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Elisabeth Irene Karlsen Dogan

Human rights education for nursing students

Introducing a human rights perspective to nutrional care in nurse education

VID

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Introducing a human rights perspective to nutritional care in nurse education

Elisabeth Irene Karlsen Dogan

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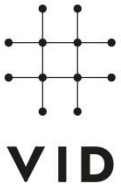

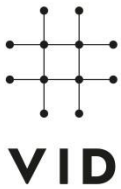

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Elisabeth Irene Karlsen Dogan

February, 2022

Summary

Human rights are an important part of everyday nursing practice and care, but a human rights perspective has not been properly addressed in nursing education and practice. This does not mean that nurses are unconcerned with human rights issues, but that for most nurses, a human rights perspective is not an explicit foundation for conceptualization or practice. The aim of this study was to explore the experience of introducing a human rights perspective in nursing education. My research can be seen as both a contribution to the field of nursing education and to the field of human rights education. The study was conducted within the context of nursing education in Norway, focusing on the right to food for older adults in nursing homes—an area with longstanding challenges. Adopting a human rights-based approach (HRBA), a coursework on the right to food was introduced and developed, combining education on campus and in placement, where first-year nursing students had their first placement in a nursing home/long-term care facility.

The study design and methods were selected with the aim of capturing the complexity of a human rights perspective and professional development in a "real-life" context. Educational Design Research (EDR) appeared to be best suited to this purpose, as this research design looks into educational design in real-life settings. The methodology selected was comprised of focus groups, multistage focus groups and students' written assignments from their placements. It included the students' own perspectives and experiences, to foster empowerment and enable students' voices to be heard through participation and dialog—all of which are important from a human rights perspective.

Human rights education is an emergent field of educational theory. Here, Tibbits' theory and model was deemed especially relevant to this thesis, as she refers to duty-bearers like health professionals. Tibbits further points out the importance of learning though socialization, and for human rights to be a practice-oriented approach in people's everyday lives. A second theory that was selected for this thesis was Wenger's learning theory of communities of practice, since this theory further explores contextualized learning and learning as social processes. Wenger's theory has been seen as relevant in nursing education, since placement has characteristics of communities of practice where students are socialized into a profession. Lastly, as human rights can be understood from a range of perspectives, in this thesis, I explore how students learn about and promote human rights from the perspective of Ife's conceptualization of constructive rights.

The findings from the thesis highlight that nursing students' learning about human rights can be enriched by integrating learning on campus with learning in practice, using other theories and concepts of learning beyond human rights education. Key to students' learning and professional development were their relationships with nursing home residents, other students and nurses and health personnel. This underscores the importance of the role of patients and communities of practice in nursing education in human rights. Study findings show that human rights education that addresses the students' own context made human rights both meaningful and relevant to them. In this study, when addressing human rights in a daily context of care, the students became aware that human rights are actually at stake in their own country. Awareness of human rights also seemed to help students make autonomous decisions regarding care following values related to social justice, but they were also dependent on a good learning environment in which they felt included. The ability to draw upon the language of human rights also seemed to enhance students' accountability and support their navigation when they experienced rights violations during placement. This study highlights the necessity of integrating the language of human rights into nursing education in local contexts. Doing so may increase nursing students' awareness of and commitment to promoting patients' rights. The findings also indicate the importance of increasing nursing students' ability to handle the complexity of the organizational structures in which they must provide nutritional and nursing care. This can be achieved by adding a human rights framework in nursing education and through supporting the students to benefit from the learning environment during placement.

A human rights perspective in nursing education aims at addressing challenges in healthcare related to systems and structures, dual loyalty and health professional rights—and to teaching student nurses to develop professional values like advocating for social justice, promoting dignity and respecting patients' rights. A human rights perspective in patient care "zooms out" from the individual nurse–patient relationship towards examining systemic issues and state responsibility. In this regard, a human rights perspective in nursing care can complement and work parallel with care ethics and bioethics and involve ethical aspects that move outwards, from the individual as the professional who must make ethical decisions towards systems and structural challenges. Human rights education can benefit from being contextualized locally and in practice. This can enhance learning through one's own experiences and through relations with others and may help promoting patients' human rights and addressing everyday human rights challenges.

Sammendrag

Menneskerettigheter er en viktig del av den daglige sykepleieutøvelsen, likevel har i liten grad menneskerettighetsperspektivet blitt ivaretatt i sykepleieutdanningen og sykepleiepraksis. Dette betyr ikke at sykepleiere ikke er opptatt av menneskerettighetsspørsmål, men for de fleste sykepleiere er et menneskerettighetsperspektiv ikke et eksplisitt grunnlag for sykepleieutøvelse eller praksis. Målet med denne studien var å utforske erfaringene med innføring av et menneskerettighetsperspektiv i sykepleierutdanningen. Forskningen min kan ses både som et bidrag til sykepleierutdanningen og til feltet menneskerettighetsutdanning. Studien er utført i konteksten sykepleierutdanningen i Norge med tema retten til fullgod mat for beboere på sykehjem, et område hvor det har vært flere utfordringer i lang tid. Ved å ta i bruk en menneskerettighetsbasert tilnærming, ble et kurs om retten til mat introdusert og utviklet som kombinerte utdanning på campus og i klinisk praksis, der 1. års sykepleierstudenter hadde sin første praksisplass på et sykehjem.

Valget av forskningsdesign i denne studien tok hensyn til perspektivet om menneske-rettigheter og læring i en naturlig kontekst. Hensikten var å velge et forskningsdesign og metoder som kunne fange kompleksiteten ved utvikling av undervisningsdesign og undersøke menneskerettighetsundervisning i en naturlig kontekst. Educational Design Research (EDR) fremsto som godt egnet for dette formålet, ettersom dette forskningsdesignet ser på undervisningsdesign i naturlige omgivelser. Metodene som ble valgt var fokusgrupper, flerstegs fokusgrupper og studentenes skriftlige oppgaver fra den kliniske praksisen. Denne tilnærmingen inkluderte studentene perspektiver og erfaringer som fremmet empowerment og deres stemme gjennom deltakelse og dialog, vektlagt i et menneskerettighetsperspektiv.

Menneskerettighetsutdanning er et voksende felt. Tibbits teori og modell ble valgt da hun refererer til plikthavere som helsepersonell, som var relevant for denne avhandlingen. Tibbits påpeker videre betydningen av å lære gjennom sosialisering og for at menneskerettigheter skal være en praksisorientert tilnærming i hverdagen. En annen teori som ble valgt var Wengers læringsteori om praksisfellesskap, siden denne teorien utforsker videre kontekstualisert læring og læring som sosiale prosesser. Denne teorien har blitt sett på som relevant i sykepleierutdanningen, hvor praksis i sykepleieutdanningen kjennetegnes ved et praksisfellesskap der studentene sosialiserer seg inn i et yrke. Menneskerettigheter kan forstås og sees fra ulike skoler og tradisjoner. I denne avhandlingen ser jeg på hvordan studenter lærer og fremmer menneskerettigheter fra perspektivet til Ifes tradisjon om konstruktive rettigheter.

Funnene fra avhandlingen peker på at sykepleierstudenters læring om menneskerettigheter kan berikes ved å integrere læring på campus med læring i praksis, og ved å bruke andre teorier og begreper om læring utover menneskerettighetsundervisning. Nøkkelen til studentenes læring, faglige og profesjonelle utvikling var deres relasjoner til sykehjemsbeboere, til andre studenter og gjennom sosialisering i praksisfellesskapet med veileder, sykepleiere og annet helsepersonell. Dette understreker betydningen av pasientenes og praksisfellesskapets rolle i sykepleierutdanningen i menneskerettighetsundervisning. Avhandlingens funn viser at menneskerettighetsundervisning som tar for seg studentenes egen kontekst gjorde menneskerettighetene både meningsfulle og relevante for studentene. I denne studien, som tok for seg læring i en daglig kontekst, ble studentene klar over at menneskerettighetene står på spill i eget land.

Bevissthet om menneskerettigheter bidro til at studentene tok selvstendige beslutninger, men de var avhengige av et godt læringsmiljø der de følte seg inkludert. Evnen til å bruke et språk om menneskerettigheter så ut til å øke studentenes ansvarliggjøring og støtte deres navigering når de opplevde rettighetsbrudd under sykehjemspraksisen. Denne studien fremhever nødvendigheten av å integrere et språk om menneskerettigheter i sykepleierutdanningen gjennom en hverdagslig kontekst. Dette kan øke sykepleierstudentenes bevissthet om og engasjement for å fremme pasientenes menneskerettigheter. Funnene peker på betydningen av å øke sykepleierstudenters evne til å håndtere kompleksiteten i organisasjonsstrukturene der de skal utøve sykepleie og matomsorg. Dette kan oppnås ved å inkorporere et menneskerettighetsperspektiv i sykepleierutdanningen og gjennom å støtte studentene til å dra nytte av læringsmiljøet under praksisperioden.

Et menneskerettighetsperspektiv i sykepleierutdanning er en tilnærming for å kunne møte utfordringer i helsevesenet knyttet til dobbel lojalitet, systemer og strukturer, helsepersonells rettigheter, og for å lære sykepleierstudenter å utvikle profesjonelle verdier som rettferdighet, fremme verdighet og respektere pasientenes rettigheter. Et menneskerettighetsperspektiv i pasient omsorgen «zoomer ut» fra den individuelle pasient-sykepleie-relasjonen til å undersøke systemiske spørsmål og statlig ansvar. I denne sammenheng kan et menneske-rettighetsperspektiv i sykepleie utfylle og fungere parallelt med omsorgsetikk og bioetikk. Menneskerettighetsundervisning kan tjene på å bli kontekstualisert lokalt og i praksis. Dette kan styrke studenters læring om menneskerettighetsutfordringer gjennom egne erfaringer og gjennom relasjoner, og bidra til å fremme pasienters menneskerettigheter i en daglig kontekst.

List of papers

Dogan EIK, Raustøl A, Terragni L. Student nurses' views of right to food of older adults in care homes. *Nursing Ethics.* 2020;27(3):754-66. https://doi.org/10.1177/0969733019884614

Dogan EIK, Terragni L, Raustøl A. Student nurses' experience of learning about the right to food: Situated professional development within clinical placement. *Nurse Education Today*. 2021;98:104692. https://doi.org/10.1016/j.nedt.2020.104692

Dogan EIK, Terragni L, Raustøl A. Human rights and nutritional care in nurse education: lessons learned. *Nursing Ethics*. Article first published online: February 7, 2022. https://doi.org/10.1177/09697330211057226

List of abbreviations

AI: Amnesty International
DBR: Design-based research
EDR: Educational design research
ESPEN: European Society of Clinical Nutrition and Metabolism
FAO: Food and Agriculture Organization of the United Nations
HOD: Ministry of Health and Care Services
HRBA: Human rights-based approach
ICESCR: International Covenant of Economic, Social and Cultural Rights
ICN: International Council of Nurses
KD: Ministry of Education and Research (Kunnkapsdepartementet)
MFA: Ministry of Foreign Affairs
MNA: Mini Nutritional Assessment
NESH: National Committee for Research Ethics in the Social Sciences and the Humanities
NGO: Non-governmental organization
NIM: National Institution for Human Rights (Nasjonal Institusjon for Menneskerettigheter)
NIPH: Norwegian Institute of Public Health
NSF: Norsk Sykepleierforbund
OHCHR: Office of the United Nations High Commissioner for Human Rights
SMR: Norwegian Centre for Human Rights (Norsk Senter for Menneskerettigheter)
SSB: Statistics Norway (Statistisk Sentralbyrå)
UDHD: Universal Declaration of Human Rights
UN: United Nations
WHO: World Health Organisation

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Content

1 Introduction

Human rights are an important part of nursing care in everyday practice (ICN, 2011; McHale & Gallagher, 2004). Human rights are referred to in the International Code of Ethics of Nursing, in national nursing guidelines and in a position statement from the International Council of Nurses (ICN) (ICN, 2011, 2012; NSF, 2019). ICN has endorsed the Universal Declaration of Human Rights (UDHR) and the International Bill of Human Rights (ICN, 2011).[1] ICN highlights the inclusion of both human rights norms and ethical standards in nursing care, and states in its own Code of Ethics that "[i]n providing care the nurse promotes an environment in which the human rights, values, customs, and spiritual beliefs of the individual, family and community are respected" (ICN, 2012). In its position statement, "Nurses and Human Rights," ICN calls on nursing to be interpreted within the framework of international human rights agreements, such as the International Bill of Human Rights and ICN's Code of Ethics for Nurses (ICN, 2011). In the statement's concluding remarks, ICN states that human rights issues and the nursing role should be included in all levels of nursing education programmes (ICN, 2011).

Since the beginning of the health and human rights movement in the 1990s, with initiatives by Mann and colleagues [2] (Mann et al., 1994; Marks, 2002), the operationalization of human rights in health practice has broadened (Gostin, Huffstetler, & Meier, 2020). Academic efforts to establish human rights coursework in health education and for health personnel in practice have followed (Gostin et al., 2020). Human rights-based approaches (HRBA) in nursing have become increasingly relevant (Cohen & Ezer, 2013; Erdman, 2017). Nevertheless, a human rights perspective has not been properly addressed in health professions, including nursing education (Backman & Fitchett, 2010; Forman, Brolan, & Kenyon, 2019; Pfendt, 2018). This does not mean that nurses are unconcerned with human rights issues, but that, for most nurses, a human rights perspective is not an explicit foundation for conceptualization or practice (Easley & Allen, 2007). The following was stated by Mann et al., (1994, p.12), and remains highly relevant today.

> The goal of linking health and human rights is to contribute to advancing human well-being beyond what could be achieved through an isolated health- or human rights-based approach.

1 The International Bill of Human Rights consists of the UDHR, the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the International Covenant on Civil and Political Rights and its two Optional Protocols.

2 Jonathan Mann was the founding director of the Harvard-based Francois-Xavier Bagnoud Center for Health and Human Rights. Mann laid the groundwork for the development of a conceptual framework for health and human rights, which Mann et al., (1994) describe in the first issue of the journal he founded (Tarantola et al., 2006).

In Norway, the 2018 Stakeholder Report from the Norwegian National Human Rights Institution (NIM) calls for integrating human rights education into Norway's health professionals' education (NIM, 2018). Although published more than 20 years ago, the White Paper "Action Plan on Human Rights" addressed the need for human rights competence for health professionals, and the necessity of looking into human rights issues in a Norwegian context (MFA, 1999). In nursing homes in Norway, human rights challenges are evident in the daily practice of care. Concerns have been raised regarding human rights violations of older adults in healthcare facilities internationally and in Norway (Dong, 2015; NIM, 2021; SMR, 2014). In healthcare facilities, older adults are particularly at risk of rights violations since they require support and help from others in their daily life (Malmedal, Hammervold, & Saveman, 2014). This vulnerability has been addressed in both international and national studies and reports (Malmedal et al., 2014; Phelan, 2015; SMR, 2014; SSB, 2018). Nevertheless, human rights education seems to lack examples in Norwegian context, and human rights violations are illustrated with examples from other countries seen as less developed (Vesterdal, 2019).

One area where several concerns have been raised—including in Norway—is "the right to adequate food" for older adults in nursing homes (NIM, 2019; SMR, 2014; SSB, 2018; UN, 2020). Food is a human right and has been recognized since the (1948) UDHR. The right to food has been defined by the former United Nations (UN) Special Rapporteur as

> the right to have regular, permanent and unrestricted access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensure a physical and mental, individual and collective, fulfilling and dignified life free of fear (Ziegler, Golay, Mahon, & Way, 2011, p.15).

The situation regarding lack of nutritional care, malnutrition and poor food intake for older adults in Norwegian healthcare settings has been addressed in several studies (Aagaard, 2010; Eide, Aukner, & Iversen, 2013; Karlsen, Stray Aurdal, Terragni, Barth Eide, & Iversen, 2013; Rugås & Martinsen, 2003). More recently, as I am writing this introduction, there is a discussion in the media about the lack of nutritional care in Norwegian nursing homes (Adresseavisen, 2021; Borchsenius, Mortensen, & Husevåg, 2021; Lilleskare Lunde, 2021; Schou, 2021). Very recently, the national television programme "The Debate" aired a segment entitled "More Older Adults are Getting Malnourished," which highlighted that this issue has been a topic of discussion every year for the last 25 years.[3] The situation has only worsened

3 NRK, 28.10.21 Flere eldre blir underernærte. https://tv.nrk.no/serie/debatten/202109/NNFA51092821/avspiller

due to the current global health pandemic (HOD, 2020, 2021). Six out of 10 residents in nursing homes in Norway are now at risk of becoming malnourished or are already malnourished (HOD, 2020). This makes the topic of my work of particular relevance.

In this study, in fact, human rights education was exemplified by and situated within daily care in Norwegian nursing homes, rather than using a case or example far away from another (non-Nordic) country. The research was anchored in my job as a teacher for nursing students. The students followed the previous national curriculum from 2008 (KD, 2008), which follows the recommendation that nursing education must be in accordance with national and international health and educational policy guidelines (e.g., international declarations, standards and policy guidelines on health policy, human rights and higher education).[4]

Human rights education is an emergent field of educational theory (Tibbitts & Kirchschläger, 2010). Tibbits' (2017) theory and model (which will be further explored later) was selected because her reference to duty-bearers (e.g., health professionals) was deemed particularly relevant for this thesis. Tibbits further points out the importance of learning through socialization and for human rights to be a practice-oriented approach in people's everyday lives. A second theoretical framework selected was the learning theory of communities of practice, since this theory further explores contextualized learning and learning as social processes (Wenger, 1999). This allowed for situated learning in a communities of practice, as introduced by Lave and Wenger (Lave & Wenger, 1991; Wenger, 1999). This theory has been seen as relevant in nursing education, where placement has characteristics of a communities of practice where students are socialized into a profession (Molesworth, 2017; Morley, 2016). Indeed, half of the nursing education programme take place in various clinical placements, focusing on situated learning and professional development through socialization into a community. The field of human rights education can benefit from real-life examples, such as experiences from clinical placement for nursing students.

With regards to the study design, my goal was to select an approach and methods that could capture the complexity of the educational design and investigate human rights education in a real-life context. Here, (McKenney & Reeves, 2018) Educational Design Research (EDR)

4 When I started my PhD, the students in the study were following the national curriculum from 2008. In the new guidelines (RETHOS) for students starting in 2020, human rights were omitted—despite the fact that human rights are acknowledged in international and national nursing guidelines, policy and law, and there have been several calls for human rights education in nursing.

methodological framework appeared most suitable,[5] as it explores educational design in real-life settings, with the aim of "developm [ent] of solutions to practical and complex educational problems" (McKenney & Reeves, 2020). The methods selected comprised focus groups, multistage focus groups and students' written assignments (completed as part of their placement). Here, the goal was to include the students, their perspectives and experiences, to foster empowerment and enable their voices to be heard through participation and dialog—all important from a human rights perspective (Smith & Smith, 2018).

