outcome of behaviourism (Silverman et al., 2001). The researcher, in this case myself, was the measuring instrument that assessed the documents gathered from the chosen method (Harris et al., 2009).

The behaviour examined was breastfeeding as a feeding practice in Norway. The association between breastfeeding and the human right framework was unknown, so an assessment of human right documents through a content analysis explored the link of breastfeeding and human rights. The documents were summarized and categorized to establish clear links to the main objective and research questions (Thomas, 2006).

The paper had a deductive approach. An existing theory formed the basis of the hypothesis used for deductive reasoning. This was done by designing a research strategy to test the original hypothesis (Hyde, 2000). The researchers' theory of breastfeeding in Norway was that, breastfeeding was promoted, supported and protected, but was not viewed as a human rights issue.

3.2.0. Data sources and collection

The data used in the thesis were solely documents, ranging from national, intergovernmental and international documents (i.e. governmental documents, handbooks, articles, reports and organizationally websites). Usually documents are used to give a broader in-depth look on

interviews and observations, but reviewing information gathered from documents generated a contextual idea about the event, that was breastfeeding.

3.2.1. Definition of breastfeeding

The term breastfeeding in the main objective and research questions were not classified as being either exclusive, partially or breastfed infants, but based on a general term that the infant was given breastmilk. The distinction between these terms were explained and discussed throughout the paper. The recommendation by the Norwegian Health Department mentions the term exclusive breastfeeding. So the general consensus of the paper was that the infant should be exclusively breastfed. Most studies gathered did not distinguish between exclusive, partially and breastfed infants, so all papers that mentioned breastfeeding were included in the search as stated in the inclusion criteria (3.2.2.). The recommendation for breastfeeding, in particular exclusive breastfeeding, varied between countries so that all definitions of the duration of exclusive breastfeeding as provided by the author and health department were accepted and assessed. Studies which used the term human milk instead of breastmilk were also accepted because breastfeeding and human milk feeding was sometimes used synonymously.

3.2.2. Inclusion and exclusion criteria

Documents that were included in the literature search were meta-analysis, systemic reviews, randomized controlled trials, non-randomized controlled trials, cohort, case control studies, white papers, governmental documents and reports that was related to maternal and/or infant health, infant nutrition, breastfeeding, human milk and breastmilk. The studies needed to evaluate associations between breastfeeding and one or more of the following short- or long-term outcomes: mortality, diabetes mellitus 1 and 2, overweight and obesity, cognitive development, physical development, cholesterol, blood pressure, gastrointestinal disease/infection, respiratory disease (including asthma), cardiovascular disease, leukaemia, infectious diseases, acute otitis media, atopic dermatitis, postpartum depression, breast cancer, osteoporosis and ovarian cancer.

3.2.3. Search strategy

Several formal literature searches were conducted, because it was impossible to have one online search that selected documents that had all the outcomes listed above. Several literature searches were conducted to include a larger number of studies on infant and maternal health. Studies which mentioned breastfeeding, in particular those that distinguished between exclusive and partially breastfed infants, were selected. The different literature searches had

to have one or more of the following words in conjunction with the different health outcomes of the infant and/or the mother: breastfeeding, breast milk, human milk, lactation, nursing, infant health, maternal health, Norway, exclusive breastfeeding, partially breastfed and breastfed infants. Health outcomes in infants: acute otitis media, atopic dermatitis, gastrointestinal infections, lower respiratory tract diseases, asthma, cognitive development, obesity, cardiovascular diseases, type 1 and 2 diabetes mellitus, leukaemia, infant mortality, sudden infant death syndrome and necrotizing enterocolitis. Health outcomes in mothers: type 2 diabetes mellitus, postpartum weight change, osteoporosis, breast cancer, ovarian cancer and postpartum depression.

Other studies were identified from the bibliographies of the selected documents with no limitation on the type of study. The main focus in gathering the additional documents was that all studies had to mention breastfeeding/breastmilk/human milk with/or without health outcomes of the infant and/or the mother. Norway is an industrialised country so it was paramount to find studies that were conducted in developed countries, but studies which compared developing and developed countries was also added as additional literature.

3.2.4. Literature search for breastfeeding in Norway

Two main web sites were selected for the collection of data and information about breastfeeding in Norway; The official website for Statistics Norway www.ssb.no, and the Norwegian Institute of Public Health www.fhi.no/en/. The main criterion for selecting the websites, was that the studies conducted was based on data from Norway. Also, the institution had to have a linkage or support by the Norwegian State.

Statistics Norway (SSB) is an autonomous organisation which reports to the Ministry of Finance (Statistics Norway, 2017). Even though the institution is subjected to supervisory guidelines and financial frameworks by the Government and the National Assembly, the Statistics Act of 1989 stipulates the fact that Statistics Norway is an independent institution, with an overall responsibility to produce official statistics based on Norwegian data (Statistics Norway, 2014). The first literature search string used breastfeeding as a search word which resulted in 1 article; “Norwegian women breastfeed as recommended”. The same word in Norwegian (amming) resulted in 5 articles whereby the article mentioned above was listed. Even though most articles used in the thesis were not retrieved from this site, the page had statistics about maternal and infant health in Norway that was used in the thesis.

The other literature search string was conducted on The Norwegian Institute of Public Health (FHI) official website (Norwegian Institute of Public Health, Undated). The institute has a study which is called, The Norwegian Mother and Child Cohort Study (MoBa). The aim of the study is to find the cause of diseases amongst Norwegian mothers and children. The MoBa study started with 90000 pregnant women being recruited in the time frame from 1998-2008 and now has over 100000 mothers participating. 70000 fathers have also participated in the study. Using breastfeeding as a search word resulted in 20 hits on the site. The website had a reference list to articles and publications that were based on the data from the cohort study. Relevant articles were added as additional literature from the list and bibliography of selected articles.

3.2.5. Literature search for Human Right Instruments

Human right documents were selected from the official United Nation Office of the High commissionaire website, www.ohchr.org. The front page of the main site had a tab called: human rights by country. Norway was typed, and a window was displayed which had a status of ratification icon. This page had a full overview of all the human right instruments that Norway had signed and ratified. All human rights documents were selected from this page for the theoretically background and discussion.

3.2.6. Qualitative content analysis

Content analysis can be used in qualitative research in either a deductive or inductive way (Elo & Kyngäs, 2008). “Content analysis is a method of analysing written, verbal or visual communication messages” (Cole, 1988). It’s a systematic and objective research method that is used to describe a phenomenon, in this case breastfeeding from a human right based approach (Elo & Kyngäs, 2008). The research form allowed the researcher to test theoretical issues concerning breastfeeding as a feeding practice in Norway. The documents were summarized into content-related categories, i.e. themes (Hsieh & Shannon, 2005). The chosen analysis was selected because it brought new insights on the fact present, which was the current situation of breastfeeding in Norway. The purpose of the content analysis was to form an understanding on how breastfeeding is viewed in context of the human right framework based upon the principles and articles stated in the various instruments.

There are three main phases of a deductive analysis process which are: preparation, organizing and reporting (Elo & Kyngäs, 2008). There was no specific rule for analysing the data, but the content was classified into smaller categories (Weber, 1990). The criterion for choosing the selected human right instruments for the analysis was the act of ratification

which established the State as the duty-bearer. The role of a duty-bearer was explained in 2.2.2. There was a limited number of human right documents selected for the content analysis, due to the criterion chosen, i.e. the ratification status. The research questions served as a guide in choosing the unit of analysis which in this case was two terms; adequate food and breastfeeding.

There are three approaches within qualitative content analysis which are: conventional, directed or summative approach (Hsieh & Shannon, 2005). The analysis was a flexible way of analysing the textual data and was a subjective interpretation by the researcher throughout the process of gathering, categorizing and identifying themes. A theory about how the food environment in Norway promoted breastfeeding was formed prior to the start of the research due to existing documents on the topic. The goal of the chosen approach was to validate the use of the human rights framework to advocate for infant rights and confirm/disconfirm the theory that;

Norway has a facilitative food environment which encourages, supports and protects the act of breastfeeding but does not consider breastfeeding as a human rights issue.

Existing documents on the topic of breastfeeding helped form the research questions, which served as an aid in the process of categorizing the highlighted paragraphs from the human right instruments. A summative content analysis was used in this thesis. The approach was conducted by identifying and quantifying a word (breastfeeding) and a term (adequate food) in the text with the purpose of understanding the underlying content. The early stages of the content analysis could seem quantitative but the words were used as an indicator to explore the content of the highlighted principles (Hsieh & Shannon, 2005). The summative approach had a latent meaning, that was a referral to the process of interpretation (Zhang & Wildemuth, 2005).The focus on using this type of analysis was to find the underlying meaning of the term and word, in order to explore the content of the document. The themes derived from the text lead to an interpretation of the content (Hsieh & Shannon, 2005).