For human rights to have meaning, the abstract values and content of human rights policy must be contextualized into practice and be relevant to learners' needs (Martínez Sainz, 2017; Tibbitts, 2017). Indeed, for health professionals, learning and professional development in-practice takes place in complex situations, through experience and reflections (Molander, 2008). Human rights education in this study therefore combined education both on campus and in placement. Incorporating a human rights perspective, I developed a two-day course on campus combined with a written assignment as part of students' seven-week clinical placement in a nursing home. This was not merely important for the students' learning and professional development, as it meant that nursing home residents could also benefit from the promotion of their rights. Introducing a human rights perspective for first-year nursing students offered students opportunities to learn about human rights at the start of their education and professional practice—thus "planting a seed" for future human rights promotion.

1.1 Aim

The overall aim of this study was *to explore the experience of introducing a human rights perspective in nursing education*. This was undertaken in the context of nursing education in Norway, focusing on the right to food for older adults in nursing homes. Through adopting an HRBA, a coursework on the right to food was introduced and developed, combining education on campus and in students' first placement (which was in a nursing home/long-term care facility). An overview of the research questions with the corresponding papers and methods are illustrated below, in Table 1.

5 Through my journey as a PhD student, I moved from utilizing Design-Based Research (DBR) and towards Educational Design Research (EDR) to frame the study, emphasizing "education." Therefore, in Paper II, I refer to DBR, whereas in Paper III, I refer to EDR. Throughout the thesis, I will use EDR. Its relevance will be further explored in the Design and Methods section (chapter 4.2).

Table 1 The research questions with corresponding papers and methods.

Sub-study	Research question	Paper	Method
Sub-study I	What are nursing students' perspectives and experiences on the right to food throughout their placement in a nursing home?	"Student Nurses' Views of Right to Food of Older Adults in Care Homes"	Qualitative study with multistage focus groups
Sub-study II	How do nursing students learn about the right to food for nursing home residents when combining education on campus and in placement?	"Student Nurses' Experience of Learning about the Right to Food: Situated Professional Development within Clinical Placement"	Qualitative study with focus groups and written assignment
Sub-study III	How can a human rights perspective contribute to nursing education?	"Human Rights and Nutritional Care in Nurse Education: Lessons Learned"	Re-analysis of data set and reflections on development of the coursework

The overall aim was specified through the following three research questions:

1. What are nursing students' perspectives and experiences on the right to food throughout their placement in a nursing home? (Paper I)
2. How do nursing students learn about the right to food for nursing home residents when combining education on campus and in placement? (Paper II)
3. How can a human rights perspective contribute to nursing education? (Paper III)

The first research question is addressed in the paper "Student Nurses' Views of Right to Food of Older Adults in Care Homes." Although there are policy papers and statements in nursing fields stating the importance of human rights in nursing education, there have been few studies targeting nursing students' perspective. Knowledge about students' views on human rights and how they interpret these in their professional practice is highly relevant for the development of coursework. In Paper I, I therefore explore nursing students' perspectives and experiences of the right to food throughout their placement in nursing homes, and how they conceptualized human rights throughout placement.

The second research question is taken up in Paper II, "Student Nurses' Experience of Learning about the Right to Food: Situated Professional Development within Clinical Placement." In this paper, I focus on the process of learning about the right to food when combining coursework on campus and in placement. The paper's main focus is on moving from "knowledge about" food and nutrition towards learning in context and through relations.

The third research question is addressed in the paper "Human Rights and Nutritional Care in Nurse Education: Lessons Learned." In this paper, the entire data set from the project is revisited, with the aim of reflecting on the implications of developing education in nursing education from a human rights perspective.

1.2 Contextualization of my thesis within the Diaconia, Values and Professional Practice PhD programme

This thesis was submitted to the Diaconia, Values and Professional Practice PhD programme at VID Specialized University. [6] The PhD programme includes a focus on research into professional practice in health and welfare services in the public and private sectors. The programme has as its starting point at the challenges arising from practice and aims to facilitate research conducted in close cooperation between professionals and citizens as participants. Combining studies about values and professional practice, the programme investigates how professionals in the healthcare sector achieve competence, realize values and deal with power and responsibility in challenging relationships. Another important aim of the programme is "to study health and welfare services as value-based and ethically challenging practices" (p. 1). The research context within which I am situating this study is nursing education, specifically *values* and *professional practice* for nursing students. Whereas values refer to the norms and ideals that guide or influence health and welfare services, and professional practice refers to the performances of professional work in the health and welfare services.

All workers are expected to act with responsibility, but groups that are defined as professionals have a public-assigned expertise to act in the best interest of both the individual and the society (Freidson, 2001). For the professional, this implies a commitment to acquiring certain skills and knowledge that can be used for individuals in a society in need of service from that professional (Dahlgren, Solbrekke, Karseth, & Nyström, 2014; Molander, 2016). Professionals are expected to make decisions grounded in professional values (Sullivan, 1995); these values—as well as norms and knowledge—are gained through formalized education programmes, which provide the basis for obtaining practice as a professional (Molander, Grimen, & Eriksen, 2012).

[6] Programme Description for PhD of Diaconia, Values and Professional Practice, 180 ECTS, Centre of Diaconia and Professional Practice, VID Oslo, 2018-2019. https://www.vid.no/planer/studieplan-ph.d-i-diakoni-verdier-og-profesjonell-praksis-engelsk-2018-2019/

In nursing care, human rights are referenced in the International Code of Ethics of Nursing, in national nursing guidelines and in a recent position statement from the ICN and are thus essential values in nursing practice and care (ICN, 2011, 2012; NSF 2019). In this thesis, I perceive the approach to human rights as an important value in my chosen research context: a value of importance for nursing students in their professional practice. Moreover, as I was conducting research within the field of human rights, it was also important for me, as a researcher, to value the human rights perspective.[7]

1.3 My engagement with the study

After working for many years as a nurse, I started a master's programme in public nutrition, and attended a course on human rights and nutrition. I found the course to be inspiring and an eye-opener. As a nurse I had never explicitly thought about the importance of human rights in my work, and certainly not in tandem with food, even though the nursing ethics code refers to human rights. The course included several examples of current human rights issues, but these examples were mainly from a context or country far removed from the Norwegian setting. During the course, as I was trying to understand and digest the new vocabulary and the theories of human rights, I also could not help but think about the numerous human rights challenges in Norway. After many years of experience as a nurse providing care to older adults in hospitals and nursing homes, I realized that many of the daily challenges I experienced could be seen as human rights challenges. I decided therefore to write my master's thesis on the topic of older adults and the right to food in Norway.

A few years later, as a teacher for nursing students, I was given the chance to develop a course in nutrition for first-year nursing students who had their first-year placement in nursing homes, taught from a human rights perspective. The course developed into a two-day course on campus combined with a written assignment in placement. At the same time, I was accepted into a PhD programme at VID, which emphasized my focus on values and professional practice in the process of developing this course. Moreover, this gave me the opportunity to delve into this under researched and arguably undervalued topic.

When I began this study, and my life as a PhD student, it was all new to me, with my former professional experience as a nurse and a teacher. During the research process, my knowledge of the human rights perspective in nursing education has changed and evolved, and I have obtained a more nuanced view of human rights and human rights education in nursing

[7] What this meant for this study will be further explored in thesis under Design and Methods, Chapter 4.9.

education. In the role of researcher, it was important to me to have an awareness of the position, biases, and values that I brought into the project.[8] Balancing between my role as a nurse, teacher and researcher has been one of the many challenges of this study.

1.4 Outline of the thesis

The thesis has the following outline: in Chapter 1, I present the introduction to the thesis, aim and research questions, the contextualization of my thesis within the Diakonia, Values and Professional Practice PhD programme, and my engagement with the study. In Chapter 2, I present the background and overview of the research field, which includes human rights education, human rights education in health professional education, and an overview of curriculum development in the field of human rights education for health personnel. I then present the right to food in both a legal and nursing practice care context, I further explore nutritional care in nursing practice and finally, I present nutrition and nursing education. In Chapter 3, I present the theoretical frameworks that are central to this thesis: three traditions on human rights, a perspective on human rights education for professional practice, and the theory of learning (communities of practice). In Chapter 4, I describe the study design and methods. In Chapter 5, I summarize the findings from the three sub-studies and papers. In Chapter 6, I discuss the findings. Lastly, in Chapter 7, I present a conclusion.

[8] This will be further explored later in the thesis under Design and Methods, Chapters 4.7 and 4.8.

2 Background and overview of the research field

In this chapter, I will explore following elements: 1) the background for human rights education; 2) the evolution of human rights education in health professional education; 3) an overview of research curriculum development in the field of human rights education for health personnel; 4) the right to adequate food and a HRBA in a nursing practice context; 5) nutritional care in nursing practice; and finally, 6) an overview of research in nutrition education in nursing education. I elaborate upon nutritional care and nutrition education, as this may help clarify for the reader my choice of "nutritional care" as a suitable example and context for human rights education.

2.1 Human rights education

Human rights education centres around translating human rights policy and global movements into local contexts (Suárez, 2006). As noted earlier, human rights education was mentioned as early as 1948, in the UDHR (UN, 1948); Article 26 identifies both the right to education, and the right to education directed towards the full development "of respect for human rights and fundamental freedoms." Since then, there have been many antecedents to human rights education from non-governmental organizations (NGOs), community-based work and individual initiatives over the past centuries. However, it was not until after the end of the Cold War in the 1990s that human rights education gained momentum as a global movement; the (1993) UN World Conference on Human Rights in Vienna, in particular, marked a watershed moment in the development of human rights education. The period from 1995 to 2004 has been labelled as the decade of human rights education, in which policymakers, activists, governmental representatives and educators were all engaged in the discussion (Bajaj, 2017). The second phase, from 2010 to 2014, targeted the training of professionals, such as civil servants (UN, 2012).[9] While health professional educators are not specifically mentioned in the World Programme for Human Rights Education's "Second Phase: Plan of Action" (UN, 2012), there are many aspects that seem relevant for nurses. For example, it is emphasized that:

[9] The first phase (2005-2009) of the World Programme for Human Rights Education focused on human rights education in the primary and secondary school systems (UN, 2005). The third phase (2015-2019) focused on strengthening the implementation of the first two phases and promoting human rights training for media professionals and journalists (UN,2014). The fourth phase (2020-2024) have special emphasis on education and training in equality, human rights and non-discrimination, and inclusion and respect for diversity with the aim of building inclusive and peaceful societies (UN 2019).

> Moreover, for those who have the responsibility for respecting, protecting and fulfilling the rights of others, human rights education develops their capacity to do so. Both what is learned and it what way it is learned should reflect human rights values […] (UN 2012, p.2)

Today, there are broad international discourses on the importance of human rights education for developing sustainable practices, promoting human rights, ensuring social justice and protecting human dignity (Erdman, 2017; Suárez, 2006; Vesterdal, 2019).

While there are several approaches to human rights education, varying in content, scope, depth, intensity and availability (Bajaj, 2017), there is wide agreement regarding its core components. Firstly, human rights education must include both *content* and *processes* (Bajaj, 2017; Tibbitts, 2017). Secondly, human rights education must include goals related to the content, values/skills and action-oriented components (Tibbitts, 2005). Human rights education does not merely mean providing knowledge about human rights and the mechanisms that protect them, but entails the skills needed to promote, defend and apply human rights in daily life (UN, 2011). Further embedded in human rights education is the fostering of attitudes and behaviours needed to uphold human rights for all members of society. In the UN's Declaration on Human Rights Education and Training adopted by the General Assembly in 2001 (UN, 2011), it is stated that:

> Human rights education and training comprises all educational, training, information, awareness-raising and learning activities aimed at promoting universal respect for and observance of all human rights and fundamental freedoms and thus contributing, inter alia, to the prevention of human rights violations and abuses by providing persons with knowledge, skills and understanding and developing their attitudes and behaviours, to empower them to contribute to the building and promotion of a universal culture of human rights (Article 2)

This declaration adopts a framework that defines human rights education as including teaching *about*, *through* and *for* human rights (Bajaj, 2017; Struthers, 2015; UN, 2011). Education *about* human rights includes developing knowledge of human rights norms and principles, the values that underpin them, and the ways they can be protected. Education *through* human rights means teaching and learning in ways that respect the rights of both students and teachers. Teaching *for* human rights aims to empower learners to exercise their rights and respect and promote the rights of others. Taken together, these three dimensions aim to foster a human rights culture.

2.2 Human rights education in health professional education

Since the pioneering studies in health and human rights of the early 1990s, in the fields of public health (Brenner, 1996; Keller, Horn, Sopheap, & Otterman, 1995), medicine (Sonis, Gorenflo, Jha, & Williams, 1996) and nursing (Chamberlain, 2001), the field of health and

human rights teaching has expanded within schools of law, policy, public health, social work, medicine and nursing (Gostin et al., 2020; Rosales, Coe, Ortiz, Gámez, & Stroupe, 2012). While curricula in health already embrace issues of ethics and justice, these new courses began to examine the ethical responsibilities of health professions to respect and promote human rights, and the legal implementation of human rights obligations that could frame public health policy (Gostin et al., 2020). These courses further aimed to enable students to translate key human rights norms and principles into action-oriented health policies, programmes and practices (Tarantola and Gruskin, 2006). Training and education play a crucial role in shaping health professional practice, and creating an understanding of the link between health and human rights (London, 2008). The importance of human rights education for health professionals has been addressed in recent decades, both in research and in statements (Amnesty International, 2005; Farmer & Gastineau, 2002; ICN, 2011; Mpinga, Verloo, London, & Chastonay, 2011; Williams & Hunt, 2019).

Nevertheless, researchers have pointed to a lack of human rights education in health professional education (Forman, 2011; Hall, 2010; Hunt, 2008). In a US study (Cotter et al., 2009), findings indicate that although a majority of deans believe that knowledge about human rights is important in health practice and support the inclusion of health and human rights studies in their medical and public health schools, human rights education is lacking at most of their institutions. Furthermore, when medical schools do explicitly address issues of health and human rights, it is usually in the context of global health electives (Premkumar, Barker, DeLoureiro, Sarathy, & Dworkis, 2013). A more recent study from Brazil (Ventura et al., 2019) aimed to identify the perceptions and understanding of nursing faculty members regarding human rights related to health in nursing undergraduate programmes; the authors conclude that this field is still in its infancy in Brazilian nursing programmes.

Furthermore, the lack of awareness and knowledge about human rights for nurses and nursing students has also been highlighted. A study from Turkey identified the need for human rights to be included in continuing nursing education, as it found a lack of awareness of patients' rights among midwifes and nurses (Özdemir et al., 2009). In a study from India, students in a bachelor's of nursing were found to have limited knowledge of human rights and mentally ill patients (Prasad & Theodore, 2016). This is in line with a more recent study from Nigeria (Iheanacho et al., 2021), which found limitations concerning the mental healthcare knowledge among nursing students; the authors recommend that nursing curricula should therefore include sufficient education regarding the human rights of people with mental illness. Another

study from Turkey, this one among nursing students, reports the need for nursing education to increase and enrich the information provided about children' rights (Yildiz, Yildiz, Yimaz, & Dogan, 2018).

Another issue addressed in a more recent review of human rights education in patient care is the importance of discussing the nature of human rights education, and of examining its potential for impacting patient care (Newham, Hewison, Graves, & Boyal, 2021). The authors also assert that approaches to human rights have implications for the outcomes of human rights education. This is a challenge, since few articles address the approach to human rights that was taken.

Twenty years after the emergence of the health and human rights movement, the concern remains that human rights education is lacking for health professionals—this concern was recently raised in *The Lancet* (Forman, Brolan, & Kenyon, 2019; Gostin, Monahan, Kaldor, & Friedman, 2019; Rubenstein & Amon, 2019). Although its relevance and importance have been acknowledged, human rights education largely remains marginal in graduate health schools (Rubenstein & Amon, 2019). As Forman et al., (2019) state:

> We call on graduate health schools globally to mitigate these gaps by integrating courses, practical training, and programmes into their curricula to ensure that health professionals graduate with basic skills in human rights law related to health. (p.1987)

Responding to Forman et al., (2019), Gostin et al., (2019), write that they "strongly support any actions to make human rights a core competency of health professionals" (p. 1988), both for undergraduate and for continuous training. They further address the importance of human rights education for global health, and in particular—as Rubenstein and Amon (2019) also point out—that the need for a better understanding of the link between health and the rule of law is particularly important in states experiencing conflict, lawlessness and humanitarian crises.

Backan and Fitchett (2010) have also highlighted the need for a deeper understanding in the health sector of what constitutes the right to health and to see its added value for practice (Backman & Fitchett, 2010). Fitchett et al., (2011) argue, however, that there seems to be a resistance to including human rights in the medical ethics curriculum. A recent article by Pfendt (2018) shows that there is minimal literature in the field of nursing addressing *how* to integrate human rights issues into nursing curricula; moreover, the author shows that the impact of human rights education on nursing students learning is also limited.

2.3 An overview of curriculum development in the field of human rights education for health personnel

In this chapter, I will give an overview of empirical studies in human rights education for health professionals. It should be noted that, while many papers have addressed the importance of human rights in education to promote quality patient care, few empirical studies have explored the implementation of human rights education in health professional education.[10]

To obtain a comprehensive overview of the field of human rights education in health professional education, I decided to include research from both nursing and medical education, since 1) nurses and physicians/doctors work in the same context and often encounter the same human rights challenges in everyday practice; 2) health and human rights is still in its infancy, so there is limited research; 3) a human rights perspective is important for the same reasons in both these fields; and 4) both nursing and medical education take place through a combination of clinical placements and on-campus education. I also selected papers from both undergraduate and postgraduate education. The aim of this overview is to identify research that describes how human rights education for health personnel was developed and utilized in practice.

Only two of the studies included undergraduate nursing education (McGaughey et al., 2019; Okenwa-Emegwa & Eriksson, 2020), and three included postgraduate nursing education (Hopia & Lottes, 2018; Lake, 2014; Mayers, 2007). One of the studies included both undergraduate nursing students and medical doctors (Reyes, Padilla Zuniga, Billings, & Blandon, 2013). Seven of the studies included undergraduate medical education (Arda, 2004; Asgary, Saenger, Jophlin, & Burnett, 2013; Atkinson, 2019; Bakshi et al., 2015; Chastonay, Zesiger, Ferreira, & Mpinga, 2012; Praschan, Mishori, & Stukel, 2016; Schonholz et al., 2020). Four of the studies included health professionals at the postgraduate level, such as nurses, medical doctors, dentists, pharmacists or clinical officers, and medical students (Ezer & Overall, 2013; Glowa-Kollisch et al., 2015; Jovic Vranes, Mikanovic, Vukovic, Djikanovic, & Babic, 2015; London & Baldwin-Ragaven, 2008).

Although limited, these studies include research from regions across the globe. This might imply the relevance of human rights education for those in developed countries, as well—i.e., not merely in countries with humanitarian crises or war: health professionals provide daily

[10] In cooperation with a librarian, I have searched for literature in the following databases: Academic Search Elite, Cinahl, Education Source, Embase, Eric, Idunn, Oria, PubMed and Science Direct..

care for people in vulnerable situations, wherever they practice. The countries in which human rights education was implemented included the United States (Asgary et al., 2013; Atkinson, 2019; Bakshi et al., 2015; Glowa-Kollisch et al., 2015; Praschan et al., 2016; Schonholz et al., 2020); South Africa (Lake, 2014; London & Baldwin-Ragaven, 2008; Mayers, 2007); Finland (Hopia & Lottes, 2018); Australia (McGaughey et al., 2019); Turkey (Arda, 2004); Sweden (Okenwa-Emegwa & Eriksson, 2020); Nicaragua and El Salvador (Reyes et al., 2013); Switzerland (Chastonay et al., 2012); Serbia (Jovic Vranes et al., 2015); the former Soviet Union (Armenia, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, and Ukraine); and the former Socialist Federal Republic of Yugoslavia (FYR Macedonia and Serbia) (Ezer & Overall, 2013).

Taken together, the studies illustrate that human rights education is often differently contextualized: i.e., different groups or fields are targeted. One study was aimed at promoting the rights of children (Lake, 2014), with findings based on lessons learned from a short course in children's rights and child law for health professionals offered by the Children's Institute at the University of Cape Town, from 2011 to 2014. The study context was the South African government's institution has incorporated a range of laws, policies and programmes designed to secure children's rights and support their survival, health and optimal development. A second study, this one from the United States, explored medical students' experiences participating in the medical examination of refugee asylum seekers and torture survivors (Asgary et al., 2013). The authors assert the relevance of their study by pointing to human rights organizations' reports that more than half of the world's countries routinely employ torture; they further state that most global health programmes focus on international experiences, overlooking global health opportunities at home. In another study from the United States, human rights education for students who run asylum clinics is described (Praschan et al., 2016); here, the authors situate the study's relevance within the fact that the world is experiencing the worst refugee crises since the Second World War, and that many people seek asylum in the United States each year.

Some of the studies focused on challenges with dual loyalty (Atkinson, 2019; Glowa-Kollisch et al., 2015).[11] Glowa-Kollisch et al., (2015) described the development of training centred on dual loyalty for all types of health staff in the prison system in the United States. Atkinson (2019) points out that, for physicians, many situations can create dual loyalty in clinical

[11] "Where nurses face a "dual loyalty" - a conflict between their professional duties and fulfilling obligations to their employer or other authority- their primary responsibility is to those who require care" (ICN 2011, p.2).

placement, both in closed institutions (e.g., prisons, psychiatric facilities and the military) and open institutions (e.g., hospitals and clinics). Her study employed a case-based approach that employed a human rights framework to teach about dual loyalty in an undergraduate medical education curriculum. Another study addressed forced migration in Sweden, presenting lessons learned from incorporating role play about forced migration in inclusive nursing classrooms (Okenwa-Emegwa & Eriksson, 2020). Reyes et al.,'s (2013) study centred on reproductive health, describing the efforts of one Central American NGO to include human-rights-related content in reproductive healthcare provider training programmes.

Some of the studies draw on a country's history to argue for the relevance of human rights education. Based on her study findings, Mayers (2007) suggests two reasons to address human rights education for health personnel in South Africa (Mayers, 2007): firstly, the fact that human rights are an integral component of nursing curricula in South Africa; and secondly, the recognition of the role that health professionals played—through lack of knowledge and awareness or direct involvement and complicity—in human rights violations during Apartheid. In another study, Vranes et al., (2015) show how the Republic of Serbia experienced a very tumultuous period after 1990, with visible consequences reflected in the governmental structure and, unavoidably, the healthcare system. In another study, Ezer and Overall (2013) discuss how, in Eastern Europe and Central Asia, health systems are too often places of basic rights violations, rather than of treatment and care. At the same time, health practitioners are largely unaware of how to incorporate human rights norms in their work.

Some of the studies were conducted on campus, where findings emphasize the importance of interactive methods, such as group discussions (Atkinson, 2019; Jovic Vranes et al., 2015), role play (Arda, 2004; Ezer & Overall, 2013; Okenwa-Emegwa & Eriksson, 2020; Reyes et al., 2013), case studies (Atkinson, 2019; Jovic Vranes et al., 2015) and simulation for the students to benefit from their own experience and reflections (McGaughey et al., 2019). However, it has also been argued that how students approach and overcome human rights challenges in practice remains unknown (Mayers, 2007), and findings address the importance equipping students to navigate the contextual barriers to human rights protection and promotion that they may face in practice (Jovic Vranes et al., 2015; London & Baldwin-Ragaven, 2008; McGaughey et al., 2019).

Studies also took place in clinics or in the community. Hopia and Lottes (2017) point out that since the participants were working as nurses while taking the course, this may have helped them provide real-life descriptions about human rights issues, which may in turn have

enhanced the course's relevance and the nurses' learning (Hopia & Lottes, 2018). Findings also show that human rights education does not merely help students learn but may be beneficial for patients as well. In a study exploring graduate public health training for refugees, the refugees expressed that they liked that the students were present in the clinical examination (Asgary et al., 2013). They further expressed that they felt less like "a subject" of an investigation, and the authors found that it was healing for asylum seekers to share their burdens with like-minded people. In another study from a similar field, Praschan et al., (2016) describe human rights education for students who run asylum clinics. By establishing asylum clinics at their medical centres, medical students and licensed clinicians can improve the probability of an asylee obtaining asylum, connect them to vital services and train more clinicians in their area to address the demand for evaluations. The potential outcome and education goals for students were improved knowledge and understanding of global health and human rights as well as the basics of forensic documentation, and the ability to recognize signs of torture (Praschan et al., 2016).

Another two studies explore experiences from the same education programme (Bakshi et al., 2015; Schonholz et al., 2020). Bakshi et al., (2015) studied human rights education for medical students and explore how participation in a community of like-minded peers and educators can preserve idealism and commitment to social justice in medicine. Shonholz et al., (2020) examined medical students' experiences participating in the programme. They suggest that involvement in the programme provided students with important clinical skills that were not otherwise attainable in their early medical education. The findings highlight the essential role of human rights and social justice in medical education.

When looking closer into these courses, it seemed to be important to incorporate real-life challenges in the curriculum, as well as interactive methods for students and their own experiences to promote their learning and ability to advocate for human rights.

2.4 The right to adequate food and a HRBA in a nursing practice context

As addressed previously, the human right to food and health has been recognized since the UDHR was adopted by the UN General Assembly in 1948 (UN, 1948). Further, the human right to adequate food is recognized by international law in the legally binding International Covenant on Economic, Social and Cultural Rights (ICESCR) (UN, 1976). To date, 171 states, including Norway, have ratified the ICESCR and are thus legally bound to enact its provisions (Eide, 1996; UN, 2021). Article 11 of the ICESCR establishes that "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." The right to food has been further clarified in "General Comment 12: The Right to Adequate Food" (OHCHR, 1999):

> The right to adequate food is realized when every man, woman and child, alone or in community with others, have physical and economic access at all times to adequate food or means for its procurement. 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[….]they recognize that more immediate and urgent steps may be needed to ensure "the fundamental right to freedom from hunger and malnutrition"[….]Its core content implies 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[….]The accessibility of such food in ways that are sustainable and that do not interfere with the enjoyment of other human rights…throughout the life cycle (Article 11).

The right to food is not the right of everyone to be fed (Cardenas et al., 2021), in the same way that the right to health is not a right to be healthy (Florencio, 2001). It is rather the right to certain health services and a right to be safeguarded from threats in which the state can be held accountable (Florencio, 2001). In this regard, patients/nursing home residents that are malnourished should have access to satisfactory nutritional care (Cardenas et al., 2021), including screening, diagnosis and nutritional assessment, in order to reduce malnutrition and associated morbidity and mortality (Cardenas, Bermudez, & Echeverri, 2019; Cardenas et al., 2021).

To meet the challenges in nutritional care in a nursing context, a HRBA applied to the right to food offers a conceptual framework rooted in international and national law, normatively based on international human rights standards (UNSDG, 2003). In a HRBA, the processes towards a desired outcome are guided by a set of principles, including participation and inclusion, accountability, equality and non-discrimination, transparency, human dignity, empowerment, and respect for the rule of law (FAO, 2012; UNSDG, 2003).[12] A HRBA is a bottom-up approach, where these principles can be operationalized and put into everyday practice (Curtice & Exworthy, 2010; UNSDG, 2003)—as opposed to a top-down approach requiring detailed knowledge of human rights and the corresponding case law (Curtice & Exworthy, 2010). These principles are actually familiar for health professionals and in nursing education, even if the language of human rights seems unfamiliar (Curtice & Exworthy, 2010). A "bottom-up approach" means that it aims to empower healthcare staff and patients with knowledge and the capacity to promote human rights.

[12] These principles are also referred to as the "PANTHER" principles; Participation, Accountability, Non-discrimination, Transparency, Human Dignity, Empowerment and Rule of law (FAO 2012).

Applying a HRBA within the context of nutritional care for older adults in institutions may help address the multiple causes of malnutrition (UNSDG, 2003). In nursing, ensuring adequate nutrition is largely seen as meeting a basic need, accomplished by the immediate causes of malnutrition, which will be further explored later. With a framework incorporating the immediate, underlying and root causes of malnutrition, an HRBA helps nurses address the structural, environmental, resource- and policy-related factors leading to malnutrition, in addition to the more-immediate causes (Kent, 2005; UNSDG, 2003).

Human rights implies three levels of obligations of states parties: the obligations to *respect*, to *protect* and to *fulfil* (OHCHR, 1999; Oshaug, Eide, & Eide, 1994). When someone is entitled to a right, someone else has the duty to help fulfil this right: this idea of "nested rings of responsibilities," a term introduced by Kent, is used to map the different levels of duty-bearers (Kent, 2005). While the state of Norway has the overall obligation of a responsible policy of care for older adults in healthcare facilities, various public actors have the immediate duty to carry it out. Thus, in the proximate "rings," the healthcare staff are the duty-bearers closest to the nursing home residents, complemented by the administration and management. Each ring of duty-bearers should support and give guidance to the duty-bearers closest to the right-holders, in supporting them to meet their duties. Since the healthcare staff are the duty-bearers closest to the nursing home residents and right-holders, they should be supported in their efforts to promote residents' rights by the administration and management (Kent, 2005).

2.5 Nutritional care in nursing practice

The ICN (2012) categorizes the aim of nursing into four main responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. As noted earlier, nutritional care[13] has long been recognized as an important part of nursing practice (Henderson, 1964; Nightingale, 1946). Kitson et al., (2013), in their revisiting of "fundamental nursing care," argue that there is a strong agreement that food and nutrition are an important part of the fundamentals of nursing care (Kitson et al., 2013). Here, "fundamental" reflects the centrality to reduce damage, optimize recovery and ensure positive experiences for patients (Feo & Kitson, 2016; Kitson, Conroy, Kuluski, Locock, & Lyons, 2013).

13 Nutritional care can be defined as "an overarching term to describe the form of nutrition, nutrient delivery and the system of education that is required for meal service or to treat any nutrition-related condition in both preventive nutrition and clinical nutrition (Cederholm et al., 2017).

Traditionally, nursing theorists have framed the aim of nursing around the idea that human beings have basic needs that must be met—one of which is nutrition (i.e., eating and drinking) (Henderson, 1964; Watson, 2008). As early the 19th century and the beginning of the profession of nursing the importance of nutrition in nursing care was acknowledged. As Nightingale (1861), the founder of modern nursing, writes: "every careful observer of the sick will agree in this that thousands of patients are annually starved in the midst of plenty from want of attention to the ways which make it possible for them to take food" (p. 46). Nightingale points to nutrition and food as the second most important area for nursing. Indeed, nurses were initially responsible for preparing and serving food to the sick (Englert, Crocker, & Stotts, 1986). Eating and drinking adequately was also addressed by nursing pioneer Henderson in her "need theory," as 1 of 14 fundamental needs (Henderson, 1964). Later, in their self-care deficit theory, Orem (2001) highlight nurses' responsibility to ensure adequate intake of water and food for patients to experience well-being and to promote health.

It is important to point out that, the need of food and fluids are not just biophysical needs (Kaplan, 2012); indeed, eating and drinking are replete with symbols and meanings that go beyond survival, like the social and cultural implications of food and meals (Fjellström, 2009). As such, caring for older adults must reflect those meanings (Hanssen & Kuven, 2016; Sydner & Fjellström, 2005). Eating and drinking also entail activities that include nurse–patient interactions in which social processes are built, and in this regard are universal and essential to life (Gastmans, 1998). As Watson (2008) argues, the human need for fluid and food is both physical and metaphysical and involves "emotional relationships, communication, and feelings of love, friendship, contentment, comfort, support, social life—good feeling" (p. 149). Food has been addressed as a challenging and complex fundamental of care (Alves, Oliveira, & Lima-Basto, 2019), since "food is permanently present in the daily life of the person, being much more than an act for the maintenance of life" (p.36). Nevertheless, the fundamentals of care are dominated by the biomedical model, which can result in dehumanizing experiences for patients and families and poor health outcomes (Feo and Kitson 2016); relatedly, a perspective of food as merely nutrition takes a medicalized and reductionistic approach (Valente et al., 2016).

Food is also about structures, resources and how the services are organized—issues that lack awareness in nursing care. As cautioned by the Council of Europe (CoE) in 2003, increasing health professionals' competence in nutrition may be insufficient to ensure adequate nutrition among older residents, as undernutrition may be caused by both individual and systemic

factors (CoE 2003). Studies indicate a lack of nutritional care due to lack of defined responsibilities and routines around mealtimes (Aagaard & Grøndahl, 2015; Hammar, Swall, & Meranius, 2016). In another study, system failure was seen as a barrier in nutritional care (Eide, Halvorsen, & Almendingen, 2015). Chapman et al., (2015) argue that nursing staff need to be able to exercise autonomy and the hospital system must offer enough flexibility to allow wards to organize nutritional screening and care in a way that meets the needs of individual patients.

In recent years, several reports, plans and strategies have been published regarding nutrition, food and meals that concern older adults in healthcare settings. In 2021, the Norwegian Ministry of Health and Care Services (HOD) published a national strategy for good diet and nutrition for older adults in nursing homes and home care services. Entitled "Live Your Whole Life—A Quality Reform for Older Adults," the nutrition strategy forwarded in this reform is aimed at supporting the focus areas of "food and meals." The publication addresses four challenges: 1) the numerous older adults with nutritional challenges, including malnutrition, 2) the lack of systematic follow-up, 3) the lack of knowledge and competence and 4) the lack of an individual approach to nutritional care. This strategy can also be viewed as a follow-up to the HOD's National Action Plan for a Healthier Diet (2017–2021) and White Paper nr. 19 (2018–2019) "A Good Life in a Safe Society." This strategy can also be seen in relation to the recent UN Committee on Economic, Social and Cultural Rights' periodic report, which stated the lack of plan and strategy for nutritional care in Norwegian healthcare service and an urgent need to deal with the issue of malnourished older residents (UN, 2020). Several years before this, even, in 2013, the World Health Organisation (WHO) was reporting on Norway's nutrition policy, calling for Norway to both increase health professionals' nutritional competence and establish adequate nutrition-related routines in the healthcare sector. Here, then, one important step is to introduce human rights education for nursing students and the right to food for older adults in nursing care facilities.

2.6 Nutrition and nursing education

Gaps and challenges in undergraduate nursing students' nutrition education have been increasingly addressed in international research (Dang & Maggio, 2017; Kris-Etherton et al., 2014; Laing & Crowley, 2021; Scammell, 2017). While nutrition is taught as part of the curriculum, precisely *what* to teach in nutrition education for nursing students remains unclear (Sacks, 2017). Moreover, despite the need for and importance of nutrition education, there has

been a decline in the availability of nutrition courses in health professional programmes (Livne, 2018) and for nursing students (Sacks, 2017).

Indeed, nurses' and nursing students' competence in nutritional care has been reported as insufficient worldwide (Bollo, Terzoni, Ferrara, Destrebecq, & Bonetti, 2019; Buxton & Davies, 2013; Eglseer et al., 2018; Kris-Etherton et al., 2015; Yfanti, Tsiriga, Yfantis, Tiniakou, & Mastrapa, 2011). Researchers have also identified a lack of proper documentation in the patient record related to nutritional care (Halvorsen, Eide, Sortland, & Almendingen, 2016). Studies indicate that nursing students lack knowledge about the fundamental nutrients in food, nutrition-related deficiencies and components of a healthy diet (Chepulis & Mearns, 2015; Yfanti et al., 2011). This supports findings from another study that indicate that nursing students lack knowledge about basic concepts in nutrition, such as the metabolism of nutrients, and the relationship between nutrients and dietary non-nutrient substances, such as fibre and cholesterol (Buxton & Davies, 2013). Research also indicates that most nurses do not update their knowledge of nutrition after they graduate (Holmberg, Klingberg, & Brembeck, 2021). Perhaps responding to the numerous calls to strengthen health personnel's nutrition-related knowledge (DiMaria-Ghalili et al., 2014; Kris-Etherton et al., 2014; Kris-Etherton et al., 2015), the importance of nutrition competencies in education and training for health personnel has been addressed as a new paradigm (Kris-Etherton et al., 2015).

Some argue that nutrition education in the health field has not yet found its place nor contents (Buxton & Davies, 2013). It has also been argued that food and nutrition in nursing education faces several challenges (DiMaria-Ghalili et al., 2014; Kris-Etherton et al., 2014). One of these challenges is that the ageing population requires greater understanding around how to address nutrition education in other settings, like long-term care facilities for older adults. Moreover, (Eglseer et al., 2018) found that the topic of malnutrition for older adults is generally not included in nutrition courses; the authors report that it is taught in only approximately 30% of nursing programmes in Europe. Another challenge is that nutrition education in undergraduate nursing has been described as limited, due to a lack of credits and an overly narrow focus on limited aspects of nutrition (Huisman-de Waal, Feo, Vermeulen, & Heinen, 2018; Sacks, 2017). In this regard, current nutrition education seems insufficient to prepare nursing students appropriately for nutritional care in clinical practice (Sacks, 2017; Sodjinou et al., 2014). A fourth challenge in nutrition education addressed by Kris-Etherton et al., (2014) is the importance of moving away from rote memorization of information towards

a more meaningful integration of new constructs with existing knowledge (Kris-Etherton et al., 2014). A final challenge relates to the assumption that nutritional care is embedded in nurses' clinical skills before they enter professional practice. This suggests a disconnect between nursing students' nutrition education and the nutritional care they are expected to apply as graduates (Scammell 2017, Chao, Luong et al., 2020). Therefore, nursing education must give due attention to nutrition education, both on campus and in clinical placement, to adequately prepare students for nutritional care in professional practice.