The content analysis identified breastfeeding and adequate food mentioned in the human rights instruments selected in Appendix. A Table 1. The articles from the documents were extracted that mentioned the breastfeeding and/or adequate food.

E.g. Art. 24*"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 breastfeeding, hygiene and environmental sanitation and the prevention of accidents" (CRC, 1989).

The article provided a basic insight of the content surrounding the chosen word: breastfeeding, which was highlighted. The content was then summarized to a theme;

"…are informed, have access to education, and are supported in the basic knowledge of child health and nutrition, the advantages of breastfeeding…".

The theme selected based on the content of the article was: Information about breastfeeding.

All articles which mentioned breastfeeding and/or adequate food was highlighted, categorized into groups and provided a theme in order to explore the underlying content

4.0 Results

4.1. Human Rights Framework

4.1.1. Human Rights Instruments in Norway

Covenants and conventions are legally binding human right instruments (Oshaug et al., 1994). Norway has undergone a formal process that established them as a State Party of the human right framework with corresponding obligations (Eide & Kracht, 2005). The formal process started by the State signing the document which showed an intent that they would ratify the instrument. The subsequent ratification status of the human right document binds the State as a State Party under the framework which entails that the State has certain obligations to uphold that are stated in the various instruments. The aim of ratification is that the State Party will implement the principles from the human right instrument at national level.

4.1.2. Breastfeeding and adequate food as an explicit right under the human right framework

It was vital to establish a clear link of breastfeeding as a feeding practice in relation to the human right instruments included in the content analysis, in order to discuss the act as a human right based approach. Only human right documents which had been signed and ratified were included in the content analysis, which established the State as a duty-bearer. The State has to uphold the principles stated in the documents they have ratified. The explicit mentioning of adequate food and breastfeeding established the infants claim under the human right framework (Table. 1). The explicit mentioning of breastfeeding and adequate food was searched for in the selected documents below.

Table 1. The Human Right Instruments and the explicit mentioning of breastfeeding and adequate food

Human Right Instruments	The explicit mentioning of breastfeeding	
	YES	NO
International Convention on the Elimination of All Forms of Racial Discrimination (UN, 1965)		X
International Covenant on Civil and Political Rights (UN, 1976)		X
International Covenant on Economic Social and Cultural Rights (ICESCR, 1966)	X	
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)		X
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN, 1987)		X
Convention on the Rights of the Child (CRC, 1989)	X	
Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty (UN, 1991)		X
Optional Protocol on the Convention on the Elimination of All Forms of the Discrimination of Women (UN, 2000)		X
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (UN, 2002b)		X
Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UN, 2006)		X
Convention on the Rights of Persons with Disabilities (UN, 2008)	X	
Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (UN, 2002a)		X

4.2. Breastfeeding recommendations in Norway

The Norwegian health department recommends that the infant should be exclusively breastfed for the first 6 months of life which is aligned with the recommendation by the WHO. The health department gives general recommendations for infant feeding and advise health care personnel to adapt their recommendation if necessary to cater to the developmental needs of the infant, noting differences between families (Helsedirektoratet, Undated). The recommendations are as follow;

> *"Breastmilk is the best food for the infant, and the child can safely receive only breastmilk for the first six months, with vitamin D supplement, if the child and mother thrive with it".*
>
> *"If there is a need for food other than breastmilk, breastmilk substitute is the only option for the first four months".*
>
> *"If there is a need for more food than breastmilk after the child is four months old, then solid foods should be introduced".*
>
> *"When the child is six months old, it should have other foods in addition to breastmilk/breastmilk substitute".*
>
> *"The child should if possible have breastmilk throughout the first year of life and readily longer if the child and mother are comfortable with it"*
>
> (Helsedirektoratet, Undated).

4.3. Policy level and implementation in Norway

Norway has implemented several health initiatives, policies and legislation that supports, promotes and protects the act of breastfeeding. The list below shows some of the national and intergovernmental policies which have been implemented in Norway which support the fact that breastfeeding is recommended as the main feeding practice. A comprehensive list of all the health policies implemented in Norway was not stated, but the aim of the various policies and initiatives listed confirms the general norm that infants should be breastfed.

4.3.1. National and intergovernmental policies in Norway

- ✓ The Ombudsman for Children
- ✓ The Baby Friendly Hospital Initiative in Norway
- ✓ The International Code of Marketing of Breast-milk Substitute
- ✓ International Labour Organisation (ILO)

- ✓ Agenda for the Sustainable Developmental Goals

4.3.2. The Ombudsman for Children

Norway was the first country to have an Ombudsman for Children (Barneombudet, Undated). The role of the Ombudsman is to be an advocate for children and young people and is responsible to "Ensure that legislation relating to the protection of children`s interests is observed, including Norwegian law and administrative routines are in accordance with Norway`s obligations according to the UN Convention on the Rights of the Child" (Ombudsman for Children, 1981). Even though the person holding the post is appointed by the King, it is an independent body that works solely for the rights of the child and has certain affiliations to the Norwegian Government. The Convention on the Rights of the Child is one of the human rights documents which explicitly mentions breastfeeding, and is implemented into Norwegian law, so the Ombudsman has certain obligations to advocate for breastfeeding as a source of adequate food.

4.3.3. The Baby Friendly Hospital Initiative in Norway

The Baby Friendly Hospital Initiative (BFHI) was launched in 1991 by the WHO and UNICEF as a global effort to protect, promote and support breastfeeding (WHO & UNICEF, 2009). The BFHI was a response to the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO & UNICEF, 1990). They had a vision that to obtain "…a global goal for optimal maternal and child health and nutrition, all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breast milk from birth to 4-6 months of age" (WHO & UNICEF, 1990). The Innocenti Declaration was adopted at the WHO/UNICEF policymakers meeting on "Breastfeeding in the 1990s: A Global Initiative" (UNICEF, 2005). The aim of the BFHI is "To implement the Ten Steps to Successful Breastfeeding and to end the distribution of free and low-cost supplies of breastmilk substitutes to health facilities". All hospitals and health facilities that are under the BFHI have an obligation to comply with all the provisions under The International Code of Marketing of Breast-milk Substitute (The Code) (WHO, 1981).

The Baby-Friendly Initiative was launched in march 1993 in Norway (Hansen et al., 2012). The aim of the BFHI was to increase breastfeeding rates in Norway. The BFHI has been implemented at hospitals, neonatal wards as well as maternal and child health centres in the Community Health Services in Norway. 43 out of 53 birthing units have been designated Baby-Friendly. The rate of exclusively breastfed infants increased from1992 to 1997,

probably due to the implementation of the BFHI. Over 90% of all infants are born at designated Baby-Friendly birthing units in Norway (Hansen et al., 2012).

4.3.4. The International Code of Marketing of Breast-milk Substitutes

In 1981 the WHO adopted The International Code of Marketing of Breast-milk Substitute "The aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (WHO, 1981). Norway has few provision of the Code made into law (WHO et al., 2016), but all BFHI facilities has to comply with The Code, as stated above, the BFHI has been implemented with the support by the Health Directorate.

4.3.5. Ten Steps to Successful Breastfeeding

In 1989 UNICEF and WHO issued a joint statement "Protecting, promoting and supporting breast-feeding: the special role of maternity services". The document presented Ten Steps for Successful Breastfeeding, these steps are principles that are implemented in order to encourage, promote and protect breastfeeding as a feeding practice under the BFHI. The statement focuses on two key points: The role of health services in protecting and promoting breastfeeding, and providing mothers with information and support. The Ten Steps for Successful Breastfeeding forms the basis of the Baby-Friendly Hospital Initiative, so all hospital and healthcare facilities that are under the initiative has to implement these steps.

4.3.6. International Labour Organisation

Norway has been a member of the International Labour Organization (ILO) since 1919 and have implemented several acts, that protect the maternal and paternal rights amongst other provisions (International Labour Organization, 1996-2017). In total, 1287 provisions from the ILO has been implemented in Norway. Some of the acts from the maternity protection of the ILO is shown in Appendix. C Table. 3. The mother is one of two groups which was mentioned in the UDHR that needed special attention and protection. The implementation of the provisions from the ILO is an effort to protect the fundamental rights of the woman which promote equality in Norway. The aim of the ILO is "to promote rights at work, encourage decent employment opportunities, enhance social protection and strengthen dialogue on work-related issues" (International Labour Organization, 1996-2017). In 1946, the ILO became the first specialized agency of the UN and is the only tripartite UN agency.