In nursing education, the didactic approaches to incorporating nutrition include single courses in nutrition, an integrated approach where nutrition is incorporated throughout nursing courses, or a combination of these (DiMaria-Ghalili et al., 2014). Nutrition is incorporated in many nursing textbooks—for instance, in gerontology.[14] There are also many textbooks on nutritional care written for nurses. Nevertheless, in a recent review by Dang and Maggio (2017) on nutrition educational interventions in the health professions, the authors report a lack of detailed descriptions of the interventions, evaluations and learning outcomes. They found that teaching in nutrition normally happens on campus, due to large groups of students. Moreover, only 7 of the 32 interventions included undergraduate nursing students (Dang & Maggio, 2017). In another recent study for undergraduate nurses, it was emphasized that educational nutrition activities should utilize active, experiential and social learning strategies (Holmberg et al., 2021). These findings are supported by another study for nurses by Mitchell et al., (2018), where nutrition education utilizing active learning strategies was associated with improvements in nutrition knowledge (Mitchell, Lucas, Charlton, & McMahon, 2018). In a recent study, Chao et al., (2020) point out the importance of nutrition education being integrated into clinical care.

Evju and Lindgren (2017) argue for the importance of cooperation between nursing schools and placement locations, and between occupational groups responsible for nutritional care. A recent study on interprofessional collaboration with dietitians found collaboration to be important for students' learning about nutrition (Shea, Brophy, Nininger, Abbott, & Wilson, 2021). Others have also reported the importance of an interdisciplinary and interprofessional approach to nutrition education (DiMaria-Ghalili et al., 2014; Wesselborg et al., 2019).

14 In Norway, this is for instance addressed in Kirkevold, Brodtkorb and Ranhoff (2020): Geriatric nursing: good care for the older patient.

Thus far, few studies have discussed pedagogic methods in nutrition education in nursing (Dang & Maggio, 2017; Holmberg et al., 2021; Yuste, Zarandona, Arrue, & Gravina, 2021), and there is limited research regarding the perspective of the students themselves regarding learning about nutrition (Huisman-de Waal et al., 2018). Laing and Crowley (2021) conclude that future research should include the views of nursing students and nurse educators regarding nutrition curriculum initiatives. In this regard, it seems like what nurses or nursing students (do not) know about nutrition has been emphasized, rather than the challenges nursing students may encounter in their placement, or the competencies nurses need in professional practice regarding nutritional care. Although having knowledge about nutrition is essential, it is not the same as handling a nutrition-related situation in practice (Scammell, 2017). In practice, challenges can involve ethical challenges regarding nutritional care, or go beyond the nurse–patient relationship, such as lack of proper routines for malnutrition screening or delegation of tasks to other staff. As addressed by others, it is important to incorporate nutrition education throughout students' entire education, including clinical placement (Chao, Luong, Dowd, & Compher, 2020; Chepulis & Mearns, 2015; Kris-Etherton et al., 2014). Further research in this field has also been called for (Kris-Etherton et al., 2014), and should include the development and implementation of innovative nutrition care programmes in nursing education (Chao et al., 2020; Laing & Crowley, 2021), in which the students themselves are involved (Laing & Crowley, 2021).

2.7 Summary and reflections

As far as I know, there are few, if any, studies that have introduced a human rights perspective in nursing education in the context of nutritional care. The aim of this overview of the empirical literature was to identify research that describes how human rights education for health personnel has been utilized in practice. As there is a lack of empirical papers in nursing education in this field, I decided to include courses for medical students. Taken together, the studies, though limited in number, illustrate that human rights education has a range of contexts, targeting different fields (e.g., nurses or medical students), groups (e.g., children, refugees, or victims of torture), and locations (e.g., a country or region's history). Moreover, some of studies were conducted on campus, while others involved communities and patients. All of the authors, however, note that how one targets human rights education is important. Many of the studies emphasize the importance of interactive methods (e.g., group discussions, role play and simulation) in on-campus learning, for students to acquire and reflect upon their own experience. However, some authors argue that, in these instances, even if students value

their human rights learning, the ways in which they will approach and overcome human rights challenges in practice is still unknown since the studies have taken place on campus. With regards to the studies that were conducted in clinical placement or in a community, it appears that human rights education has the potential to facilitate patient inclusion and promote human rights alongside student learning.

As much of human rights education comes from the field of public health, there has been a tendency to approach human rights education from a global perspective. This of course is important, but it is equally important to address human rights education in daily care, as the linking of human rights and health has several added values. When education takes place on campus, the students build an awareness of human rights, but still face challenges around how to take action when experiencing rights violations in context. Here, then, it seems crucial to build a curriculum that enables students to encounter real-life challenges; indeed, many of the studies stress the need for practical experience and exercises in human rights education to promote students' learning and ability to advocate for human rights. Moreover, it appears that research is needed within the field of human rights education for nursing students since the literature is scarce, despite its relevance; and not only should real-life challenges be incorporated, but also learning both on campus and in clinical placement.

The field of nutrition education seems to have many of the same challenges as human rights education: firstly, there is a need to tailor education to students' needs; secondly, education generally occurs outside practice contexts; thirdly, explicit nutritional care is largely lacking in nursing education, despite its relevance; and fourthly, nutrition education has not yet found its place and content. These similarities—along with longstanding concerns regarding inadequate nutritional care for older care in healthcare facilities—informed the study design, in which human rights education was combined with a nutritional care perspective in nursing education.

3 Theoretical perspectives

In this chapter, I present the three theoretical perspectives that are central to the thesis: a perspective on human rights, a perspective on human rights education for professional practice and a perspective on learning. It has been argued that, within the academic literature on human rights, there is no consensus around what human rights actually are, with researchers and writers emphasizing different concepts and definitions (Dembour, 2010; Ife, 2012). As such, there is a lack of agreement around what constitutes human rights in practice, even though human rights are universal and derived from reason and legally binding documents (Dembour, 2010). Therefore, in my selection of theoretical frameworks for this thesis, it was important that they 1) emphasized students' learning and their own understanding about how they can contribute to change in professional practice, and 2) could "work together," meaning that they could either fulfil each other and share the same perspective regarding human rights promotion.

3.1 Three human rights traditions

As human rights can be viewed from different traditions, it is necessary to reflect upon the ways in which one can understand human rights (Dembour, 2010; Ife, 2012). Ife (2012) has categorized three traditions of human rights thinking addressed in the literature: the natural rights tradition, the legal and stated obligations tradition, and the constructed rights tradition.

Natural rights tradition

The first tradition, the *natural rights tradition*, assumes that we are born with human rights. Earlier natural theorists, such as philosopher John Locke, have argued that human or "natural" rights are "non-visible properties of personhood" (Orend, 2002), p. 18); in other words, we have rights in the same way that we have a soul (Orend, 2002), and to understand our rights we must understand our humanity (Ife, 2012). In this tradition, human rights exist independently of social recognition (Dembour, 2010). In the tradition of viewing human rights as natural rights, Perry (2000) points out:

> The idea of huma rights that informs these various international documents (and many others) is, then, in part, the idea that there is something about each and every human being, simply as a human being, such that certain choices should be made, and certain other choices rejected,; in particular, certain things ought not to be done to any human being and certain other things ought to be done for every human being (p.13).

There is wide consensus that human rights rest on living with dignity and are thus a broader concept than human survival and "basic needs" thinking (Donnelly & Whelan, 2020). As

Donnelly and Whelan (2020) state, "we have human rights not to what we need naturally as animals for survival but to what we need for a life of dignity" (p. 24).

According to this tradition, human rights are literally the rights one has because one is human (Donnelly 2013). Human rights are equal rights, in the sense that all human beings have the same rights. They are also inalienable rights, meaning that one does not stop being a human, no matter how terribly one is treated or behaving. And finally, they are universal rights, in the sense that all humans are holders of human rights (Donnelly, 2013).

Legal and state obligation tradition

In the second tradition, Ife (2012) is approaching human rights in the *legal* and *state obligation tradition*. As the natural rights tradition views human rights as "given," the tradition of legal rights views human rights as "agreed upon" (Dembour 2010, p. 2); in other words, there are no human rights outside the law. This tradition suggests that our rights exist only to the extent that they are protected, guaranteed or realized as a result of state action. Moreover, if we want to know what our human rights are, we investigate not the essence of our humanity, but rather the combinations of laws, conventions and government programmes that provide and promote those rights. As Merry (2006) points out:

> The human rights legal system produces culture by developing general principles that define problems and articulate normative visions of a just society in a variety of documents ranging from lawlike ratified treaties to nonbinding declarations of the General Assembly (p. 229).

The rights are defined through legislation and are identified and promoted by the welfare state, through the legal system (Ife, 2012). From this perspective, it is the legislators and the lawyers who have the main responsibility to articulate human rights, particularly for human rights practice. This view is arguably the most dominant of the three traditions and is therefore reflected in much of today's human rights discourse. Human rights education in this regard would include information about the law for health personnel.

Constructed rights

In the third perspective, Ife (2012) approaches human rights in the tradition of *constructed rights*. This approach places less emphasis on rights as existing in some objective sense, but rather looks at how people, either individually or collectively, define their own rights or the rights of others. Fields and Narr (1992) argue that:

> If people are not aware of the historical and contextual nature of human rights and not aware that human rights become realized only by the struggles of real people experiencing real instances of domination, then human rights are all too easily used as symbolic legitimizers for instruments of that very domination (p. 5).

In this approach, we are constantly negotiating and renegotiating rights in our interactions with others and in our daily lives. It also emphasizes how rights are defined by people themselves, rather than defined by theologians and philosophers (natural rights) or lawyers and politicians (legal rights) (Ife, 2012).

While the UDHR (UN, 1948) is arguably the most important statement of its time, it needs to be understood within the context in which it was developed, and it is not "written in stone" (Ife, 2012). In the constructed rights tradition, the UDHR is a rejection of a positivist notion of rights that exist "out there," in an objective form that can be identified and discovered or empirically measured. The idea that rights exist independently and objectively of human agency is characteristic of a positivist world view in the social sciences. Viewing rights as constructed rights means that they are constructed though human interaction and dialog around what should constitute a common or shared humanity. Here, then, human rights are not static, but vary over time and in different cultures and contexts (Ife, 2012).

The constructed rights tradition sees human rights as transformative and fought for. In this approach, then, viewing rights as constructed gives human rights education a transformational structure (Dembour, 2010; Newham, Hewison, Graves, & Boyal, 2020), meaning that human rights education holds the potential for change.

3.2 Human rights education as practice-oriented in everyday life

As noted earlier, human rights education is an emergent field of educational theory (Tibbitts & Kirchschläger, 2010), and within this context, Tibbits' (2017) theory and model was chosen for three key reasons. Firstly, she refers to duty-bearers (e.g., health professionals), and this was seen as relevant for this thesis.[15] Secondly, her theory can also be related to Ife's (2012) conceptualization of rights as constructed, and as societal and institutional transformations and change. Thirdly, Tibbit's model has a practice-oriented approach to people's everyday lives. As illustrated in Table 2, the model emphasizes accountability and professional development for professionals who work directly with people in situations where there is a risk of human rights violations (e.g., nurses working with patients).

[15] The theories of human rights education within critical pedagogy refers to people who are oppressed (Freire 1970).

Table 2 Key features of the Revised Human Rights Education Model (Tibbitts 2017).

Model / Features	Values and awareness—socialization	Accountability—Professional Development	Activism Transformation
Sponsors	Typically, government agencies or authorities	Both government agencies and civil society organizations, sometimes in partnership	Typically sponsored by civil society organizations
Kind of learner participation	Usually involuntary	Both voluntary and involuntary	Usually voluntary
Education sector	Usually in the formal education sector	Both formal (pre-service) and non-formal (in-service) sectors	Usually in the non-formal education sector, including youth and community development
Common target audiences	Students, sometimes the general public	Law enforcement officials, lawyers and judges, civil servants, health and social workers, educators, journalists, religious leaders	Marginalized populations, youth
Incorporation of critical stance	Non-critical stance	Critical view of one's professional role in relation to prevention of human rights violations	Critical stance towards one's society or local environment, the nature of power, the human rights system itself
Orientation	Transmission of information	Development of capacities related to work roles and responsibilities	Personal transformation, human rights activism, social change
Key content	General human rights theory, history and content, with some attention to learner's rights	Human rights content relevant for groups, with links to national protection systems and professional codes of conduct	Human rights content relevant for the learners, with strong focus on learners' rights and contemporary, local human rights violations
Treatment of human rights norms and standards	General treatment, with reference to norms to promote positive social behaviour	Selected as relevant for professional groups; may include appeal to personal value systems	Selected as relevant for the learners, with strong appeal to personal value systems
Teaching and learning strategies	Didactic to participatory	Participatory to instrumentally empowering	Instrumentally to intrinsically empowering/transformational
Strategy for reducing human rights violations	Passive: socialization and legitimization of human rights discourse	Active-agency: application of human rights values and standards within one's professional role	Active-transformational: integration within one's analytical framework, taking action to reduce violations in both private and public domains, participation in collective action and creation of social change agents

Tibbits (2018) defines human rights education as "a practice-oriented expression of the high-minded ideals of the UDHR, including equality and respect for human dignity" (p.64). Tibbits (2017) points out that the overall goals of human rights education are rooted in the aim of eliminating human rights violations. Through the lens of the legal standards, it is the signatories to treaties (i.e., the governments and states parties) that are responsible for preventing such abuses, and for protecting their citizens. However, the goals of human rights education can also be oriented towards everyday people, including health professionals addressed in the model; this can be accomplished through the lens of social change.

In the model, Tibbits (2017) further emphasizes that learning and awareness of values happens through socialization. She argues that human rights education not only attempts to influence laws and states' behaviour but is also an important part of connecting human rights to people's daily lives. For human rights to become a moral framework, human rights must be part of the "fabric of values that are acted on in daily life" (Tibbits 2018, p. 65).

In the model, Tibbits' emphasis on accountability and professional development is of particular relevance for nursing educators and student nurses. The aim is to develop professionals' motivation and capacity to fulfil their responsibilities in accordance with human rights values. This approach is skills-oriented and aims to move beyond participatory engagement strategies. I will elaborate further on the two last points in the model: *teaching and learning strategies* and *strategy for reducing human rights violations*.

The model suggests four pedagogic approaches or learning strategies in human rights education: didactic methodologies, participatory/interactive methodologies, empowerment methodologies and transformative methodologies.

The didactive methodologies is influenced by the traditional culture of education, in which learners are not given the opportunity to influence their own learning, e.g., through open discussion or reflection. For example, learners are often instructed to memorize the UDHR. This approach has been criticized and associated with a human rights system that is itself hegemonic and neo-colonial (Tibbitts, 2017). Moreover, this didactic approach seems to only be about human rights (Tibbitts, 2017), which is problematic given that human rights education is meant to be *about*, *for* and *through* human rights, as mentioned earlier (UN, 2011).

Participatory and interactive methodologies are used more often in human rights education than the other approaches. Here, the intention is to motivate learners and engage them in the learning process. This approach does not necessarily foster agency in the learner but is useful for critical reflection on human rights values and standards as an analytical exercise. This approach is part of the pedagogy used in the accountability and transformative features of the model.

Empowerment methodologies are linked to the cultivation and development of agency in learners. This occurs through specific capacities, like leadership development or the integration of values (e.g., non-discrimination or dignity) into work roles. This methodology is linked to "instrumental empowerment" in the accountability and transformative features of

the model. The difference between empowerment methodologies and solely participatory approaches is the fact that empowerment methodologies explicitly approach the learning process as instrumental for individuals to develop increased capacity to influence their own environment.

Transformative methodologies extend the methodologies of instrumental empowerment. This approach is suitable in the transformation model. The aim of both the empowerment and transformative methodologies is to cultivate agency in the learner. However, the transformative approach is different in two ways: 1) the cultivation of the learners' agency is geared towards transformation through human rights activism; and 2) transformative methodologies draw upon critical reflection around power imbalances and oppression in one's own (local) environment. The underlying idea here is that the reshaping of one's understanding of the world can lead one to combat oppression.

3.3 Theory of learning and communities of practice

To understand students' learning and professional development in nursing education, it is important to study learning in the context of the clinical setting, where they are being socialized into a profession and participating in complex working situations. Social anthropologist Lave and computer scientist Wenger's (1991) theory about situated learning helped change the fields of cognitive science and pedagogy by approaching learning from a novel angle. Traditionally, theories of learning and education had focused on processes of cognition as individual. Lave and Wenger's (1991) pioneering book, *Situated Learning: Legitimate Peripheral Participation*, included the concept of communities of practice, which shifts the focus from the process of learning as individual to learning as a collective process, which Wenger (1999) elaborated further in his book *Communities of Practice: Learning, Identity and Meaning*. The key concepts developed in the works of Lave and Wenger include legitimate peripheral participation,[16] situated learning and communities of practice, which will be further elaborated. The later works by Wenger will also be discussed.

Since human rights can be understood as social practices, and human rights education takes place in communities, applying a social theory of learning to understand nursing students' experiences and perspectives seems reasonable. As noted earlier, the field of the complex human rights education can benefit from real-life examples, such as nursing students' experiences from clinical placement. Prior research also argues that placement has

[16] Not so commonly used today.

characteristics of a community of practice (Cope, Cuthbertson, & Stoddart, 2000; Molesworth, 2017), and this theory has increasingly gained traction in nursing education (Andrew, Tolson, & Ferguson, 2008; Cope et al., 2000; Li et al., 2009; Morley, 2016; Thrysoe, Hounsgaard, Dohn, & Wagner, 2010).

Situated learning and communities of practice

> Learning viewed as situated activity has its central defining characteristic a process that we call *legitimate peripheral participation*. By this we mean to draw attention to the point that learners inevitably participate in communities of practitioners and that the mastery of knowledge and skill requires newcomers to move toward full participation in the sociocultural practices of a community (Lave and Wenger, 1991, p.29)

As mentioned earlier, Lave and Wenger introduced a novel perspective with their theory: namely, that learning is not merely an individual process, but a social one, and that it occurs though *legitimate peripheral participation*. Situated learning emphasizes that learning is dependent on the social situation taking place through interaction with experts and peers in a community organized around a common interest, in "communities of practice." This hypothesis applies to learning as a continuously evolving set of relationships situated within a social context. Wenger further elaborated the concept of communities of practice (Wenger, 1999; Wenger, McDermott, & Snyder, 2002; Wenger, 2010; Wenger & Snyder, 2000).