4.3.7. Sustainable Development Goals

The Agenda for Sustainable Development and its 17 Sustainable Development Goals was adopted in 2015. The Agenda is a plan of action with 169 targets that aim to "…end poverty and hunger, in all their forms and dimension, and to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment" (General Assembly, 2015). Breastfeeding is considered to be a way of achieving some of the goals of the Agenda, and Norway has signed the agreement to complete these goals by 2030

5.0 Discussion

5.1. The Human Right Framework

5.1.1. A human right based approach to development

Until the late 1980s development and human rights where considered to be two different issues which were not interrelated (Filmer-Wilson E, 2005). The notion of the dichotomous nature of this ideology was evident in the 1948 Universal Declaration of Human Rights which drafted two separate legally binding documents, the Covenant for Civil and Political Rights and the Covenant for Economic, Social and Cultural Rights (UN, 1948). Traditionally development was viewed in light of economic growth providing wealth and human development, but this was not apparent after the Cold War which saw a rapid growth in international trade and investment paving the way for globalisation, but causing wealth disparities, health inequality and food insecurity amongst the people (Filmer-Wilson E, 2005). Economic growth was therefore not an adequate measure to ensure human development during this period.

In 1986, the General Assembly of the UN adopted the Declaration on the Right to Development (UN, 1986b). The Declaration stated that "The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized" (UN, 1986b). The linkage between development and human rights was reaffirmed at the 1993 World Conference on Human Rights held in Vienna "Democracy, development and respect for human rights and fundamental freedoms are interdependent and mutually reinforcing" (UN, 1993).

Today human rights are acknowledged in most developmental works and are considered to be a solution to alleviate health inequality, achieve equity and end discrimination suffered by some marginalised groups. The Ministry of Foreign Affairs in Norway submitted in 2014 a white paper that stated the fact that "The Government will intensify its efforts to promote

respect for human rights, not least in the light of the ever more complex challenges the world is facing" (Norwegian ministry of foreign affairs, 2014). The statement of Common Understanding confirms the fact that "All programmes of development co-operation, policies and technical assistance would further the realisation of human rights as laid down in the Universal Declaration of Human Rights and other international human rights"(OHCR, 2006).

5.1.2. A Human Rights-based approach to health

The aim of a human rights-based approach (HRBA) to health is to support sustainable development by analysing outcomes (inequality, discriminatory practices and unjust power relations) that are the cause of developmental problems (WHO, Undated). One of the core principles of the HRBA is to eliminate all forms of discrimination, in this thesis this was a matter relating to women's rights. The common understanding of a human rights based approach are divided into three: goal, process and outcome.

Table. 2 The UN Common Understanding on a Human Rights-based Approach

The UN Common Understanding on a Human Rights-based Approach		
GOAL	PROCESS	OUTCOME
"All programmes of development cooperation, policies and technical assistance should further the rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments"	*"Human rights standards and principle guide all development cooperation and programming in all sectors and phases of the programming process"*	*"Development cooperation contributes to the development of the capacities of duty-bearers to meet their obligations and/or of rights-holders to claim their rights"*

Table. 2 adapted from A human rights-based approach to health (WHO, Undated).

The act of sustainable development, in this regard, was the infants right to an adequate standard of living through the provision of adequate food (breastmilk). The program assessed was the BFHI in Norway and the ratification of human right instruments. Norway has used human rights in their foreign and development policy, in addition, several human right principles have been adopted into the Norwegian constitution. The State has also signed and ratified several human right documents which should be an integral part of all policy formation. Considering the stance, the Norwegian government has towards human rights in

their governance, breastfeeding in view of this approach was therefore a natural choice to highlight the rights of the infant.

5.2. The Human Rights Framework and the State

The member States of the United Nations General Assembly affirmed the UDHR in Paris 1948, which states the fact that every individual have fundamental human rights (UN, 1948). The Declaration is not a legally-binding agreement, but can however be regarded as a morally binding document, with subsequent obligations that should be upheld by the State (Singh, Govender, & Mills, 2007). The UDHR was the first human right document which mentioned food as a part of an adequate standard of living (UN, 1948). The State has an obligation to respect, protect and fulfil fundamental human rights under the human right framework (UN & FAO, 1999). The obligation to fulfil also incorporates an obligation to facilitate and provide (Eide & Kracht, 2005). The State is not physically able to provide breastmilk for the infant, but they are obligated to facilitate pre- and post-natal care which ensures that the mother`s rights are respected, that she is informed about the advantages of breastfeeding and facilitates food environments that promote the act of breastfeeding (CRC, 1989).

International human right instruments can be used as a tool to enforce the right to health for individuals and communities (Singh et al., 2007), in this case the right to health of the infant is discussed through the provision of breastmilk. The country's ratification status affirms the obligations of the State to realize the rights of their citizens. If the State fails to realize these rights they can and should be held accountable. Human rights instruments such as the ICESCR, CEDAW and CRC are legally-binding human right documents which have been signed and ratified by the State (CEDAW, 1979; CRC, 1989; ICESCR, 1966). In total Norway has signed and ratified 13 different human right instruments (fig.2) and the Constitution affirms the fact that "The authorities of the State shall respect and ensure human rights as they are expressed in this Constitution and in the treaties concerning human rights that are binding for Norway". The right to adequate food has been stated in some of the human right documents Norway has ratified.

The infant is the right-holder that has a claim to adequate food (breastmilk), the State as a duty-bearer is obligated to assure that this right is realized by facilitating conducive food environments of which the infant dwells and the agent of accountability, which could be the Ombudsman, has a duty to ensure that the State does everything to the maximum extent of their ability to realize the infants right to adequate food.

5.3. Accountability under the Human Right Framework

The term accountability clarifies who shall be responsible for the various actions that should be implemented that realize the fundamental human rights of people (OHCHR, 2013). Under the human right framework, the agent which is responsible for realizing the rights of the citizen are termed as a duty-bearer and their obligations are clearly stated in the various instruments (fig.1). An accountability framework should be implemented based on human right principles to ensure that the rights of individuals are met, if the State fails to meet their obligations (act of omission) the accountability mechanism could/should be used. There are several agents that have a shared responsibility for the human development, which are institutions, private sectors and civil society. It is therefore important to differentiate the different responsibilities of the various actors. The human right framework clearly states the State as the responsible agent (main duty-bearer) for facilitating good food environments. The accountability mechanism could also be used to identify which policies that are working, or identify failures that need to be addressed (OHCHR, 2013).

A way of strengthening policymaking is by making it a legal imperative. The explicit mentioning of breastfeeding and adequate food in the human right document make it possible for agents such as the Ombudsman to advocate for the rights of the infant, and the woman can claim that the State should facilitate the environment, by measures such as nursing breaks in order to breastfed their child during working hours. This has been implemented in Norway.

The term accountability can be divided into three dimensions; responsibility, answerability and enforceability (Swinburn et al., 2015). The authority is responsible to establish well-functioning public establishments that are transparent and objective in their practices. The information about the advantages of breastfeeding as a feeding practice is made available to all mothers by healthcare practitioners, through the implementation of the BFHI.

However, accountability can be undermined if the responsibilities are not clearly stated between the various actors (Hansen et al., 2012). Accountability has both a corrective and preventative function. When well-functioning mechanisms are established it makes it easier to identify problems and/or failures within the systems so that corrective measures can be implemented. The Norwegian government has implemented the BFHI, an initiative that does not only comprise of hospitals but also maternal and child health centres under the Community Health Services that has an aim of encouraging breastfeeding. The challenges that occurred during the implementation of the initiative was quickly addressed due to the fact

that the responsibility was clearly defined between the Norwegian Competence Centre for breastfeeding and the government (Hansen et al., 2012).

5.4. The International Code of Marketing of Breast-milk Substitutes

In some countries the marketing of breast-milk substitutes undermined the benefits of breastfeeding as a feeding practice (WHO, 1981), and as a result there was an increase in the rate of bottle-feeding and introduction of solid foods at an earlier age than recommended (Piwoz & Huffman, 2015). The International Code of Marketing of Breast-milk Substitute was adopted by the World Health Assembly in 1981, as a response to the rise of child mortality due to the promotion and use of breastmilk substitute (Piwoz & Huffman, 2015; Rollins et al., 2016; WHO, 1981). Norway has few provisions of The Code implemented into law, but they are obligated to comply with the provisions stated in The Code due to the BFHI which has been implemented. In countries where breastfeeding is protected, promoted and supported through policies and initiatives, mothers are more likely to breastfeed their children (Piwoz & Huffman, 2015).

It is stated that "The availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture" should be provided to individuals (UN & FAO, 1999). A large number of the world's population lacks safe and clean drinking water which could result in the infant being exposed to adverse substances due to the fact that breastmilk substitutes are mixed with water, resulting in an increased risk of adversely affecting the infant's health due to contamination (UNICEF & WHO, 2015). The access to clean and safe drinking water is not a concern of infants in Norway, because approximately 90% of the population have access to water from waterworks that have been approved and registered in the Waterworks Register, that checks if the water is safe for consumption (Norwegian Institute of Public Health, 2017).

The statement that "Baby formula is as good as breast milk" is a highly controversial statement that has been the cause of debate worldwide. The notion that breastmilk and breastmilk substitutes are equal in terms of nutritional value has been researched and debunked (Ballard & Morrow, 2013). However, breastmilk contains environmental pollutants (Norwegian Institute of Public Health, 2016). Organic pollutants are found mainly in food and can be excreted in breastmilk. Norway has been a part of the World Health Organizations breast milk monitoring programme that analyses breastmilk samples that provide information about which pollutants the infants are exposed to. There has been a significant decrease of the amount of environmental pollutants found in breastmilk, the levels of dioxins has decreased

by almost 70% (Norwegian Institute of Public Health, 2016). Although breastmilk contains environmental pollutants it is still recommended that the infant should be breastfed (Nickerson, 2006).

6.0. Approaching breastfeeding as a human right

6.1. Adequate food and health

"The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and the continuous improvement of living conditions." (ICESCR, 1966). The term adequate food was clarified by the global society which adopted General comment no.12, the Right to Adequate Food (art. 11) which states that "The right to adequate food is realized when every man, woman and child, alone or in community with others, has the physical and economic access at all times to adequate food or means for its procurement" (UN, 1999). However, "The right to adequate food shall therefore not be interpreted in a narrow or restrictive sense which equates it with a minimum package of calories, proteins and other specific nutrients" (UN, 1999). Accessibility and availability are key terms relating to adequate food, which are two of the four main dimensions of food security. "Food security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meet the dietary needs and food preferences for an active and healthy life" (FAO, 2006). Malnutrition is an effect of the infant being food insecure. To prevent food insecurity of the infant it is vital to know the causes of malnutrition which is a state of undernutrition or overweight (WHO, 2016).

Figure. 2 UNICEF`s Conceptual framework of malnutrition

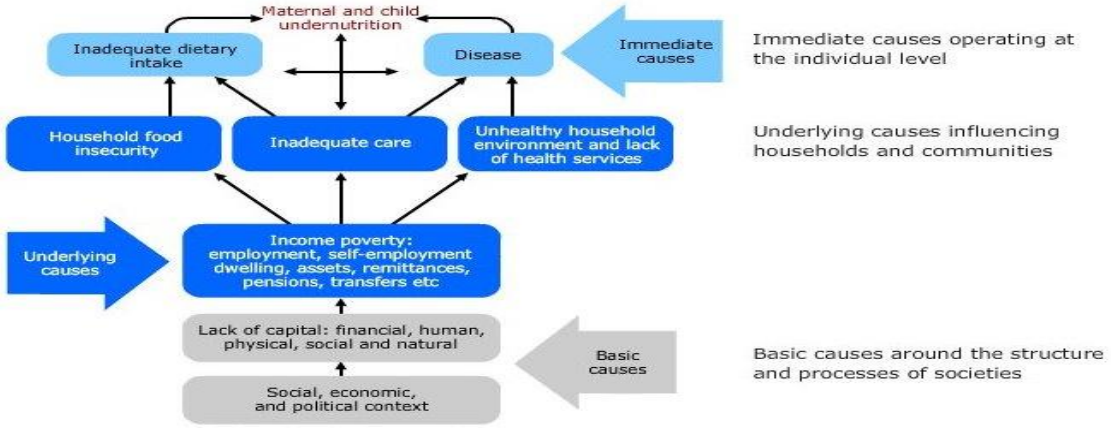


Figure. 2 The Conceptual framework is modified by Black et al, Lancet 2008 (UNICEF, Undated).

The conceptual framework provides a holistic perspective of how the different causes are interconnected which determine the nutritional environment of the infant. The framework has been used by different agencies in policy planning (Oshaug et al., 1994). The framework could be adapted to have adequate food (breastmilk) as a goal to achieve good health of the infant. The causes stated in the framework will therefore be conditions that must be fulfilled to achieve the optimal development and health of the infant. The basic and underlying causes of the framework are the same determinants that facilitate a good or bad food environment, which is the responsibility of the State to realize.

6.2. Breastfeeding as a right to adequate food

Breastmilk is a natural source of food for the infants that is needed for the optimal growth of the child (Ballard & Morrow, 2013; Victora et al., 2016). The benefits of breastfeeding are not limited to the infants' health but also affect the maternal health (Aaltonen et al., 2011). The mother and child have a lower risk of adversely affecting their metabolic health due to the fact that breastfeeding is practised. The "Dietary needs imply that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation. Measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns, including breast-feeding, while ensuring that changes in availability and access to food supply as a minimum do not negatively affect dietary composition and intake" (UN & FAO, 1999).

Breastmilk has all the nutrients needed for the infants' development, and the nutritional composition changes throughout the different developmental stages of the infant (Ballard & Morrow, 2013). In comparison, breastmilk substitutes has a standardized nutritional profile which lack certain bioactive components and the nutritional composition cannot be altered (Heymann et al., 2013). The implications that breastmilk can be a source of adequate food is viable. The notion that breastmilk is a right of the child is not discussed in this paper, but how breastfeeding can be used as a human right based approach to realize the infants right to adequate food through the administration of breastmilk.

The Norwegian health department is responsible to address and safeguard the health of their citizens, and the recommendations for infant nutrition forms the basis of what is considered as adequate food for the infant by the State. General comment no.12 The Right to Adequate food states that "if children's food does not contain the nutrients necessary for their physical and

mental development, it is not adequate" (UN & FAO, 2010). Under certain instances breastmilk substitutes can be deemed inadequate, while breastmilk is considered as the most optimal source of food for the infants globally and in Norway.

Almost all mothers are biological capable of producing breast-milk (Rollins et al., 2016). But if the mother chooses not to breastfeed her infant or has a medical condition which makes breastmilk an unsuitable choice for the infant's nutrition, the access and availability of breast-milk is therefore void and the only other available source for food is breastmilk substitutes. People have "…the fundamental right…to be free from hunger and malnutrition" (ICESCR, 1966). Breastmilk substitutes can be a source of adequate food if it is administered properly and could therefore prevent undernourishment and malnutrition in certain instances, but as stated previously breastmilk is a more suitable option for the infants nutrition and it is the general consensus that infants should be breastfed if possible (Piwoz & Huffman, 2015).

Table. 3 The agents responsible for the infants right to adequate food

Agents responsible for a conducive food environment for adequate food for the infant
1. The infants right to adequate food (breastmilk)
2. The mother as the main provider of adequate food
3. The act of breastfeeding supported and encouraged by the father
4. Breastfeeding supported by community, extended family, non-governmental organizations, health departments
5. Conducive food environments that promotes, support and protect breastfeeding as a norm by government, health department, policies, hospitals

Adapted from: Rings of responsibilities by George Kent (Kent, 2008).

The agents responsible for the infant's right to adequate food is interconnected. The first line of responsibility lies with the mother, which is responsible for producing breastmilk and feeding the child. The father is at the second line of responsibility, which can be viewed as being supportive of the woman while breastfeeding or could also be the act of feeding the infant with breastmilk through the practice of bottle-feeding. If the parents fail to meet their

responsibility to provide adequate food to the infant, the responsibility is then "transferred" to the next ring of responsibility. In Norway, community based health care facilities are under the BFHI, which promotes the act of breastfeeding. The facilities are therefore obligated to give information about the advantages of breastfeeding, provide support to the family that is struggling with giving their infant adequate food, and having the infant's health as the primary concern in all actions. All infants born in Norway are called in for regular check-ups by the community health services. The State has implemented the Baby-Friendly Initiative that promotes and encourages the act of breastfeeding, and since more than 90% of infants are born in these facilities one could say that the primary duty-bearer of ensuring that the infant is breastfed lies with the State, that has facilitated the food environment which promote breastfeeding.

6.3. Determinants for breastfeeding

6.3.1. Hormones as determinants for breastfeeding

Hormones are a determinant for the initiation of breastfeeding, e.g. testosterone. (NTNU, 2010). Before the 1800s androgens was used for lactation inhibition (Carlsen, Jacobsen, & Vanky, 2010). An association between breastfeeding and androgens have been found in a study where breastfeeding was negatively associated with second trimester androgen levels (Carlsen et al., 2010). This implied that pregnant women who had higher levels of androgens breastfed their infants less. It's a known fact that women that smoke, are obese or have polycystic ovary syndrome breastfeed less and have higher levels of testosterone during pregnancy (Carlsen et al., 2010). The implication is that the initiation and duration of breastfeeding is not a matter of a will to breastfeed their infants, but an effect due to the hormone(s) that inhibits breastfeeding.