Legitimate peripheral participation

Lave and Wenger see learning as social participation which in turn is important to human identity. In their theory, the individual is an active participant in the practices of social communities, and is constructing identities in relation to these communities (Wenger, 1999). This conceptualization of learning is more than "learning in situ" or "learning by doing"—learning is an integral and inseparable part of social practice (Lave & Wenger, 1991). For instance, participating in a team at work is both action and belonging; it does not merely shape what we do, but influences who we are and in what way we interpret what we do (Wenger, 2018). In this way, people create their shared identity through engaging in and contributing to the practices of their communities.

As examples, Lave and Wenger (1991) draw for instance on midwives, tailors and butchers to show how they learn new, tacit knowledge relevant to their trades while they are participating in and being accepted into the community of practice (Lave & Wenger, 1991): from peripheral to central membership. A community of practice involves much more than technical skills. The key to legitimate peripheral participation is access by the apprentice to

the community of practice, and the benefits and opportunities that such a membership involves. The denial of access and limiting of the centripetal movement for newcomers changes the learning process. The authors emphasize the importance of transparency for the newcomers, and argue that all this take place in a social world, dialectically constituted in social practices involving reproduction, transformation and change.

Health professionals encounter situations every day that require them to have a complex situational understanding if they are to respond correctly. To develop skills of this nature, nursing students need to learn in authentic contexts. For learning to be meaningful for the students, it ought to be situated in real-life contexts—contexts in which there is room for students to participate as learners, to be able to learn to navigate and interpret complex situations. Newcomers or novices are not yet skilled to play a central role, and are therefore given responsibilities which are peripheral, and described as legitimate peripheral participation. For the newcomers, their move from peripherality to centripetally creates possibilities for understanding the world as experienced (Lave & Wenger, 1991).

This theory of learning is thus placing of knowledge on the practitioners: in that sense, this theory does not grant higher status to theory or rules over practice-based approaches—and can thus contribute to bridging the theory–practice gap in the human rights field. By understanding each other's stories, difficulties and insights, this allows individuals not just to learn from one another but also build on each other's expertise (Wenger, 1999). This does not mean, Wenger cautions, that practitioners know everything. There is a need for good dialog with other communities of practices, and expertise outside the community.

What are communities of practice?

Wenger (2018) concludes that there are four premises when it comes to learning: 1) as we are social beings, our sociality is an important fact of learning; 2) knowledge is a matter of competences with respect to valued enterprises; 3) knowing is a matter of participating in the pursuit of such enterprises; and 4) our engagement and experiences are meaningful.

Based on this perspective, then, learning is seen as social participation. A social theory of learning thus includes and integrates the components to characterize social participation as the process of learning and knowing.

> Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (Wenger et al., 2002. p.4).

There is certainly variety in the form communities of practice take, but they all share three basic structures (Wenger, McDermott, & Snyder, 2002): a *domain* of knowledge, defining a set of issues; a *community* of people who are interested in this domain; and the shared *practice* developed to enable community members to be efficient in their domain. It is worth describing these elements in further detail to facilitate better understanding of the concept of community of practice.

Domain

> Whatever creates that common ground, the domain of a community is its *raisons d'être*. It is what brings people together and guides their learning. It defines the identity of the community, its place in the world, and the value of its achievements to members and others (Wenger et al., 2002, p.31)

The domain is the common concern and creates common ground and refers to a set of problems or passions that all members of the community share. If the domain is well defined, it can legitimize the community by acknowledging its value and purpose to its members. The domain can inspire its members to contribute and participate and can guide their learning and give meaning to their actions. Membership implies commitment to the domain, and a shared competence can distinguish its members from others.

The domain of a community ranges from mainstream knowledge (e.g., "exercising is healthy") to highly specialized professional expertise (e.g., the knowledge and skills health professionals need to care for patients). A domain is not necessarily a fixed set of problems or passions but evolves along with the community and the wider society. For instant, for a group of professionals, the sharing of knowledge itself can be as important as the company or institution in terms of acknowledging their professional authority. The identity of the community is also influenced by the importance of the domain within the society and the world. Moreover, knowing the boundaries in a community helps its members decide how to present new ideas and what is worth sharing.

Community

> The community creates the social fabric of learning. A strong community fosters interactions and relationships based on mutual respect and trust (Wenger et al., 2002, p.28).

Although researchers have identified this element as the most troublesome to reconcile, the community creates the social structure that facilitates learning through interactions and relationships with others. A strong community is built on mutual respect and trust between its members and thus requires an open atmosphere that encourages the sharing of ideas, asking

difficult questions and listening carefully. Trust is also important when handling conflicts and discussions; strong bonds can bear disagreement, and a community's members might even deepen their relationship and learning through a conflict. Moreover, learning is as much a matter of belonging as an intellectual process, which make communities an important element. Members of a "healthy" community may also have the sense that contributing to the community will also benefit them; this can be seen as a "pool of goodwill" or "social capital." For instance, including nursing students during their placement in a nursing home may benefit the nurses working there, because the students might be those nurses' colleagues in the future.

The practice

> The practice is a set of frameworks, ideas, tools, information, styles, language, stories, and documents that community members share (Wenger et al., 2002, p.29)

The practice refers to the specific knowledge the community shares, maintains or develops. A community of practice both explores the existing body of knowledge and is oriented to the future by providing resources that enable its members to handle new situations and create knew knowledge. Given that one must learn the terminology of participation, this leads to implications regarding how to understand and support learning at various levels (Wenger, 2018). For *individuals*, this means that learning is a matter of engaging in and contributing to the practice of their community. For *communities*, it is a matter of refining their practice and including new members. And finally, for *organizations*, this entails facilitating interconnected communities of practice (Wenger et al., 2002).

Human rights can be a vital tool for social change and development for the better in a community. In Wenger's theory of learning, knowledge development and social change take place when three fundamental elements of domain, community and practice function well together, and when they "make a community of practice an ideal *knowledge structure*—a social structure that can assume responsibility for developing and sharing knowledge" (Wenger et al., 2002, p. 29). This can take place when the "old-timers" (e.g., nurses) and the "newcomers" (e.g., nursing students) participate together in clinical placement. Here, in contrast to the status of knowledge within the sciences being abstracted from practice, knowledge creation takes places *in* practice, thorough participating and socializing (Morley, 2016).

4 Design and methods

A research paradigm is defined by Guba and Lincoln (Guba & Lincoln, 1994) as "[t]he basic belief system or worldview that guides the investigator (p.105). A paradigm describes a worldview based on philosophical assumptions about the nature of social reality (ontology), ways of knowing (epistemology) and an ethics and value system (axiology) (Chilisa & Kawulich, 2012).

The research paradigm for this thesis can be placed within the aim of social constructionism. In this postmodern interpretive framework, the qualitative inquirer seeks to understand and give meaning to the world in which they live and work (Creswell & Poth, 2018). These meanings are multiple and varied and lead the researcher to look for the complexity of perspectives rather than narrow meanings from a few categories or ideas (Creswell & Poth, 2018). The study employed a qualitative approach; according to Denzin and Lincoln (2011), this involves an interpretative approach to the world, where the aim is to "study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them that meant the study" (p. 3).

Since the 1960s, the term constructionism has radiated across the social science (Gubrium & Holstein, 2008). From its inception, constructionist research has drawn special attention to both the dynamic of social reality and the processes of how social reality is given meaning and put together. The main ideas have been that the world in which we live and our place in that world are not simply "there"; rather, participants in fact construct the world in their daily life. Here, Berger's and Luckman's (1996) *The Social Construction of Reality* has been influential, as it problematizes and gives empirical attention to the most common, taken-for-granted process of reality construction. The authors emphasize the mutuality between society and humans: we influence society, and we are influenced by society.

In this study, the nursing students are giving meaning to a human rights perspective through their negotiations, interactions and relationships in a community of practice. Knowledge then becomes constructions that are shared within a specific group at a certain time in a community of practice. In this study, it was not relevant to identify the students' knowledge about human rights, food or nutrition; instead, what was important was that participants were included with their views, perspectives and experiences regarding human rights. In other words, emphasis was placed on how they constructed and learned about human rights, which included and

combined learning on campus and in placement through their interactions and relationships in a nursing home.

In this chapter, I will reconstruct the process of conducting this study, and the reflections and choices that were made. This process was extensive, and it is thus impossible to describe completely. As this chapter was written at the end of a rather long journey, my reflections on what was done and why undoubtedly reflect my own reconstruction of how the process has gone. The research process involved continuous reflection, back and forth, and making methodological considerations, choices, adjustments, and reflections throughout. Conducting research is very seldom a straightforward process, particularly when projects continue for a long duration, and when academic and personal paths intersect. As such, in this chapter, I present what I find to be most central to the study, which is 1) the context and aim of the study, 2) the research design, 3) the development and redesign of the coursework, 4) the choice of research methods and a qualitative approach, 5) sampling and recruitment, 6) the analysis, 7) validity of the study, 8) limitations and 8) ethical considerations.

4.1 Context and aim of the study

The coursework on "the human right to food and nutrition" was developed at a Norwegian university college for first-year nursing students from 2017 to 2018 and combined a two-day module on campus with clinical placement and a written assignment. Table 3 illustrates the three parts of the study, including the research questions, participants (data material), setting and analysis.

Table 3 The study, research questions and methods on which this study is based.

Aim of the study	**Introduction of a human rights perspective in nursing education regarding nutritional care in nursing homes**		
Sub-studies (Paper)	**Sub-study I (Paper I)**	**Sub-study II (Paper II)**	**Sub-study III (Paper III)**
Research questions	What are nursing students' perspectives and experiences on the right to food throughout placement in a nursing home?	How do nursing students learn about the right to food for nursing home residents combining education on campus and in placement?	What are the reflections and lessons learned from the development of coursework for nursing students regarding the right to food for older adults in nursing homes?
Methods and participants	Two multistage focus groups with 18 first-year nursing students	Four focus groups with 26 first-year nursing students and 25 of their written assignments from their placement	Based on data and reflections from previous two sub-studies
Setting	Combining campus education and clinical placement in nursing homes	Combining campus education and clinical placement in nursing home	Combining campus education and clinical placement in a nursing home
Analysis	Thematic analysis	Thematic analysis	Thematic analysis

4.2 Research design: Educational design research

In developing this study, the purpose was to choose a research design that could capture the complexity of educational design and investigate human rights education in a real-life context: this meant nursing students learning to realize the right to food and nutrition within their own experiences and perspectives on human rights and finding a methodological framework that was in line with a human rights perspective. Smith (2018) argue that good research on human rights issues could and should follow the requirements of an HRBA. In other words, I—as a researcher conducting research regarding human rights in nursing education—needed to organize my study around key human rights principles, such as participation, empowerment, dignity and respect for the rule of law (UNSDG, 2003). Moreover, as human rights research should help strengthen the capacity of duty-bearers or right-holders towards the realization of human rights (Ulrich, 2017; Smith, 2018), this entailed strengthening the capacity of the nursing students as future duty-bearers.

The methodological framework of EDR (McKenney & Reeves, 2018) appeared best suited to this purpose. Initially, I had selected Design-Based Research (DBR) but moved towards EDR.[17] In this thesis, I use the term "Educational Design Research" (shortened to EDR), defined by McKenney and Reeves (McKenney & Reeves, 2020) as "a genre of research in which the iterative development of solutions to practical and complex educational problems also provides the context for empirical investigation, which yields theoretical understanding that can inform the work of others" (p. 2). EDR is particularly concerned with the development of what McKenny and Reeves (McKenney & Reeves, 2018) refer to as applicable and usable knowledge; in this way, the research is relevant for educational practice and hence human rights research (Smith & Smith, 2018).

EDR was also chosen as the methodological framework because of its flexible and systematic approach to improving practice and teaching in an area that has been sparsely explored (Koivisto et al., 2018). This framework is also appropriate within health sciences (Chen & Reeves, 2020; McKenney & Reeves, 2020), and recent studies report favourable results from using this method with PhD candidates (Goff & Getenet, 2017; Herrington, McKenney, Reeves, & Oliver, 2007). However, choosing EDR was also a way of "keeping the pieces of

[17] EDR and DBR can be seen as the same; however, in DBR, research that addresses "technology" has been emphasized, which was outside the scope of this thesis. Moreover, EDR emphasizes "education," which may reduce confusion around the concept of the framework. Finally, more recent papers suggest that EDR is suitable within health education (McKenney and Reeves 2020, Chen and Reeves 2020). In Paper II, I refer to DBR, while in Paper III, I refer to EDR.

the puzzle together": in other words, selecting a research design that was systematic and wrapped in iterative rounds meant there would be a starting point and an endpoint—invaluable for PhD projects.

As well described by McKenney and Reeves (2018), different kinds of epistemologies are compatible with EDR (Bakker, 2018; Goff & Getenet, 2017; McKenney & Reeves, 2020); this includes those that take into consideration that learning actually "occurs in the buzzing, blooming confusion of real-life setting" (Barab & Squire, 2004, p. 4). In this project, the real-life setting was nursing education, which took place both on campus and in placement. To understand how student nurses learn in that context and to develop the coursework, the voices of the students themselves were important within the study's social constructivist approach (Creswell & Poth, 2018). This involved seeing them as active agents and experts on their own learning (Bovill, Cook-Sather, & Felten, 2011). It is also of importance in human rights research, which emphasizes participants' participation and empowerment (Smith & Smith, 2018).

According to (McKenney & Reeves, 2020), EDR involves three main phases: 1) analyses and exploration, 2) design and construction, and 3) evaluation and reflection. The phases are both iterative and flexible. In this study, the course on the right to food was developed through two iterative rounds, with modification of the module from 2017 to 2018 (following the first round). The research design and phases of the study are illustrated in Figure 1.

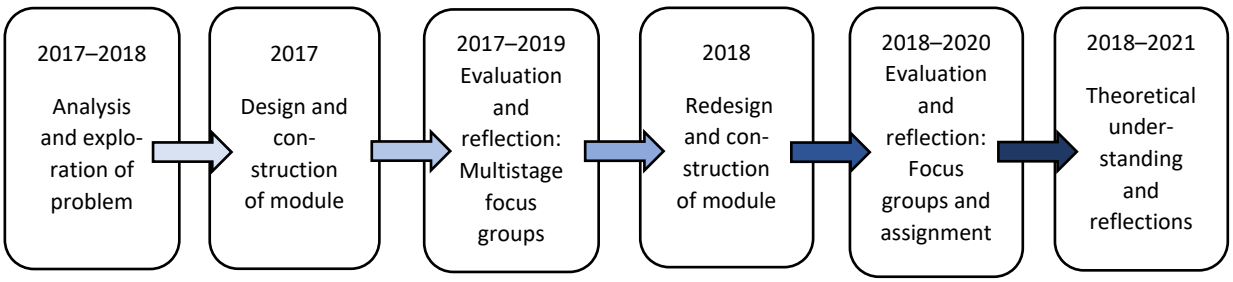

Figure 1 Research design and iterative rounds of the study.

The "analyses and exploration" phase entails collaboration between practitioners and researchers to identify "the problem" to be resolved. In my project, "the problem" was how to introduce human rights in nursing education, with nutritional care as an example. I was both the researcher and the practitioner, which is fairly common in EDR (Bakker, 2018). During the "design and construction" phrase, the ideas and operationalization regarding how to solve the problem are addressed; in this phase of the study, the first module of the right to food was

developed. During the "evaluation and reflection" phase, the idea of the design is empirically investigated, and reflections of the findings are made with the aim of refining the theoretical understanding and the module. There was both a theoretical and practical focus in the research design in accordance with EDR. The results from the theoretical understanding of EDR can be utilized to describe, explain, or implement the educational phenomena. In this study, Paper III builds on the reanalysis of the data, and reflects upon the findings and reflections from the first two rounds.

4.3 The development and redesign of the coursework

In the study, first-year nursing students were introduced to food and nutrition, and the right to food for older residents in nursing homes combining coursework on campus and in placement. I can see that the course description and development do not "fit" into a chapter on design and methods. However, I have chosen to include it here, since in EDR, research and practice (meaning the development of the coursework design) are intrinsically linked. It is my hope that by doing it this way, it will be more transparent for the reader.

The design and evolution of the course in the human right to food is illustrated in Figure 2. The educational path consisted of 1) a two-day course on campus before students started the clinical placement, and 2) a clinical placement in a nursing home, which included a written assignment. The course was integrated within a seven-week course on campus about older people in care facilities, prior to students' clinical placement for seven weeks in nursing homes. Attendance at the on-campus lectures was voluntary, while the clinical placement and written assignment were mandatory. The course was in the students' second semester, and this was the nursing students' first placement in nursing education. They were supervised during placement by a registered nurse from the placement location and a teacher from the university. Two teachers were responsible for the course on campus—myself and one other.

In the first round, the coursework on campus included malnutrition in older patients, the importance of mealtimes, screening for undernutrition, calculating residents' energy needs, assessing residents' nutritional status and food as a human right. In the second round, the two-day course on human rights took into consideration the findings from the first round of the study, and several changes were made. The changes were made to better prepare the students on campus to cope with the challenges of rights at risk in nursing homes regarding food, to empower the students to reflect upon and discuss ethical challenges with their supervisor and co-students in placement, and to contextualize learning about the right to food from the

students' own experiences during placement. On campus, we also continued with some themes, as illustrated in Figure 2.