6.3.2. Food environments as determinants for breastfeeding

The food environment is multi-levelled and complex, and there are some implications of each feeding practice that is available for the infant (Helsedepartementet). Breastmilk substitutes comes with an environmental and economic cost, through the production and preparation of the product. There are certain conditions that need to be established in order for breastmilk substitutes to be adequate: the access to clean and safe drinking water is essential, as well as having a hygienic environment for the preparation of the food. Another factor to consider is the family's financial capacity to purchase the product. On the other hand, breastmilk is a cost-free commodity, that is both accessible and available for the infant in most instances. But there is only one person that can produce breastmilk, which is the mother. The State cannot

impose that the woman is obligated to breastfed her child, so it becomes a matter of choice for the mother if the child is breastfed.

6.4. The mother's freedom of choice

There are many factors that can affect the mothers choice makes regarding the feeding practice she chooses for her infant (WHO, 2014). It has been shown that the food environment affects the mother's decision to breastfeed her infant (Glanz, 2009; NTNU, 2010). If the mother is part of a conducive food environment which promotes breastfeeding as a feeding practice, she is likely to breastfed her child (Helsedepartementet; Victora et al., 2016). The State has an obligation "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 breastfeeding, hygiene and environmental sanitation and the prevention of accidents" (CRC, 1989). The infant has no power of influence to affect the mother's choice. However, health care practitioners are obligated to inform the mother about the advantages of breastfeeding. "In all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration". According to the Norwegian health department breastfeeding is considered as a human right for the mother and the child, and the State has ratified human right instruments which explicitly mentions breastfeeding (Häggkvist, Tufte, Hansen, Heimli, & Hay, 2011).

7.0. Policy level and implementation in Norway

7.1.1. The implementation of the Baby Friendly Hospital Initiative in Norway

The implementation of the Baby-Friendly Hospital Initiative (BFHI) in Norway was funded by the Directorate of Health (Hansen et al., 2012). The Norwegian Resource Centre for Breastfeeding is responsible for the external assessment of the BFHI (The Norwegian Government, Undated). The Ten Steps for Successful Breastfeeding was altered to suit the needs of Norwegian mothers after its implementation (Hansen et al., 2012). In 2004, the BFHI expanded to the neonatal intensive care unit, and in 2005 the BFHI also included maternal and child health services in the Community Health Services. The State has to "…in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing". (United Nations General Assembly, 1989). Even though the

implementation of the BFHI was funded by the Directorate of Health, the Norwegian Resource Centre for Breastfeeding does not get allocated money from the Norwegian government, which is a direct violation of the article mentioned above. The State as a duty-bearer under the human rights framework has an obligation to "undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention…" and " …shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation" to fulfil their obligations (CRC, 1989).

7.1.2. The Ombudsman for Children

The Ombudsman for Children is responsible to ensure that the State is upholding its responsibilities under the CRC (Ombudsman for Children, 1981). "For the purpose of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". The definition of a child includes the infant, therefore the Ombudsman is obligated to advocate for the right to adequate food for infants as stated in the document (CRC, 1989). The CRC is one of the human rights instruments which explicitly mentions breastfeeding as a feeding practice (CRC, 1989). And "In all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration" (CRC, 1989). The Convention clearly states the responsibilities that lies within the State to have a special focus on children. The Ombudsman, as a third party, has the power of advocacy to influence policy makers regarding the implementation of policies that "… ensure to the maximum extent possible the survival and development of the child" (CRC, 1989) in specific nutrition specific policies that involves the right to adequate food for infants.

8.0. Law and policy implementations in Norway regarding breastfeeding

8.1. Gender roles and equality in Norway

The most common profession for Norwegian women during the time period 1900-1946 was housekeeping (Hagemann, 2015c). This line of work supported the fact that the women's place was in the household, responsible for the maintenance of the home and upbringing of the child. For many decades the home was the most important and only workplace for more than half of all adult women in Norway (Hagemann, 2015b). The housewife period in Norway was a term used for married women during the first decades after World War 2, from 1945-

1970 (Hagemann, 2015b). Most women became fulltime housewives after they conceived their first child. Norway experienced a rapid developmental growth after World War 2, with an increase of household appliances production that reduced the need for help at the home. The woman became more self-reliant, resulting in housekeeping as a profession became redundant. However, the economic growth gave rise to strengthened government regulations, which resulted in welfare systems being built (Equally, 2015).

Also, during the late 1960s there was a shift in attitudes amongst women in the society, that gave rise to feminism (Hagemann, 2015d). The women's movement fought for the right to education amongst other equal opportunities in politics and society (Hagemann, 2015c). The State was obligated to take appropriate measures "To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customs and all other practices which are based on the idea of the inferiority or the superiority of either sexes or on stereotyped roles for men and women" (CEDAW, 1979). More women were eager to enter the workplace, because the societal norm of gender specific roles had changed. As a result, women's participation into the labour force increased, but a subsequent effect resulted in lower fertility rates in the country. However, the establishment of public child welfare and maternity leave resulted in an increase in fertility rates (Hagemann, 2015a). The human right framework states that the right to work is "an inalienable right of all human beings" (UN, 1948).

"In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work" (CEDAW, 1979), States parties shall take appropriate measures:" "To introduce maternity leave with pay or comparable social benefits without loss of former employment, seniority or social allowances" (CEDAW, 1979). The Convention on the Elimination of All Forms of Discrimination was adopted in 1979 and it emphasises "the maximum participation of women on equal terms with men in all fields" (CEDAW, 1979). Norway has been a member of the International Labour Organization since 1919, and several maternity protection provisions have been implemented into Norwegian law which secures the woman's right to work (International Labour Organization, 1996-2017). The State has therefore realized its obligation "To adopt appropriate legislative and other measures" that protects the women against any form of discrimination at the workplace (CEDAW, 1979).

8.2. Parental leave

"States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child" (CRC, 1989) because "…the upbringing of children requires a sharing of responsibility between men and women and society as a whole…" (CEDAW, 1979). Norway was early in the implementation of parental leave that secures both the maternal and paternal rights to take care of their infant without repercussion due to their employment or other discriminatory factors (Schou, 2017). The Norwegian system regarding parental leave is flexible and is considered to be one of the best in the world (Chris Weller, 2016), but there are certain limitations to the framework. "The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interest of the children shall be paramount" (CEDAW, 1979). The best interest of the child is ensured through the act of breastfeeding, but that is a feeding practice which is provided by the mother, so the responsibilities and rights are skewed in relation to the article mentioned above, because the father does not have the ability to biologically produce breastmilk, therefore he does not have the same responsibility as the mother.

The State is obligated "in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing" (CRC, 1989).

8.2.1. Paternity leave

Since 1978, fathers had the opportunity to take paternity leave, but there were few that used the scheme (Schou, 2017). The duration of paternal leave has changed throughout the years, from 4 weeks in 1993 to 14 weeks in 2014 and is now at 10 weeks in 2017 (Schou, 2017). Norway was the first country to implement the paternity quota in 1993, which is an explicit right of fathers. If the father does not claim this right, the weeks assigned to him will be forfeited. There are two ways of transferring the paternal quota to the mother, i.e. if the mother has the sole responsibility of the child or the father does not have the right to parental benefits (NAV, 2017a). However, the father is only entitled to the paternal quota if the mother has accumulated parental benefit rights. Special rules for parental benefit paid to the father can be claimed if certain conditions are fulfilled (NAV, 2017b).

8.2.3. Maternity leave

"States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period…as well as adequate nutrition during pregnancy and lactation"(CEDAW, 1979) and "Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits" (ICESCR, 1966) . The maternal quota is at 10 weeks, but 6 weeks of the quota has to be used immediately after birth due to medical reasons. Also 3 weeks of the shared parental quota is reserved for the mother to be used prior to the due date (NAV, 2017a). The Norwegian government has implemented legislation that protects the mother's rights. The State recommends that the infant should be exclusively breastfed for 6 months, so the mother should have 24 weeks of maternity leave after child birth that is entitled to her in order to be able to exclusively breastfed her infant.

The State has an obligation "To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children…". The legislation of parental leave and the maternal quota takes into consideration the role of the mother. The ILO also safeguards the mother's rights at the workplace "To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave…" (CEDAW, 1979). Also, the State has "To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances" (CEDAW, 1979), this right is protected under Norwegian law, through ILO and maternity protection (ILO, 1999; NAV, 2017a).

9.0. Human Rights and health policies

Fundamental human rights have not been used in forming health policies and programmes, even though most human right documents mentions these terms they do not form the basis in the development of nutrition specific policies in Norway (Oshaug et al., 1994). The State has ratified some human rights instruments into national law and are therefore obligated under both national and international law to follow these principles. The term adequate food and health have been widely discussed from the first time it was mention in the Universal Declaration of Human Rights which states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services..." (UN, 1948). Food is no longer viewed as the mere accessibility and availability of food but takes into the consideration the

multi-levelled factors which forms the food environments that are determined by the economic, physical, social, political and cultural surroundings (Swinburn et al., 2015; Vandevijvere et al., 2015).