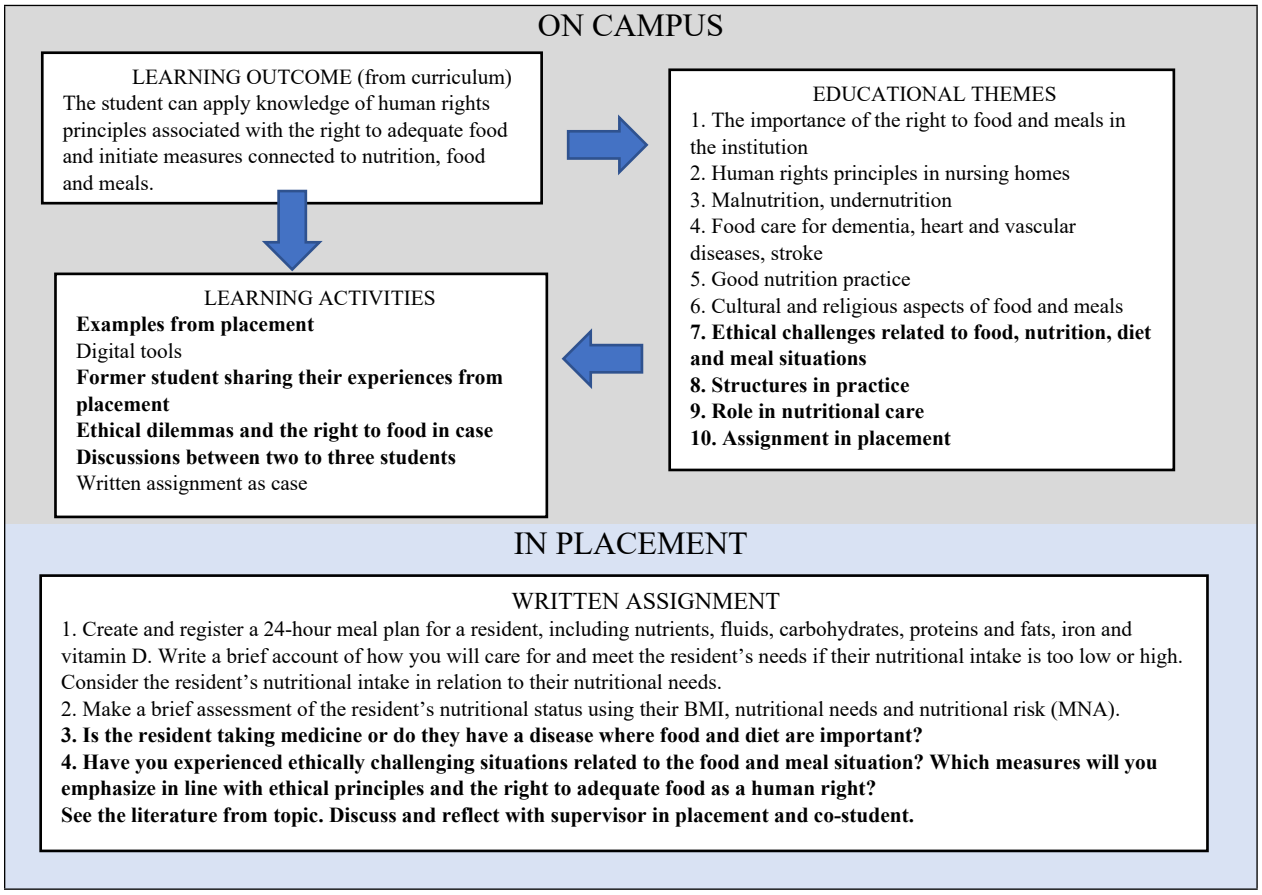

Figure 2 Coursework on campus and written assignment during clinical placement, and relationship between learning outcome, themes and learning activities. Changes in the course from round 1 to round 2 are marked with **bold text** (Dogan, Terragni, & Raustøl, 2021).

In the new design, we opened the course on campus with lectures about the right to food, and the meaning of the right to food in nursing homes and nursing care. We also introduced and emphasized themes that the students found challenging in the first round (Dogan, Raustøl, & Terragni, 2020; Dogan, Terragni, & Raustol, 2022). These themes were 1) ethical challenges related to food, nutrition, diet and meal situations, 2) structures in practice, and 3) role in nutritional care. Further, the learning activities in the new design emphasized student activities (e.g., reflections in small groups), and we used digital learning tools where the students could be anonymous but still participate, which can be suitable for big classes. A student from the previous year also came to talk about his experience doing the assignment during her placement. The assignment was expanded with two additional tasks (see Figure 2), as well as encouragement to discuss and reflect upon the tasks with their supervisor and co-students during placement. To prepare the students for the assignment in placement, we further developed a case for their on-campus education, where the students had to respond to

and reflect upon similar tasks to those they would encounter in placement. We continued to work with the software programme "Diet Planner" (www.kostholdsplanleggeren) with the students, on campus. This data programme was part of the student's assignment in placement and calculates a person's nutritious food intake when types of food and meals are entered. The students were also introduced to the mini nutritional assessment (MNA) form on campus. All the material was available on the digital platform "itslearning."

4.4 Choice of research methods and a qualitative approach

The whole study adopts a qualitative approach. I selected a qualitative approach to this study for several reasons. Firstly, this approach is compatible with a human rights perspective (which I explore in more detail below). Secondly, because this method is suitable with my aims and research questions; this meant it was important to obtain an understanding of how students construct their ideas about the right to food, the students' experience of learning about the right to food and the development of the coursework, to foster interaction between and among the researcher(s) and participants to gain knowledge. A qualitative approach would facilitate this, as qualitative data collection takes place in real-life settings, aimed at an understanding of the whole from participants' perspectives and experiences (Creswell & Poth, 2018; Denzin & Lincoln, 2011; Polit & Beck, 2012).

Moreover, Smith and Smith (2018) argue that qualitative methods offer an opportunity to deeply understand the real-life experiences of participants in relation to human rights. As such, I decided that a qualitative approach would enable me to answer my research questions.

In the first round in 2017, two multistage focus group interviews with 18 nursing students were conducted to obtain knowledge and understanding about nursing students' views of the right to food throughout their placement (Dogan et al., 2020). As mentioned above, two teachers (of whom I was one) developed the coursework further, based on the results from the study and reflections. The second sub-study, in 2018, explored how nursing students learned about the right to food, with changes to the module (Dogan et al., 2021). Qualitative methods were employed here, as well: focus group interviews were conducted with 26 nursing students following their placement, and 25 of their written assignments were analysed to gain insight into the students' learning about the right to food (Dogan et al., 2021). Drawing upon reflections from these studies and the development of the coursework led to theoretical understanding and lessons learned developing education in nursing education regarding nutritional care from a human rights perspective (Dogan et al., 2022).

4.4.1 Choice of focus groups

Focus groups represent a qualitative methodology that is aligned with human rights research (Smith & Smith, 2018). In this study, focus groups and multistage (longitudinal) focus groups with nursing students were utilized to answer the research questions, as were students' written assignments from placement. These methods are in accordance with a human rights perspective and a constructionist approach valuing the students' voice and their participation in the study. Focus groups support a human rights perspective, with their focus on dialog and participation (Morgan, 1996; Smith & Smith, 2018); this method has also been found to be empowering for participants in human rights research (Smith & Smith, 2018).

I will now elaborate upon the choice of methods and the data collection in the study. I will follow the chronological order that evolved in the study, so will first explore the choice of multistage focus groups, then the focus groups, written assignments, and finally the combinations of focus groups with written assignments.

4.4.2 Multistage focus groups

Multistage focus groups are characterized by the same group of participants exploring a certain theme, problem or phenomenon through several meetings (Hummelvoll, 2008). Morgan (Morgan, 1996) has explained some of the purposes and effects of multistage focus groups:

> As the group members get to know each other, a sense of rapport is built, individual biographies and preferences are learned, and a sense of shared history develops. These "longitudinal groups" thus raise a variety of issues that do not occur in the typical "one-shot" use of focus groups. (p. 69)

This method can be perceived as acquiring knowledge through dialog, focusing on experiential material (Hummelvoll, 2008). In multistage focus groups, the researcher functions as a moderator and leads the dialog in the groups. The researcher decides the theme and elaborates upon it with the participants. Compared to "traditional" focus groups, in the multistage focus group, themes are gradually enriched by new perspectives and experiences from practice that occurs between meetings. (The opposite also occurs, in which student participants can enrich their practice with perspectives and experiences from the focus groups.) The group dynamics slowly evolve through interaction, as participants gradually get to know one another. In turn, the development of trust among the participants can facilitate open-mindedness and appreciation of different viewpoints.

The purpose of the first research question (e.g. "What are nursing students' perspectives and experiences on the right to food throughout their placement in a nursing home?"), is based on

a constructionist and interpretative paradigm and emphasizes the importance of the nursing students' perspective and understanding. Divergence and consensus in opinions were explored to achieve breadth and variation in the presentation of the participants' perspectives through the multistage focus groups (Hummelvoll 2008).

4.4.3 Focus groups

Conventional focus group interviews were selected for the second round, since the aim was not to follow changes over time. Focus groups are suited to learn more about people's experiences, attitudes, views, goals and challenges in an environment where many people interact (Kitzinger, 1995; Morgan, 1996), e.g., in nursing education and clinical placement. In focus group interviews, the participants can verbalize their practical knowledge and experiences, and this can prove especially useful when participants have experienced similar situations (Stewart & Shamdasani, 2014). Kitzinger (1995) asserts that focus groups can encourage contributions from people who feel they have nothing to say, such as first-year nursing students who might feel inexperienced and like "novices"—these participants can become engaged in the discussion generated by the other group members. Focus groups may also facilitate the full expression of ideas and experiences that may be left underdeveloped in an interview (Kitzinger, 1995). My aim was that this would help mitigate the uneven power balance rooted in the fact that I was both a researcher (moderating the focus groups) and a teacher in the students' university college (who had also developed the coursework). It was important to me that students not to feel reluctant to give negative feedback, since the goal was to improve the educational design and coursework—this was especially important since participants' comments and reflections may be more critical (and thus more useful) in focus groups than in interviews (Kitzinger, 1995).

4.4.4 Written assignment

In addition to focus groups, I opted to include students' written assignments in my study. The written assignment consisted in 4 tasks, presented earlier in Fig 2 (Chapter 4.3). In nursing education, writing assignments are common, and include scholarly plans, reflection notes and care plans. These are intended to support the students to develop cognitive and metacognitive skills that are an important part of clinical decision-making and professional practice (Chaudoir & Trepanier, 2016). Therefore, "writing to learn" is essential in nursing education (Allen, Bowers, & Diekelmann, 1989; Mitchell, 2018), as it can be an important tool for professional development, supporting students to learn content, values and tacit knowledge, to

develop critical thinking and to cultivate professional identity (Chaudoir & Trepanier, 2016; Elton, 2010).

Communication skills, both verbal and written, are known to have an important impact on patients' safety (McMillan & Raines, 2010), and are a vital element of nursing care (Kourkouta & Papathanasiou, 2014). Studies have shown that writing assignments can support students to develop competence and communication skills, both of which are critical to professional practice (Chaudoir & Trepanier, 2016). Historically, nurses have relied on face-to-face verbal communication to exchange information, and to provide patient care, but this tradition has been critiqued as informal and unstructured (Miller, Russell, Cheng, & Skarbek, 2015).

Today, nurses use written skills in a range of contexts: for example, documenting in the patients' records, communicating across the healthcare setting, generating deviation reports, conducting research, developing written guidelines, and contributing to writing policies. It is therefore important for nursing students to develop writing skills to be able to support patients' care in professional practice—including documenting effectively when human rights are at stake and developing care plans and guidelines in accordance with human rights. As such, this assignment was created to support the students to develop competence in nutritional care and the right to food for nursing home residents, and for the students to practice and learn writing regarding human rights challenges.

These aspects made it interesting to explore the students' assignments, and to hear in the focus groups about their experiences with the assignment. Moreover, the focus group discussion seemed to remind students both of their experiences from placement and with their written assignment, and they then further discussed the experiences about which they had written. In this way, when I read the written assignments (after the interviews), many of them were already familiar to me. On the one hand, reading the students' assignments was a way of "checking" whether they had understood the written task; however, it also provided useful information about the nursing home residents for whom they were caring. Although this information cannot be generalized, 22 out of 25 residents were malnourished or at risk of malnutrition.

4.4.5 Combining written assignment with focus groups

In the second sub-study, both the focus groups and the students' written assignment were utilized to gain understanding around how the students learn about human rights. Combining

the written assignment with the focus groups gave new perspectives on the students' reflections, as these data were created in different contexts and could give a more "complete" story.

In fact, these two data sources presented some differences regarding the context in which the knowledge was developed. The assignments were completed individually, as an assessment, and were not set up for investigation. In the focus groups, the emphasis was on the sharing of experiences and creation of meaning, and I as a researcher was part of that research situation (as a moderator). The purpose of the written assignment, on the other hand, was to help students learn academic writing and develop their critical thinking (Borglin & Fagerström, 2012), and was undertaken individually. Further, the assignment was written over a timespan of about seven weeks, which allowed the students to follow the residents' situation over a longer period, giving them time to have experiences around and reflect upon realizing the right to food. In the focus groups, as participants had already completed the assignment in placement, they were prepared for the subjects and could bring their experiences and reflections into the group discussions.

4.5 Sampling and recruitment

The recruitment criteria were the same in the two rounds. Nursing students in their first year were invited to participate, since they were participating in the course and had their placement in a nursing home.

4.5.1 Recruitment in the first round

In the first round, nursing students who had their placement in a nursing home that recently had been involved in a project focusing on nutrition were invited to participate. Perhaps for that reason the management was supportive of the study and proved quite helpful. The nursing home had four wards for residents needing permanent, long-term care, including one specialized unit for residents with dementia. The manager of the nursing home was asked in a meeting at the university if the students and some of the nursing home staff wanted to be part of the study. When she answered in the affirmative, I then made plans with a nurse at the nursing home regarding recruitment and reserving rooms for the focus groups.

All 19 students who had their placement the nursing home were invited to participate by their instructor at the university. They received both written and oral information about the study. In total, 18 female nursing students in their 20s agreed to participate in the study and were divided into 2 groups. After the first focus group, one participant from each group took the initiative to find a time and place to meet for the next session. Once the first round of focus

groups was completed, the plan was to divide the students into three groups to facilitate better exchange of information and discussion. However, as some of the participants said that they would be unable to attend the second focus group, leading to smaller groups, it seemed more reasonable to continue with the two groups. The teaching session on campus occurred between the first and the second focus groups, and before placement. Most of the participants attended all three sessions, and a few students changed groups during their placement due to their work shifts. Hummelvoll (2008) argues that this latter may actually benefit the group dynamic.

Developing the interview guide and conducting the interviews

I used an interview guide to structure the discussions (Morgan, 1996). My supervisors proved very helpful in the development of an interview guide that could answer the research questions. The interview guide ultimately centred around four main themes, with open questions. I organized the guide so that themes that were more challenging to discuss were raised later. The first theme I called "learning and pedagogies": this was related to the students' learning and the coursework. The second theme I called "food, nutrition and health," the third was "human rights," and fourth was "ethical challenges." I found that following an interview guide thematically helped to organize the focus groups interviews. If the students mentioned themes that were targeted further on in the guide, I still asked the relevant question later in the interview, to purposely delve deeper into the topic. It is also important to note that the interview guide evolved from the first interview to the second and third.[18] In the first interview I asked questions like: "What are your thoughts about human rights related to food and meals at an institution?" During placement I followed up with questions like; "Can you describe the challenges related to fulfilling the right to food for the residents in your placement? How have you dealt with these?" After placement I asked questions like: "Can you tell me about what you did when you experienced challenges related to fulfilling residents' right to food?" and "How did you act when you encountered ethically challenging situations relating to food, nutrition and mealtimes?"

Before and after placement, the focus group interviews took place on campus; during placement, the interviews took place at the nursing home. A moderator participated in the first group, but for the rest of the focus groups, I was both the moderator and interviewer. The focus group sessions lasted from 1 to 1½ hours and were audio-recorded, transcribed verbatim

[18] See appendix for interview guides from before, during and after placement.

and reviewed by me, then discussed with my supervisors before each subsequent session. The session continued with questions about students' expectations regarding challenges related to nutritional care and meals and their understanding of the right to food and ethical dilemmas. This helped elaborate any nuances. These themes and the students' reflections that emerged during the first interview were followed up in the subsequent two focus groups. As noted earlier, at the end of each session, I summarized the main topics, and the students were asked for further comments. This was done in an effort to capture any additional critical elements, but also to see whether the students had found participation to be useful and meaningful. The transcripts were approximately between 8,000 to 14,000 words each, and though the interviews were challenging and time-consuming to transcribe, they provided fruitful input for further analysis.

4.5.2 Recruitment in the second round

In the second sub-study, a total of 170 students were asked to participate in the study, and 26 students agreed to participate in the focus groups and to include their written assignment in the study. I had tried to recruit nursing students whose placement was at the same nursing home as the one from the first sub-study, but their teacher informed me that they were participating in another project and were therefore too busy to join mine. As such, I decided to recruit students at a lecture one week after their placement, where I informed them about the project during a break. They could choose themselves on which day they wanted to participate, in accordance with their schedule on campus. This also meant that students could choose a specific group, which was done purposely so that students could sign up with a student from the same placement or friend, if they so desired. The goal here was to help students feel more comfortable sharing their experiences.

The students were divided into four groups and interviewed two weeks after their placement. The participants were all female, primarily in their early 20s. They were stationed at 14 different long-term care institutions. Twenty-two of the students participated in the voluntary two-day course on campus. There were between three and nine participants in each focus group, and some groups had students in them who knew each other from campus or placement. Though all the students agreed to include their assignment from placement in the study, one student had bought a new computer and could not find her assignment.

Developing the interview guide and conducting the interviews

The interview guide from the second round delved into the challenges that were identified in

the first round. There were similarities between the interview guide from the first and second round. Since the interview guide from the first round was developed "with" the students, I also thought that it would be meaningful to discuss the same issues with the students in the second round. Emphasis was placed on the coursework changes, the reflections from the assignment in placement, the meaning of human rights in their placement, and ethical challenges. In the focus group interviews I asked questions like, "How did you experience the relevance of the lectures in food, nutrition and meals?" "How did you experience working with the written assignment?" "Can you talk about the challenges in realizing the right to food for the residents during your placement?" and "What ethical challenges did you experience during your placement in relation to food and meals?"[19]

The focus group interviews lasted between 1 to 1½ hours and took place on campus. As noted earlier, if themes were brought up in the discussion that would be covered later in the interview, I still asked the relevant questions further on, to delve more deeply into the topic. I was the moderator in all the focus groups. After I asked the last question in the interview guide, I summarized the interview for the participants, encouraging them to add comments, clarify things, or express disagreement. The interviews were recorded and transcribed verbatim by an external transcriber and listened to and corrected for errors by me. The transcripts were approximately between 9,000 to 13,000 words each.

4.6 Analysis

Data analysis in qualitative inquiry involves preparing data for analysis, including transcribing interviews, organizing the data, conducting a preliminary read-through of the data, coding and organizing themes, representing the data in figures and tables, interpreting the data and reporting and discussing the findings (Creswell & Poth, 2018). These steps are not linear but are rather interconnected through a back-and-forth process (Creswell & Poth, 2018). I decided to employ thematic analysis in the study, following (Braun & Clarke, 2006): "Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data" (p.6). Another benefit of thematic analysis is its flexibility. Braun and Clarke (2006) divide qualitative analysis into two groups. In the first group, there are those analyses that are tied to a specific theoretical or epistemological approach. The second group comprises methods that are independent of theory and epistemology, and therefore can be

[19] See appendix for interview guide in the second round.

applied across a range of theoretical and epistemological positions, meaning that this approach is compatible with a constructionist paradigm (as in this study). A study's epistemology guides what one can say about one's data. For instance, in this study, from a constructionist perspective, meaning and experience are perceived as socially produced and reproduced. Therefore, the thematic analysis conducted within a constructionist framework seeks to theorize the sociocultural contexts, and how meanings and experiences are constructed through language (Braun and Clarke, 2006).