The question that comes to mind, is how can the human right framework be used to secure the right to food for infants? Ensuring that all citizens have access to adequate food is a primary concern of the government. “The human being is the central subject of development and should be the active participant and beneficiary of the right to development”(General Assembly, 1986). Also, “All human beings have a responsibility for development, individually and collectively, taking into account the need for full respect for their human rights and fundamental freedoms as well as their duties to the community, which alone can ensure the free and complete fulfilment of the human being, and they should therefore promote and protect an appropriate political, social and economic order for development” (General Assembly, 1986). The States obligations are divided into three levels as mentioned previously: they are obligated to *respect* the mothers’ freedom of choice of what she considers to be adequate food for her infant, *protect* the infants right to adequate food through legislation and facilitative food environment and last an obligation to *fulfil* (facilitate and provide) the basic needs and rights of the mother and child. The State shall provide pre- and post-natal care for the mother and information about the advantages of breastfeeding shall be given, which is stated in the human right documents.

An individual has the responsibility to take necessary measures to use the available resources individually or collectively to ensure the fulfilment of their needs that is provided by the State. The State must respect this freedom of the individual(s). The available resources have to be protected by the State to ensure that all citizens have access, most important is the availability of food. The last obligation of the State is to fulfil which incorporates the obligation to facilitate and provide the right to food, health and nutrition which are the aspects discussed surrounding food environments taking into consideration that “Motherhood and childhood are entitled to special care and assistance” (UN, 1948).

The following statement sums up the infants right according the factors mentioned in the thesis on how to achieve an adequate standard of living with access to adequate food “Care is the provision in the household and the community of time, attention and support to meet the physical, mental and social needs of the growing child and other family members. It leads to the optimal use of human, economic and organisational resources. Particularly in the context

of child nutrition, care allows for the best use of household food resources for feeding of children. It implies the effective use of resources to protect children from infection, to attend to a child during illness and to assist others who may be unable to care for themselves because of disability or old age. More generally, care includes nurturing full psychological and emotional wellbeing. These are goals in themselves, and in turn they can benefit nutrition and health" (Gillespie and Mason, 1990; FAO/WHO, 1992a).

10. Conclusion

3.2.1. Human Right Framework

1. *Which human rights instruments has Norway signed and ratified?*

Norway has signed and ratified 11 different human right instruments. The different instruments were stated in Table.1.

   a. *Does Norway have any obligations to protect, promote and support breastfeeding under the human rights framework?*

The Norwegian government has an obligation to protect, promote and support breastfeeding under the human rights framework since breastfeeding has been explicitly mentioned in different human right documents.

2. *Which human rights instruments has a reference to breastfeeding?*

The Convention on the Rights of the Child, The International Covenant on Economic, Social and Cultural Right, and the Convention of the Rights of persons with Disabilities.

   a. *Is breastfeeding mentioned as an explicit right for the infant?*

Breastfeeding is not mentioned as an explicit right for the infant under the human rights framework, but the State is obligated to inform parents about the advantages of breastfeeding.

3.2.2. Policy level and implementation in Norway

Norwegian policies and laws on breastfeeding

1. *What are the recommendation for breastfeeding in Norway?*

The Norwegian Health Departments recommends that the infant should be exclusively breastfed up to 6 months.

a. *Are the recommendations aligned with WHO?*

The Norwegian recommendations for exclusive breastfeeding are the same as the recommendations from the WHO.

2. *What laws and policies have been adopted/implemented in Norway that promotes breastfeeding?*

Several policies have been implemented in Norway that promotes breastfeeding, but the Baby-Friendly Hospital Initiative, is the main initiative that was highlighted that promotes and encourage the act of breastfeeding of which >90% of infants are born in units which are designated Baby-Friendly.

3. *To what extent do Norwegian policies and laws on breastfeeding recognize breastfeeding as a human rights issue?*

The Norwegian Health department recognizes breastfeeding as a human right for the infant and mother, this is stated in a document provided by the Norwegian Health Department to mothers.

The limitations of the thesis were related to the search strategy. It is not possible to confirm with 100% certainty that all of the human rights documents that was relevant for the thesis was included, also the short selection of policies implemented in Norway that promotes breastfeeding was not optimal. The main focus of the thesis was the human rights framework which formed the theoretical background, in order to establish breastfeeding as a human rights issue. The theory that; *Norway has a facilitative food environment which encourages, supports and protects the act of breastfeeding, but does not consider breastfeeding as a human rights issue,* was incorrect. Norway has a conducive, facilitative food environment which supports, protects and promotes the act of breastfeeding, but the Norwegian health department also recognizes breastfeeding as a human right for infants and the mother.

However, the human right framework is not used in forming health policies in Norway. The thesis highlighted the importance of human rights principles in Norwegian governance, and breastfeeding is explicitly mentioned as human right in a health document provided by the Norwegian Health department, which is given to all Norwegian mothers. The State has not taken appropriate measures in supporting the BFHI in Norway. The responsibility of the implementation and assessment of the initiative has been given to the Norwegian Resource Centre for Breastfeeding. Though the adaptation of the initiative was a collaboration between

these two parties, the State has not sufficiently met their obligation to ensure that the BFHI is successful after its implementation.

The framework should therefore be used by jurisdictional decision makers to implement nutrition specific policies that further secures the right to adequate food for infants.

References

Aaltonen, J., Ojala, T., Laitinen, K., Poussa, T., Ozanne, S., & Isolauri, E. (2011). Impact of maternal diet during pregnancy and breastfeeding on infant metabolic programming: a prospective randomized controlled study. *Eur J Clin Nutr, 65*(1), 10-19.

Ballard, O., & Morrow, A. L. (2013). Human Milk Composition: Nutrients and Bioactive Factors*60*(1), 49-74. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3586783/ doi:10.1016/j.pcl.2012.10.002

Barneombudet. (Undated). About the Ombudsman. Retrieved from http://barneombudet.no/english/about-the-ombudsman/

Carlsen, S. M., Jacobsen, G., & Vanky, E. (2010). Mid-pregnancy androgen levels are negatively associated with breastfeeding. *Acta Obstetricia et Gynecologica Scandinavica, 89*(1), 87-94. doi:10.3109/00016340903318006

CEDAW. (1979). *Convention on the Elimination of All Forms of Discrimination against Women*. United Nations Human Rights Office of the High Commissioner Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx.

Chris Weller. (2016). These 10 countries have the best parental leave policies in the world. Retrieved from

Cole, F. L. (1988). Content Analysis: Process and Application. *Clinical Nurse Specialist, 2*(1), 53-57.

CRC. (1989). *Convention on the Rights of the Child*. United Nations Human Rights Office of the High Commissioner Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

Eide, W. B., & Kracht, U. (2005). *Food and Human Rights in Development. Volume I. Legal and institutional dimensions and selected topics.* (Vol. 1). Antwerpen - Oxford: Intersentia.

Eide, W. B., & Kracht, U. (2007). *Food and Human Rights in Development. Volume II. Evolving issues and emerging applications.* (Vol. 2). Antwerpen - Oxford: Intersentia.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. doi:10.1111/j.1365-2648.2007.04569.x

Equally, L. (2015). Higher standard of living, minor differences. *1945-1970: welfare state and western turn.* Retrieved from http://www.norgeshistorie.no/velferdsstat-og-vestvending/mennesker/1803-hoyere-levestandard-mindre-forskjeller.html

FAO. (2006). *Food security*. Retrieved from http://www.fao.org/forestry/13128-0e6f36f27e0091055bec28ebe830f46b3.pdf.

Filmer-Wilson E. (2005). The human rights-based approach to development: The right to water. *Netherlands Quartely of Human Rights, 23/2*, 213-241.

General Assembly. (1986). *41/128. Declaration on the Right to Development*. Retrieved from http://www.un.org/documents/ga/res/41/a41r128.htm.

General Assembly. (2015). *Resolution adopte by the General Assembly on 25 sptember 2015. 70/1. Transforming our world: the 2030 Agenda for Sustainable Development*.

Glanz, K. (2009). Measuring Food Environments: A Historical Perspective. *American Journal of Preventive Medicine, 36*(4), 93-98. doi:https://doi.org/10.1016/j.amepre.2009.01.010

Hagemann, G. (2015a). Baby boom and fire wave. *1970-today: oil age and abundance.* Retrieved from http://www.norgeshistorie.no/oljealder-og-overflod/hus-og-hjem/1915-babyboom-og-eldrebolge.html

Hagemann, G. (2015b). Housewife Paradise. *1945-1970: welfare state and western wing.* Retrieved from http://www.norgeshistorie.no/velferdsstat-og-vestvending/hus-og-hjem/1804-husmorparadiset.html

Hagemann, G. (2015c). The maids on their way out. *1914-1940: World War 1 and the Middle-war House.* Retrieved from http://www.norgeshistorie.no/forste-verdenskrig-og-mellomkrigstiden/teknologi-og-okonomi/1611-hushjelpene-pa-vei-ut.html

Hagemann, G. (2015d). Womens liberation. *1970-idag: Older age and abundance.* Retrieved from http://www.norgeshistorie.no/oljealder-og-overflod/mennesker/1914-kvinnefrigjoring.html

Hansen, M. N., Bærug, A., Nylander, G., Häggkvist, A.-P., Tufte, E., Alquist, R., & Støre, E. G. (2012). Challenges and Successes. *Journal of Human Lactation, 28*(3), 285-288. doi:10.1177/0890334412444162

Helsedepartementet. *Report No. 16 (2002-2003) to the Storting. Short version. Prescriptions for a Healthier Norway. A broad policy for public health.* Oslo: Helsedepartementet.

Helsedirektoratet. (Undated). Nasjonal faglig retningslinje for spedbarnsernæring. Anbefalinger for morsmelk, morsmelkerstatning og introduksjon av mat.

Heymann, J., Raub, A., & Earle, A. (2013). *Breastfeeding policy: a globally comparative analysis*.

Hsieh, H.-F., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi:10.1177/1049732305276687

Hyde, K. F. (2000). Recognising deductive processes in qualitative research. *Qualitative Market Research: An International Journal, 3*(2), 82-90. doi:doi:10.1108/13522750010322089

Häggkvist, A.-P., Tufte, E., Hansen, M. N., Heimli, H., & Hay, G. (2011). *Hvordan du ammer ditt barn. Noen råd den første tiden.* Oslo: Andvord Grafisk.

ICESCR. (1966). *International Covenant on Economic, Social and Cultural Rights*. United Nations Human Rights Office of the High Commissioner Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.

IJRC. (Undated). Overview of the human rights framework. Retrieved from http://www.ijrcenter.org/ihr-reading-room/overview-of-the-human-rights-framework/

ILO. (1999). Act (No. 30 of 1999) to strengthen the position of human rights in Norwegian law (Human Rights Act). Retrieved from http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=53741

International Labour Organization. (1996-2017). About the ILO.

Ip, S., Chung, M., Raman, G., Chew, P., Magula, N. P., DeVine, D., . . . Lau, J. (2007). *Breastfeeding and Maternal Health and Infant Health Outcomes in Developed Countries* (Vol. 153).

Kent, G. (2008). *Global Obligations for the Right to Food*. United Kingdom: Rowman & Littlefield Publishers.

Lande, B., Andersen, L. F., Bærug, A., Trygg, K. U., Lund-Larsen, K., Veierød, M. B., & Bjørneboe, G. E. A. (2003). Infant feeding practices and associated factors in the first six months of life: The Norwegian Infant Nutrition Survey. *Acta Paediatrica, 92*(2), 152-161. doi:10.1111/j.1651-2227.2003.tb00519.x

Lovdata. (2008). *Forskrift om morsmelkerstatning og tilskuddsblandinger*. Lovdata.

McFadden, A., Gavine, A., Renfrew, M. J., Wade, A., Buchanan, P., Taylor, J. L., . . . MacGillivray, S. (2017). Support for healthy breastfeeding mothers with healthy term babies. *Cochrane Database of Systematic Reviews*(2). doi:10.1002/14651858.CD001141.pub5

Meltzer, H. M., Bransæter, A. L., & Haugen, M. (2014). MoBa magazine.

NAV. (2017a). Paternal quota (paternity leave), maternal quota and shared period.

NAV. (2017b). Special rules for parental benefit paid to the father.

Nickerson, K. (2006). Environmental contaminants in breast milk. *J Midwifery Womens Health, 51*(1), 26-34. doi:10.1016/j.jmwh.2005.09.006

Norwegian Institute of Public Health. (2016). Breast milk and environmental pollutants in Norway - fact sheet.

Norwegian Institute of Public Health. (2017). Drinking water in Norway. *Public Health Report*.

Norwegian Institute of Public Health. (Undated). Norwegian Mother and Child Cohort Study (MoBa).

Norwegian ministry of foreign affairs. (2014). *Opportunities for All: Human Rights in Norway`s Foreign Policy and Development Cooperation. Meld. St. 10 (2014-2015) Report to the Storting (white paper)*.

NTNU. (2010). Breastfeeding is not as beneficial as once thought. Retrieved from

OHCHR. (2013). *Who will be accountable? Human Rights and the Post-2015 Development Agenda*.

OHCHR. (Undated). International Human Rights law. Retrieved from http://www.ohchr.org/en/professionalinterest/Pages/InternationalLaw.aspx

OHCR. (2006). *Frequently asked questions on a human rights-based approach to development cooperation*. New York and Geneva Retrieved from http://www.ohchr.org/Documents/Publications/FAQen.pdf.

Ombudsman for Children. (1981). Barneombudet. The Ombudsman for Children, Norway. ACT and INSTRUCTIONS for the Ombudsman. Retrieved from http://barneombudet.no/english/act-and-instructions-for-the-ombudesman/

Oshaug, A., Eide, W. B., & Eide, A. (1994). Human rights: a normative basis for food and nutrition-relevant policies. *Food Policy, 19*(6), 491-516. doi:https://doi.org/10.1016/0306-9192(94)90042-6

Piwoz, E. G., & Huffman, S. L. (2015). The Impact of Marketing of Breast-Milk Substitutes on WHO-Recommended Breastfeeding Practices*36*(4). Retrieved from http://journals.sagepub.com/doi/pdf/10.1177/0379572115602174 doi:10.1177/0379572115602174

Rollins, N. C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., . . . Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *The Lancet, 387*(10017), 491-504. doi:10.1016/S0140-6736(15)01044-2

Sankar, M. J., Sinha, B., Chowdhury, R., Bhandari, N., Taneja, S., Martines, J., & Bahl, R. (2015). Optimal breastfeeding practices and infant and child mortality: a systematic review and meta-analysis. *Acta Paediatrica, 104*, 3-13. doi:10.1111/apa.13147

Save the children. (2015). *The urban disadvantage. State of the world`s mothers 2015*. Retrieved from Save the children:

Schou, L. (2017). Fedrekvoten - Uttk og holdninger. *Arbeid og velferd, 3*, 81-95.

Shah, R., Miles, C., Agnew, A., Cattaneo, A., Christian, W., Cote, E., . . . Weinberg, T. (2012). *Nutrition in the First 1000 days. State of the World`s Mothers 2012*. Retrieved from Save the Children:

Silverman, D. (2006). *Interpreting Qualitative Data: Methods for Analyzing Talk, Text, and Interaction*: SAGE Publications.

Singh, J. A., Govender, M., & Mills, E. J. (2007). Do human rights matter to health? *The Lancet, 370*(9586), 521-527. doi:10.1016/S0140-6736(07)61236-7

SSB. (2003). Norske mødre ammer mye. Retrieved from

Starks, H., & Trinidad, S. B. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research, 17*(10), 1372-1380. doi:doi:10.1177/1049732307307031

Statistics Norway. (2014). This is Statistics Norway - Statistics and analyses that benefit society.

Statistics Norway. (2017). About us.

Stortinget. (Undated). The Constitution. Retrieved from https://www.stortinget.no/nn/In-English/About-the-Storting/The-Constitution/

Swinburn, B., Kraak, V., Rutter, H., Vandevijvere, S., Lobstein, T., Sacks, G., . . . Magnusson, R. (2015). Strengthening of accountability systems to create healthy food environments and reduce global obesity. *The Lancet, 385*(9986), 2534-2545. doi:10.1016/S0140-6736(14)61747-5

The Norwegian Government. (Undated). *St.meld. nr. 16 (2002-2003). esept for et sunnere Norge. Folkehelsepolitikken.*

Thomas, D. R. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation, 27*(2), 237-246. doi:10.1177/1098214005283748

UN. (1948). *The Universal Declaration of Human Rights*. Retrieved from http://www.un.org/en/universal-declaration-human-rights/.

UN. (1965). *International Convention on the Elimination of All Forms of Racial Discrimination*.

UN. (1976). *Internatioanl Covenant on Civil and Political Rights*. United Nations.

UN. (1986a). *41/128 Declaration on the Right to Development*. Retrieved from http://www.un.org/documents/ga/res/41/a41r128.htm.

UN. (1986b). *41/128. Declaration on the Right to Development*.

UN. (1987). *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations.