I followed Braun and Clarke's (2006) six phases of thematic analysis, which enabled me to analyse the material while strengthening trustworthiness. They recommend 1) familiarizing oneself with the data through transcribing the data and noting initial ideas; 2) generating initial codes; 3) searching for themes, and collating codes into potential themes; 4) reviewing themes; 5) defining and naming the themes; and 6) producing the "report." In addition, I also used the software programme NVivo to support the analysis and the coding of the data. I shared the files from the analysis in NVivo with both my supervisors, to facilitate discussion of the coding process and themes.

The analysis process was both inductive (bottom up) and deductive (top-down) (Braun & Clarke, 2006). Some questions and themes evolved through the coding process without my trying to fit them into a pre-existing frame, which was an inductive approach. In some instances, the themes that were identified had little relationship to the specific question posed to the participants. In that sense, the analysis was data-driven. However, I—as the researcher—could not free myself from my theoretical approach, and "data are not coded in an epistemological vacuum" (Braun and Clarke, 2006, p.12). Taking a deductive approach, I was driven by an analytic interest, and I therefore looked into specific aspects of the data, such as "What are the students' experiences and perspectives regarding the right to food?" I thus coded for specific research questions.

Multistage focus groups

Following the six stages proposed by Braun and Clarke (2006), I read the interviews several times, looking for themes and patterns before, during and after placement. The students were informed in all three meetings that it was their experiences and perspectives that were of interest and that there were no (in)correct answers. Data analysis began immediately following the interviews, as I wrote a summary of each session, and I listened to the audio-

recordings as soon as possible after each interview. This also enabled me to bring interesting themes that had emerged to the next focus group, for further discussion and follow-up. Here, the analysis was aimed at understanding patterns of continuity and change in the students' perceptions on the right to food before, during and after their placement. As part of my analysis, I compared the themes from the different focus groups sessions. These were then refined following discussion with my supervisors and organized into broader themes. The students' understanding of the right to food in a nursing home was a dynamic process: their perceptions evolved from what I termed a "polarized perspective" to a "reality orientation" and, after placement, to "retrospective reflection."

Focus groups and written assignment

In the second sub-study, I initially analysed the two data sources (the focus groups and the assignment) separately and then searched for patterns between them, illuminating new themes. Moreover, when patterns were identified across the two sources, this provided a more "complete" story (Flick, 2004). The themes found in the second sub-study were: Learning through development of a language promoting the right to food; learning through coherence between campus and placement; learning through experiencing situations where rights are at risk; learning through relations with others; and learning through a "student approach" or an "activist approach."

To become familiarized with the data from the interviews, I read the transcripts and listened to the recordings several times. I participated in and moderated all the interviews, and immediately following each interview I wrote a summary. After I was reading the interviews, initial ideas were written down. Initial coding was done systematically through the entire data set. Here, the students' perspectives and how they talked about the right to food were viewed as potentially reflecting how they navigated and learned in placement. Therefore, the coding emphasized "in vivo coding," which is a participant form of coding that refers to codes that are based on the participants' language (Saldaña, 2014). In the first interview, the codes and categories were developed inductively, but in the following interviews, the codes were increasingly organized under already established codes and categories. While the coding was descriptive, aiming at capturing the participants' voice and language, some of the themes that emerged had a theoretical approach that was developed in later analysis. I did the initial coding, and further analysis was discussed in several rounds with supervisors. The analysis involved continuously moving backwards and forwards between the entire data set, searching for repeated patterns of meaning; in this process, I also sought to capture important aspects in

relation to the overall research question and aim of the study (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013).

The written assignment was a compulsory part of the coursework. It was not analysed as a test of students' knowledge, but with the aim of identifying their perspectives and understanding regarding human rights and the right to food, and how they learned about human rights. In the analyse of the written assignments I also employed a thematic approach (Braun and Clarke, 2006). In the first phase of the analysis (coding), I structured students' answers into themes. This gave an overview over the students understanding of the questions, and how they evaluated the residents' condition and situation regarding nutritional care. However, to obtain an understanding of the students' learning, I investigated how they approached the assignment and their experiences from doing the assignment. In this way, the focus group interviews informed the analyses of the written assignments, enabling me to trace patterns from the focus group interviews to the assignments. The analyses looked beyond the content of "what" the students had written to "how" the students created meaning around the assignment and "how" they solved the assignment, giving the analysis a constructionist approach (Braun & Clarke, 2006).

The students reported various experiences from doing the assignment. In the focus group interviews, some of the students described that, although they had learned from the assignment, they experienced it more as a "private" task. According to these students, the assignment had no impact on the residents and was meaningful only to themselves as a learning tool. Other students were able to "try out" their textbook learning in practice and to involve their supervisors or other staff. Some were also able to use the assignment more actively. Many found that the residents were malnourished when the MNA was conducted, and suggested steps to handle malnutrition that represented new information for the staff.

Although the students had the same assignment, it was solved differently. In this regard, it seemed like the students could be placed along a continuum between what I called a "student approach," where the student did the assignment on their own, and an "activist approach," where they involved staff and other residents in what they discovered and learned from doing the assignment. When analysing the assignments, I discovered that students engaged in a range of approaches to complete the assignment: referring exclusively to theory from books; relying on experiences from placement; drawing on what was "tried out" and discussed with a supervisor; or simply describing their own reflections. Other students combined many of these aspects. In most of the written assignments, the students referred to human rights and/or

ethical principles. Students also reported that the assignment increased their awareness about the importance of the right to food

4.7 Validity of the study

In the first part of this section, I address the validity of my study. The term validity is debated in qualitative research (Rolfe, 2006), and definitions of validity are related to the paradigm adopted by the researchers in their study (Creswell & Miller, 2000). A constructivist approach underlines that research findings do not reflect a single "truth" but pluralistic, interpretive, open-ended, and contextualized perspectives (Creswell & Miller, 2000). The validity procedures reflected in this thinking present criteria with labels distinct from quantitative approaches. The classical work by Lincoln and Guba, *Naturalistic Inquiry* (1985), provides extensive discussions about these forms of validity in qualitative research and propose the use of a new concepts to indicate a discontinuity with the parameters of assessing validity in quantitative research. These are trustworthiness (i.e., credibility, transferability, dependability, and confirmability), and authenticity (i.e., fairness, enlarges personal constructions, leads to improved understanding of constructions of others) (Creswell & Miller, 2000; Lincoln & Guba, 1985, 1986). In the second part of this section, I look into the reflexivity of the study (Creswell & Poth, 2018).

4.7.1 Trustworthiness of the study

The criterion of *credibility* outlined by Guba and Lincoln (1985) refers to the interpretation of the data (Forero et al., 2018; Polit & Beck, 2012). Credibility involves establishing confidence that the results (from the perspective of the participants) are credible, true and believable (Forero et al., 2018). In the first sub-study (first round), utilizing multistage focus groups, I met with the participants several times, and this contributed to in-depth knowledge (Hummelvoll, 2008). Meeting with the students more than once helped create a safe environment, allowed them to delve deeper into certain topics and gave them an opportunity to bring knowledge from the group discussions back to their placement. In the second sub-study (second round), the students' familiarity with the topic, setting and other focus group participants may have allowed them to delve even more deeply into certain aspects. The students' placements were at different nursing homes in sub-study two, which contributed to diversity in the findings. Furthermore, the study's theoretical framework and concepts—including data collection, analysis and presentation of the findings—were discussed throughout the research process. This contributed to bring different perceptive and nuances to

the data material, and not necessarily consensus, in line with qualitative research (Malterud, 2017), and social constructionism (Creswell & Poth, 2018).

The second criteria addressed by Lincoln and Guba (1985) is *dependability*. In this study, following EDR, there were two rounds with similar participants (i.e., with the same inclusion criteria) and context (i.e., the nursing students were participating in coursework including teaching on campus and in clinical placement). Although the coursework was further developed in the second round, the findings from both rounds share similarities. To further enhance dependability, I employed dialogical validity, where I asked the participant to elaborate if something was not clear to me (Kvale, 1995). I transcribed all the interviews in the first sub-study, and in the second sub-study the transcripts were carefully checked by listening to the recordings several times. In the publishing process, further details were added through the paper revisions, which added thick description of the study process, further enhancing confirmability. The rich descriptions from the nursing students together with the written assignments represent a strength of this study and helped provide a more "complete" story. In turn, this enhanced the dependability of the research (Polit & Beck, 2012). The rich descriptions from the nursing students before, during and after their clinical placement in a nursing home represents a main strength of this study. While some of the students participated only once, and two of the students changed their groups during placement due to shift schedules, this mobility and the change in group composition proved fruitful for the group dynamic and was an important part of the multistage focus group method (Hummelvoll, 2008). Moreover, and as already mentioned, at the end of every interview, I summarized what was said and encouraged the participants to comment, clarify, ask questions or elaborate further.

The third criteria addressed by Guba and Lincoln (1985) is *confirmability*. Here, one must ask: Do the data represent the information that the participants provided? In other words, do the interpretations of those data reflect the participants' voice and the conditions of the inquiry, and not the researcher's imagination, motivations or perspectives? (Polit and Beck 2012). This aspect is further explored in the next section under reflexivity of the study (Chapter 4.7.2).

The fourth criteria, *transferability*, refers to generalizability; this refers to the extent to which the qualitative findings, particularly the concepts produced in the analysis can be transferable to other contexts or groups (Polit & Beck, 2012). The researcher is responsible for providing descriptive-enough data for the reader to be able to evaluate the applicability of data to other

settings. One of the most common critiques of qualitative research is that the findings are not transferable beyond the sample itself (Greenhalgh, 2019). Greenhalgh (2019) argues that it is of importance with a purposive sample to enhance transferability. Moreover, the publishing process with the results of published papers, in highly relevant journals, was enhancing the value of communicative validity (Kvale 2015; Malterud 2017). While the findings cannot be generalized, these approaches may have increased the study's transferability and strengthened its insights, helping the findings be transferable to other settings (Polit & Beck, 2012).

The fifth criteria, *authenticity*, refers to the extent to which the researchers faithfully and fairly show a range of different realities (Polit & Beck, 2012). Authenticity is best shown in a report when it conveys the tone of participants' lives and perspectives as they are experienced. A text has authenticity if it enables the reader to understand the lives of the participants, including their experience, perspectives, feelings and language. Conducting the focus group interviews before, during and shortly after their clinical placement may have resulted in more reflections from students on their real-life experiences. This in turn may have enhanced the study's authenticity. Quotes were selected if they could illustrate and shed light on the findings and to give the participants a voice (Polit & Beck, 2012). To include and give voice to the participants, the papers drew on a range of quotes from different participants and focus groups.

4.7.2 Reflexivity of the study

Reflexivity of the study refers to whether the researcher is conscious of the biases, values and experiences they bring to the research process (Creswell & Poth, 2018). In qualitative research, the aim is not to be objective, but it is important that the researcher discusses their own subjectivity, previous experiences with the central phenomenon in the study and how these experiences may potentially shape their interpretation of the data (Creswell & Poth, 2018). Creswell and Poth (2018) further explain reflexivity as involving two components. Firstly, the researcher needs to address their own experiences with the phenomenon being explored. I have already done this in the introduction of this thesis. Secondly, the researcher needs to discuss how past experiences may shape their interpretation of the phenomenon: it is to this that I now turn.

During the research process, my knowledge about the human rights perspective in nursing education changed, and my views of human rights education in nursing became more nuanced. In my role as a researcher, it was important to be aware of my position, and of the biases and values that I brought to the project. More than once, my supervisors challenged me

to move from using activist language towards a research approach, making better arguments and exploring the foundation of theories and methodologies that could be used in this thesis. It has been a true struggle (though also meaningful and fruitful) to express my reflections through academic writing. In addition, it has been challenging to shift to a focus on students' learning, placing less emphasis on the residents' condition (which I emphasized as a nurse). My proximity to the field will be further explored in the next section under limitations in the study (Chapter 4.8). It took a great deal of reflection and many thoughtful discussions with supervisors to truly understand and embrace the research process, and to search for and be open to the knowledge I was seeking through the study's aim and research questions.

4.8 Limitations of the study

The study has several limitations. The first limitation is related to my role as both teacher and researcher. There are several challenges for educational researchers who investigate their workplace, as in this study. Recent research has attempted to move beyond a strict outsider vs. insider dichotomy,[20] to emphasize the relative nature of researchers' identities and social positions that depend on the specific research context (Kerstetter, 2012). Early discussions of insider/outsider status have asserted that the researcher is either an insider or an outsider, and that each status carries with it certain advantages and disadvantages (Merton 1972; Kerstetter 2012). In this study, I found myself to be both an insider and an outsider, and that I was somewhere in between (Kerstetter, 2012). For instance, in the beginning of my PhD programme, I was an insider working as a teacher at the university college where I was studying. This gave me the chance to introduce a human rights perspective into the nursing curriculum. Moreover, I was a researcher in my own workplace, so I was familiar with the context and was in many ways an insider. My experiences and proximity to the topic (which were explored earlier) may have influenced the research. I have had the benefit of being educated as a nurse and have studied nursing education. Moreover, with my nursing background, I was well acquainted with the experiences the students had in their clinical placement. I believe that their reflections and discussions in the focus groups would have been different, if I had another background or was a teacher from another institution. I was able to easily understand what they were talking about and ask pertinent follow-up questions.

While being an insider gave me access to the field and a deeper frame for the study, my own proximity to and pre-conceptions about the field have made me reflect on my own role and

[20] For instance, Merton (1972) suggests two opposing views: the Insider and Outsider doctrines.

how I may have influenced what was said in the focus groups (Mercer, 2007). To mitigate this, I engaged in several rounds of discussion about my analysis and interpretations with my supervisors, but this was not a straightforward process.

Another challenge related to being an insider was the fact that I was one of the students' teachers. This had no influence on whether the students passed their placement or other evaluations, and I explained this to them: however, as noted above, this may have influenced students' answers and may have contributed to self-reporting bias as they strove to be seen in a "good light." As a teacher in the same institution that the students attended, I also felt a responsibility towards them, wanting them to have a good experience with taking part in a study that would hopefully prove beneficial to them. As such, I worked to create an atmosphere in which they would feel safe. The students were informed by me before each interview that there were no right or wrong answers, and the importance of hearing their reflections, understandings and experiences was emphasized. In this study, data were collected only among students. Including the teachers as well could have brought more perspectives and voices to the table regarding perspectives on human rights in nutritional care and students learning. However, the fact that we were two teachers developing the coursework also contributed to useful insights, including several perspectives regarding the design to help students learn.

Some critiques have been raised regarding EDR (McKenney & Reeves, 2020). McKenney and Reeves (2020) suggest that utilizing EDR as a research design can make the study seem too large or complex to report on in one paper; as such, it is recommended to portray design projects as a collection of sub-studies, reported on separately, each making a significant contribution in its own right (McKenney and Reeves, 2020). The division of the papers in this study thus incorporate the different "stages" of the study—including Paper III, which elaborates upon "lessons learned," and this is in fact emphasized in this type of research design. Another challenge addressed utilising EDR, has been due to organizational factors. In this case, the merging of several university colleges into one and the curriculum was being restructured. The coursework therefore had to be completed within a specific timeframe. Therefor the data collection needed to be conducted at an early stage in the project and the development of the coursework was limited to first-year nursing students and to two iteratives rounds.

4.9 Ethical considerations

NESH's (2021) *Guidelines for Research Ethics in the Social Sciences, Humanities, Law and Theology* were important tools in my research. In the following, I will present the ethical issues involved in this study, following Ulrich (Ulrich, 2017), through the principles of non-maleficence, communication and beneficence.

Non-maleficence

The principle of *non-maleficence* concerns whether one's decisions and actions can affect others, meaning *what* one does to others—either directly or indirectly. It has been seen as a guiding principle in medical ethics since antiquity, and is widely recognized in professional ethics as a foundational principle (Ulrich, 2017). This principle is also recognized in NESH's (2021) *Guidelines for Research Ethics*. When research involves real people, their well-being should be the primary consideration (Smith, 2018). With this in mind, I sought to develop a research design that could both empower students and treat them with respect, and at the same time answer the research questions (Smith, 2018).

As the nursing students' primary role was that of student, not research participant, it was necessary to schedule every focus group interview in accordance with their schedule. There was also a risk for the students when they were participating in the group that they would feel stigmatized for not taking care of the residents well enough, if they had experienced a violation of the residents' rights. However, the purpose of meeting with the students in groups was to reduce that stigma. The interview guide therefore focused on their experiences and perspectives rather than whether they were doing the "right" thing or knew a great deal about human rights. When ethical challenges were discussed in the groups, the students seemed supportive of each other, and neither I nor the students acted judgmental towards one another in the groups. Moreover, and as stated elsewhere, I introduced every focus group meeting by saying that there were no right or wrong answers.

Another issue here centred on my ethical obligation as a researcher regarding human rights issues brought up by the students in the focus groups (Ulrich, 2017). In this study, as the students were discussing different ethical challenges during placement, they were empowered to return to their placement and deal with the situation, guided by the experiences and perspectives of the group. Moreover, the focus group sessions raised their awareness of how things could be done differently to promote the right to food. I was also able to ask follow-up questions, such as "Was it possible to discuss this matter with anyone at your placement? Or

with your supervisor?" This made it more clear to me 1) how the students had dealt with violations, 2) and that the violations were indeed dealt with.

Communication

Communication concerns *how* one relates to others, and the recognition of the autonomy and competence of the participants in the research (Ulrich, 2017). This relates to core human rights principles such as participation, non-discrimination, social inclusion and respect for the dignity of the human person (Ulrich, 2017). As stipulated by NESH (2021, Article 5) in their ethical guidelines, "researchers must base their work on a fundamental respect for human dignity". Further, the guidelines state that personal data must not identified, and publication of the research material must be anonymized wherever possible (NESH, 2021). In other words, the researcher must promise confidentiality to the participants in the study. In the same guidelines, it is also stated that researchers must obtain consent from the participants, and this must be freely given, fully informed and conveyed explicitly.

The study involves nursing students and was approved by the Norwegian Centre for Research Data.[21] The nursing students in the first round were recruited by their teacher in placement, and they might have felt obligated to participate in the study due to a power imbalance. In both rounds, the participants were provided with both oral and written details of the study's purpose prior to their participation.[22] They were also instructed that participation was voluntary. In the first round, we met three times, and they were informed each time that their continued participation was voluntary. Most of the students participated three times in the multistage focus groups. Some explained that due to their placement schedule they would be unable to participate all three times. One nursing student from each group arranged the time for the subsequent focus group interviews during placement; this might have supported the students' voluntary participation.

The nursing students in the second sub-study were recruited after placement on campus. Due to final exams, they were given several options of dates and times so they could participate without missing any classes. The students were recruited on campus after they had conducted their placement, and all participants in the second sub-study received a small gift card for a bookstore. This may be seen as a common incentive in focus group interviews (Krueger and Casey, 2002), and was done to acknowledge the importance of their participation. In all the

21 See appendix for guidance from Norwegian Centre for Research Data (Norsk senter for forskningsdata).

22 See appendix for the written consent form.

interviews, I also provided snacks and beverages to show my appreciation for their participation, as suggested by Krueger and Casey (2002).