UN. (1991). *Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty*.
UN. (1993). *Vienna Declaration and Programme of Action*. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx.
UN. (1999). *Substantive issues arising in the implementation of the International Covenant on Econimic, Social and Cultural Rights: General comment 12 (Twentieth session, 1999). The righ to adequate food (art. 11)*. FAO Retrieved from http://www.fao.org/fileadmin/templates/righttofood/documents/RTF_publications/EN/General_Comment_12_EN.pdf.
UN. (2000). *Optional Protocol on the Convention on the Elimination of All Forms of the Discrimination of Women*. United Nations.
UN. (2002a). *Optional Protocol to the Convention on the Rights of the Child on the involvment of children in armed conflict*. United Nations.
UN. (2002b). *Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography*. United Nations.
UN. (2006). *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment*. United Nations.
UN. (2008). *Convention on the Right of Persons with Disabilities*. United Nations.
UN. (2015). *Universal declaration of human rights*.
UN. (Undated). What are human rights? Retrieved from http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx
UN, & FAO. (1999). *CESCR General Comment No. 12: The Right to Adequate Food (Art. 11)*. Office of the high commissioner for human rights.
UN, & FAO. (2010). The Right to Adequate Food(34). Retrieved from http://www.ohchr.org/Documents/Publications/FactSheet34en.pdf
UNICEF. (2005). Innocenti Declaration 2005. On Infant and Young Child Feeding. Retrieved from
UNICEF. (2015). Breastfeeding. Retrieved from https://www.unicef.org/nutrition/index_24824.html
UNICEF. (Undated). UNICEF Conceptual framework. Retrieved from https://www.unicef.org/nutrition/training/2.5/4.html
UNICEF, & WHO. (2015). 25 Years. Progress on Sanitation and Drinking Water. 2015 Update and MDG Assessment. Retrieved from https://www.unicef.org/publications/index_82419.html
Vandevijvere, S., Dominick, C., Devi, A., & Swinburn, B. (2015). The Healthy food environment policy index: findings of an expert panel in New Zealand. *World Health Organization, 93*, 294-302.
Victora, C. G., Bahl, R., Barros, A. J. D., França, G. V. A., Horton, S., Krasevec, J., . . . Rollins, N. C. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet, 387*(10017), 475-490. doi:10.1016/S0140-6736(15)01024-7
Weber, R. (1990). *Basic Content Analysis*. In. Retrieved from http://methods.sagepub.com/book/basic-content-analysis doi:10.4135/9781412983488
WHO. (1981). *International Code of Marketing of Breast-milk Substitutes*. Retrieved from www.who.int/nutrition/publications/code_english.pdf
WHO. (2001). *The optimal duration of exclusive breastfeeding. Report of an expert consultation.* WHO.
WHO. (2002). *Infant and young child nutrition. Global strategy on infant and young child feeding. Report by the Secretariat.*
WHO. (2009). Acceptable medical reasions for use of breast-milk substitutes. Retrieved from http://www.who.int/maternal_child_adolescent/documents/WHO_FCH_CAH_09.01/en/
WHO. (2014). Comprehensive implementation plan on maternal, infant and young child nutrition. Retrieved from http://www.who.int/nutrition/publications/CIP_document/en/
WHO. (2016). What is malnutrition?
WHO. (Undated). *A human rights-based approach to health*.
WHO, & UNICEF. (1990). *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*.

WHO, & UNICEF. (2003). Global Strategy for Infant and Young Child Feeding, 30. Retrieved from http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/

WHO, & UNICEF. (2006). Infant and Young Child Feeding Counselling: An Integrated Course. Retrieved from http://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/

WHO, & UNICEF. (2009). Baby-Friendly Hospital Initiative. Revised, updated and expanded for integrated care. Retrieved from http://www.who.int/nutrition/topics/bfhi/en/

WHO, & UNICEF. (2014). *Global Nutrition Targets 2025: Breastfeeding policy brief*. Retrieved from http://www.who.int/nutrition/publications/globaltargets2025_policybrief_breastfeeding/en/.

WHO, UNICEF, & IBFAN. (2016). *Marketing of breast-milk substitutes: National implementation of the international code. Status report 2016.* Geneva: WHO Press.

Zhang, Y., & Wildemuth, B. M. (2005). Qualitative Analysis of Content. *Analysis, 1*(2), 1-12.

Appendixs

Appendix A

Human Right Instruments in Norway

Table 1. Shows the various human right instruments the Norwegian State has signed and ratified, establishing the States responsibilities and obligations under the human rights framework.

Table. 1 List of human rights instruments Norway has signed and ratified

Human Rights Instrument	Ratification Status
International Convention on the Elimination of All Forms of Racial Discrimination	Signature 1966
	Ratification 1970
International Covenant on Civil and Political Rights	Signature 1968
	Ratification 1972
Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty	Signature 1990
	Ratification 1991
International Covenant on Economic, Social and Cultural Rights	Signature 1968
	Ratification 1972
Convention on the Elimination of All Forms of Discrimination against Women	Signature 1980
	Ratification 1981
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Signature 1985
	Ratification 1986
Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	Signature 2003
	Ratification 2013
Convention on the Rights of the Child	Signature 1990
	Ratification 1991
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography	Signature 2000
	Ratification 2001
Convention on the Rights of Persons with Disabilities	Signature 2007
	Ratification 2013
Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	Signature 2000

	Ratification 2003

Appendix. B

Content Analysis of Human Right Instruments

The content analysis started by reviewing the human rights documents selected for specific words, i.e. the explicit mentioning of breastfeeding and adequate food. The two terms were categorised into two groups, and a theme was selected for each article highlighted.

Extraction of all the articles that mentions breastfeeding

"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 breastfeeding, hygiene and environmental sanitation and prevention of accidents" (CRC, 1989).

Extraction of all the articles in the human right framework that mentions adequate food

"To combat disease and malnutrition, including within the framework of primary 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" (CRC, 1989).

"The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions" (ICESCR, 1966).

"States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:…" (UN, 2008).

Theme selected for breastfeeding

"*…are informed, have access to education, and are supported in the basic knowledge of child health and nutrition, the advantages of breastfeeding…".*

- ✓ Information about breastfeeding

Themes selected for adequate food

"…the provision of adequate nutritious foods...".

- ✓ Duty-bearer as a provider of food

"…the right of everyone to an adequate standard of living for himself and his family, including adequate food…".

- ✓ Right-holders claim to adequate food

"…the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food…".

- ✓ Right-holders right to adequate

Latent meaning of themes

The State is obligated to inform the parents/caregivers of the infant about the advantages of breastfeeding. The State is also responsible to facilitate a conducive food environments which provide adequate nutritious foods. The right-holder has a right to adequate food and can claim this right if it is not provided by the State.

Content analysis of general comment no.12: The Right to Adequate Food

Another content analysis was conducted on general comment no.12 The Right to Adequate food, because it explained the term adequate food as a human right. The unit for analysis was the explicit mentioning of breastfeeding.

"Dietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation. Measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns, including breastfeeding, while ensuring that changes in availability and access to food supply as a minimum do not negatively affect dietary composition and intake".

"…The United Nations Children`s Fund (UNICEF) has equivalent expertise concerning legislation with regard to the right to adequate food for infants and young children through maternal and child protection including legislation to enable breastfeeding, and with regard to the regulation of marketing of breast milk substitutes".

Themes selected for breastfeeding under the general comment no.12

"…appropriate consumption and feeding patterns, including breastfeeding…"

- ✓ Right-holders claim to adequate food

"…maternal and child protection including legislation to enable breastfeeding…".

- ✓ Right-holders right to adequate food

Latent meaning of themes under general comment no.12

The right-holder has a right to adequate food and can claim the right if it is unavailable.

Appendix. C

Table. 3 Maternity protection policy implemented into Norwegian law from the International Labour Organization

Maternity protection	
Regulation, Decree, Ordinance	Law, Act
Ordinance (No. 814 of 2004) to amend Ordinance (No. 382 of 1995) respecting the right to leave in cases of pregnancy, child birth and adoption. *Ordinance (No. 382 of 1995) respecting the right to leave in cases of pregnancy, child birth and adoption.* *Provisions to grant a maternity (confinement) cash benefit to persons covered by s. 2 (7) 1 of the National Insurance Act/1*	*Act (No. 63 of 1997) to amend the National Insurance Act (No. 19 of 1997) and the Act respecting worker protection and working environment (No. 4 of 1977).* *Act (No. 34 of 1996) to amend the National Insurance Act (No. 12 of 1966).* *Act to amend the National Insurance Act (No. 12 of 1966), the Act (No. 4 of 1977) respecting workers' protection and the working environment etc, and the Seafarers Act (No. 18 of 1975) (No. 25 of 1994)* *Act to amend the National Insurance Act (No. 12 of 1966), the Act (No. 131 of 1993)* *Act to amend the National Insurance Act (No. 12 of 1966), the Act respecting worker protection and working environment (No. 4 of 1977) and certain other Acts (No. 71 of 1993).* *An Act to amend the National Insurance Act (No. 12 of 17 June 1966) [LS 1970-Nor.1, cons., 1971-Nor.2] and certain other Acts.* *An Act to amend the National Insurance Act (No. 12 of 17 June 1966) [LS 1970-Nor.1 (consolidation), 1971-Nor.2 No.84.*