Within both health and human rights research, there is a risk of revealing identifiable information about a third party who is not part of the study (such as a nursing home resident) (NESH, 2021). Therefore, students were informed by their supervisors about the latter before they did their assignment, which is a common procedure when undertaking written assignments during placements in nursing education. In addition, at the beginning of each interview, the students were informed of their own confidentiality, and reminded that they should not give information that could identify the residents. In the published articles, if I was uncertain whether a quote could identify a student or patient, it was shortened to omit identifiable information or not included. Here, it was helpful that the papers were written in English, as students' dialects would not be revealed by the words they used.

While I tried to communicate openly about the study aim and how the students could benefit from it, research nevertheless takes valuable time and reflection away from their education. However, after the focus group interviews, the students expressed that it was useful to participate in the study, and I believe that a study that includes the students' participation, competence and voices has its own value.

Beneficence

Doing good for others is perhaps the most well-known aspect of ethics (Ulrich, 2017). The principle of *beneficence* concerns doing good for others and preventing or redressing wrongs. Along with non-maleficence*,* the importance of treating others with dignity and respect, the principle of beneficence ought to be seen as part of ethical considerations. The important questions to ask in relation to research are then (Ulrich, 2017): What are the benefits of the research? In what way might this research contribute to scientific knowledge? How are the study findings going to distributed? Who will benefit from the study? And regarding human rights research, it is essential to also query whether the research will promote and protect human rights; indeed, NESH (2021) states the importance of the right and duty to publish findings.

My goal for the study was to develop both a research design and educational design that could support students' learning about the right to food and their ability to promote that right. Also, choosing a human rights focus emphasizes that food is a human right, and not merely a basic need in nursing education. Through publications and participating in conferences, this has

likely helped shed light on a neglected issue and added important knowledge in nursing ethics education. I believe that the finding from this study is also important for the field of human rights education. These aspects will be further discussed later in the thesis.

5 Summary of the papers

In the following, I will present and summarize the findings of the three articles upon which the thesis is based. Papers I and III were published in the *Journal of Nursing Ethics*, and Paper II was published in *Nurse Education Today*.[23]

Paper I

In "Student Nurses' Views of Right to Food of Older Adults in Care Homes," I explore nursing students' perspectives and experiences regarding the right to food through their placement in nursing homes. Multistage focus groups with 18 first-year nursing students were conducted before, during and after clinical placement in a nursing home. This paper discusses how nursing students define, reflect upon, learn about and understand human rights within and throughout their placements. The students' understanding of older nursing home residents' right to food was a dynamic process. Findings shows that students' perspectives shifted and evolved throughout their placement, from a "polarized perspective" to a "reality orientation" and finally to "retrospective reflection."

The first theme, a *polarized perspective*, emerged during the first round of focus groups, conducted before their placement. The students' reflections about food and human rights seemed normative, with few nuances: the right to food is either fulfilled or it is not. They defined this right as having access to nutritious food that one wants to eat. They also discussed the importance of being able to eat in accordance with one's religion and to follow a specific diet; this included having access to appropriate food for those with allergies or specific diseases. They wanted to do things "by the book" and to learn how to do what is correct—indeed, they described how they looked forward to doing things "the right way."

The second theme, a *reality orientation*, was identified during the second round of focus groups, conducted during the students' placement. When I met with the students, new aspects emerged regarding the right to food. The students' polarized perspective became blurred and their experiences around food, nutrition and meals seemed to centre on identifying the boundaries between what is "right" and what is "wrong." They found it difficult to motivate residents to eat enough, and wondered how to find the balance between facilitating,

[23] The papers were published in my top choice of journals. Papers I and II were published after the acceptance of abstracts at two conferences: the 19th International Nursing Ethics Conference/4th International Ethics in Care Conference in Cork (September 2018) and the 8th International Nursing Educators Conference in Barcelona (April 2019). However, the second conference has been postponed until 2022 due to the pandemic situation.

motivating, tempting and forcing in meal situations. They also discussed whether "'no' means 'no'" in relation to human rights. One of the students expressed it like this:

> [I]t's a little difficult...with coercion and motivation. You just want to do what's best for the patient ..when the patient doesn't know what's best for them...One patient was malnourished and didn't eat much. Often, she would just take a bite or two...because I was sitting there, asking her to do it. And she felt pressured...and is that right? I felt it was very hard to tell what was the right thing to do in these particular cases.

They also experienced challenges around making the mealtime enjoyable; when many residents were eating together, it was difficult to meet individual needs—both nutritionally and socially—especially when some residents made other residents uncomfortable.

The third theme, *retrospective reflections*, emerged in the focus groups after the students' placement. When I met with the students shortly after they concluded their placement, new thoughts and reflections had arisen. The students seemed to have moved towards a more reflexive perception of their and others' role, and of the right to food. They expressed that it took time for them to find their role as students—and many were surprised to find they had to prepare residents' food, feeling unqualified to do so. Students emphasized the benefit of having a good supervisor with whom they could discuss things, particularly when they experienced ethical dilemmas, as a good supervisor helped them feel comfortable to speak freely. Some found it difficult to question things outright, as they remained unfamiliar with the routines, so being able to share their reflections was important. They also mentioned how nutritional care seemed dependent upon who was on duty and that it was often not prioritized over other, more acute tasks. If something acute arose, it would clearly take precedence over nutrition. The students further discussed how food preparation and variation were limited by a strict budget and organizational structures, but also by the residents' preferences. One of the students expressed the following:

> One challenge is [the] different preferences. Some have allergies and can't eat it, or this or that. You need to consider that as well. So you set out to draw up a menu, but no, we can't have that, because she doesn't like chicken. Then there will never be any chicken...Because you cannot make three different dishes for practical reasons. And economics, too, of course.

In the focus groups both during and after placement, the students related the importance of learning about nutrition and ethical principles before their placement: this enabled them to use their competence to adequately care for the residents. The students also related how challenging nutritional care for older residents could be—for example, making the residents break their "night fast" was not as easy as the textbooks made it seem. Finally, students discussed their own and other staff members' lack of competence around food preparation,

feeling that nursing education did not provide such competence. They also questioned whether the realization of the right to food is even possible in nursing homes.

The paper concludes with and suggests the importance of not merely increasing nursing students' nutrition-related competence but also enhancing their understanding of and ability to handle challenges and ethical dilemmas related to food and mealtimes. Findings also indicate the importance of enhancing students' ability to handle the complexity of the organizational structures in which they will provide nutritional care. This can be achieved by adding an HRBA framework to nutritional care in nursing education and through supporting the students to benefit from the learning environment during placement.

Paper II

In "Student Nurses' Experience of Learning About the Right to Food: Situated Professional Development within Clinical Placement," I explore how nursing students experience learning about the right to food, combining on-campus teaching with placement experience. The coursework was developed based on the findings from Paper I, and emphasized learning though relations and in context. Twenty-six first-year nursing students participated in four focus groups shortly after their clinical placement in a nursing home. Twenty-five students provided the written assignment they completed during their placement to be analysed as part of the study.

Findings regarding students' learning about the right to food centred on four themes: development of language about the right to food; coherence between campus and placement; experiencing situations where rights are at risk; and relations with others. Analyses of the assignments revealed that students seemed to be positioned along a continuum, between a "student approach" and an "activist approach."

The findings from the first theme, development of language about the right to food, shows that the on-campus module and the assignment both seemed to help give students a "language" about the right to food, and made the students reflect upon the importance of dignity in the meal situation. The students sometimes experienced challenges around being heard when they had suggestions or different opinions. They also used their learning about the right to food to justify their actions when they did the opposite of what they were instructed, such as giving residents food outside regular mealtimes when residents expressed that they were hungry.

In the second theme, coherence between campus and placement, the students highlighted the importance of learning about the right to food on campus to prepare them for the reality of their placement. They discussed the importance of relevant lectures on campus when they experienced corresponding situations in practice. They described how learning about the right to food before placement made them more aware of the quality of the meals during their placement.

In the third theme, experiencing situations where rights are at risk, the students discussed several situations when they experienced ethical dilemmas in their placements regarding the right to food, which they had to navigate to find solutions. For example, when residents refused food, the students discussed whether the residents had the ability to express what they really wanted. The students found that the staff solved these situations differently, and that learning occurred when students observed the right to food being either violated or promoted. The students also reported experiencing inconsistent documentation in the patient's record. Many of the students observed staff writing that the residents had been eating well, but since the nursing students were noting what the residents ate, they discovered that this was sometimes incorrect. They discussed how documenting a 24-hour meal plan for the written assignment increased their awareness of the nutrients in the food, and the residents' intake. For example:

> And in the patient's record they always wrote "The patient has eaten well today." Never how much or whether it was good in relation to that patient…

The fourth theme, relations with others, shows that the students' daily encounters with the residents seemed to be one of the most important factors for the students' learning. Through these interactions, they developed relationships that were important for safeguarding the residents' rights; moreover, when the residents acknowledged them as students, this created more space for learning. This improved their experience as nursing students and provided opportunities for increased reflection, which further promoted their learning. As one student noted,

> I used it a great deal with him, my primary patient, that we should try to get him to do as much as possible himself…as he had worked in the health sector and so on before, so he was very focused on the fact that he had the right to try to do things himself.

The nursing students also found that a good relationship with their supervisor was important for their learning—especially when the residents' right to food was at risk due to routines at the ward. However, while some students described their supervisors as role models, others

found that their supervisors were too busy for them and had other tasks that were prioritized over student supervision. Some students also engaged in reflection and discussion with other students in their placement when they experienced difficult situations. This was experienced as productive and empowering, and was important not just for their learning, but also for changing aspects of the routine at the ward. It also seemed important for the students' learning to feel included by the staff during placement. However, it appeared to take time for both staff and students to understand the students' role, and for the students to be accepted

The analysis of the assignment that students completed during their placement indicated that they approached this task differently. Though they learned from the assignment, some of the students experienced it more as a "private" task, considered irrelevant by the staff or supervisor. For these students, the assignment had no impact on the residents and was meaningful only to themselves, as a learning tool. Other students "tried out" their textbook learning in practice and were able to involve their supervisors or other staff. In undertaking the assignment, many students found that the residents were malnourished, and some suggested steps to handle malnutrition that were new to the staff. Students also reported that the assignment increased their awareness about the importance of the right to food.

The paper concludes that nursing students' learning about human rights can be enriched by integrating learning on campus with learning in practice, using other theories and concepts of learning beyond human rights education. Key to students' learning and professional development were their relationships with nursing home residents, other students and nurses and health personnel. This underscores the importance of the role of patients and community of practice in nursing education for both human rights education and professional development. Awareness of human rights also seemed to make the students make autonomous decisions regarding care following values related to social justice, but they were also dependent on a good learning environment in which they felt included. This study illustrates the complexity of professional development and highlights the necessity of integrating the language of human rights into nursing education in local contexts. Doing so may increase nursing students' awareness of and commitment to promoting patients' rights.

Paper III

The aim of "Human Rights and Nutritional Care in Nurse Education: Lessons Learned" was to investigate the development of coursework in nutritional care as a human right in a nursing programme for first-year nursing students. The paper therefore draws upon reflections and lessons learned in developing this coursework. The coursework, developed through two

rounds, combined learning on campus and clinical placement in nursing homes. Nursing students' perspectives and experiences, gathered through focus groups and a written assignment, informed the coursework development. In the first round of the coursework, multistage focus group interviews were conducted with 18 nursing students before, during and after placement. In the second round, four focus group interviews were conducted with 26 nursing students, following their placement.

The findings highlight the three main "lessons learned" regarding the introduction of nutritional care from a human rights perspective in nursing education: 1) learning about human rights through relationships and experiences, 2) changing the narrative of "vulnerable and malnourished patients" through a human rights perspective and 3) combining the development of ethical competence with a human rights perspective.

The paper concludes that nursing students learned about human rights through their relationships and experiences, and human rights education addressing the students' own context made human rights both meaningful and relevant. Introducing a human rights perspective challenged the narrative of "vulnerable and malnourished patients" in nursing homes. The ability to draw on the language of human rights also seemed to enhance students' accountability and support their navigation when they experienced rights violations during placement. On the other hand, the students' development of ethical competence was limited by institutional structures. While the importance of including a structural perspective in nursing care has received limited attention in nursing ethics education, an HRBA may be one way to bridge this gap. The students experienced ethical dilemmas that originated at a structural level, but also in their interactions with the residents in the mealtime setting. This emphasizes the importance of combining the development of ethical competence and a human rights perspective in nursing education.

6 Discussion

The thesis aimed *to explore the experience of introducing a human rights perspective in nursing education*. In this chapter, the overall thesis findings are discussed in context with the existing research literature and the theoretical perspectives presented earlier. The three sub-studies with their research questions and related findings are discussed in the papers included in this thesis. In Paper I, I discuss how nursing students understand human rights, and how the right to food was an evolving concept throughout their placement. In Paper II, I discuss the importance of situated and relational human rights education and how to facilitate professional development. In Paper III, I discuss three lessons learned in introducing a human rights perspective in nursing education: 1) the contribution of the human rights perspective in changing the narrative of "vulnerable and malnourished patients," 2) the importance of relationships and experiences for learning about human rights and 3) the benefit of combining the development of ethical competence with a human rights perspective.

Human rights education has often addressed rights using far-away cases in the global south as examples, and much of the teaching has taken place on campus (Hahn, 2020; Klug, 2000; Rubenstein & Amon, 2019). This study combines both campus and placement education in the local context of the study, Norway. In this section, I will discuss my findings when introducing a human rights perspective in everyday practice in nursing education, and I will elaborate further on the discussions from the papers. In this discussion, I am also concerned with exploring in more detail how a human rights perspective can contribute to the already rich tradition of nursing education, but also how a nursing education perspective can contribute to the much newer tradition of human rights education. In addition, I believe that the discussion can go beyond the example and context of the right to food and contribute more broadly to the field of both nursing education and human rights education.

The first part of the discussion addresses how a human rights perspective can contribute to nursing education. While some of the elements have already been discussed in the papers, here I will further elaborate and add new reflections. The following elements that will be explored are: 1) raising awareness of and being able to identify situations as human rights issues, 2) understanding the connection between rights and needs, 3) seeing beyond the nurse–patient relationship, and 4) enriching the ethical perspectives in nursing education with a human rights perspective.

The second part of the discussion address what a nursing education perspective can add to human rights education. The following elements will be discussed: 1) learning in a local context and in daily practice of care, 2) combining education on campus and in placement, and 3) learning in communities of practice and through socialization. Finally, I will summarize in a figure the important elements for developing human rights education, based on experiences, findings and reflections from this thesis.

6.1 What can a human rights perspective bring to nursing education?

6.1.1 Awareness and identifying situations as human rights issues

The first contribution of introducing and adopting a human rights perspective is that health professionals often encounter people in vulnerable situations, in which they are deprived of their liberty, discriminated against or stigmatized. These may be people with disabilities, children, prisoners, sex workers or refugees (AI, 2005; Erdman, 2017), but also older adults living in institutions, such as the nursing home residents in this study. However, although nurses may encounter human rights issues daily (ICN, 2011), they may not be aware that human rights violations are occurring and, in some instances, may even be complicit in those violations (Atkinson, 2019; Glowa-Kollisch et al., 2015; London, 2008). Nurses who have awareness and knowledge about human rights are better equipped to recognize and cope with situations where human right are challenged (London, 2008). Moreover, a human rights framework can support nursing students to advocate on behalf of the most vulnerable members of society (Bakshi et al., 2015; Premkumar et al., 2013).

As my study suggests, introducing a human rights perspective in nursing education is not only about recognizing when rights are potentially at stake. Introducing a human rights perspective can provide a language to articulate concerns about justice and discrimination, as also suggested by other authors (Cohen & Ezer, 2013; Newham et al., 2021). My study indicates that a human rights perspective provided nursing students with a "vocabulary" with which to name situations as violations (Dogan et al., 2022). This is in the tradition of Ife's (2012) constructive rights, and the accountability approach from Tibbitts' model (Tibbitts, 2017). The importance of developing a language about human rights with which to realize human rights has also been highlighted in other studies (Cohen & Ezer, 2013; Graves et al., 2021; Newham et al., 2021). In this regard, and as addressed by Cohen and Ezer (2013), human rights become more than a legal framework: they "provide a powerful language to articulate

and mobilize around justice concerns" (Cohen and Ezer, 2013, p.7). In this study, awareness about the right to food and developing a language about the right to food seemed to help students both "name" the situations and empower them to advocate for the patients' rights.

6.1.2. The connections between rights and needs

Introducing a human rights perspective also added several dimensions to food concerning ethical challenges (Dogan et al., 2022). "Needs thinking" is central in nursing, and in nursing practice, the concept of basic needs is common in everyday care (Kitson et al., 2013). These basics or fundamentals—for instance, ensuring appropriate nutrition, hydration, personal hygiene and sleep—have traditionally been nurses' responsibility (Kitson et al., 2013). However, many healthcare reports have shown the harsh consequences of poor nutritional care and hydration (Kitson et al., 2013), as explored earlier. Ife (2012) points out that the defining of other peoples' needs may disempower them by preventing them from defining their own needs; here, a rights-based practice values the choice of patients (Kent, 2005), compared to a needs-based practice. Ife (2012) further points out that it is important to work to address the human rights behind the basic needs. As addressed in Papers I and III (Dogan et al., 2020; Dogan et al., 2022), and by others (Donnelly and Whelan, 2020; Kent, 2005) human rights are fundamentally about dignity and go beyond basic human needs and survival In the context of this study, the patients were served food and meals; however, as the students experienced, the residents could not always decide for themselves with whom to sit during mealtimes, nor could they influence the menu or when to eat (i.e., if they were hungry outside the regular meal schedule) (Dogan et al., 2020; Dogan et al., 2021).

As this study suggests, a human rights perspective emphasizes the issue of food as an *ethical* issue in nursing care, and not merely an issue of basic needs. Introducing a human rights perspective in this way seemed to support the students to deal with ethical challenges that may emerge in nutritional care. When the students brought human rights principles into their everyday practice, they were emphasizing the values of social justice, dignity, non-discrimination and participation. The students also explored the challenges and what it can mean when a patient turns down an offer of food, and the balance between facilitating, motivating, tempting and coercion in mealtime settings (Dogan et al., 2020; Dogan et al., 2021). Relatedly, Cardenas et al., (2021) point out that the right to food does not imply that there is an obligation to feed all patients at any stage of life and at any cost. On the contrary, this right implies, from an ethical point of view, that the best decision for the patient must be made together with the patients, families and/or caregivers.

6.1.3 Seeing beyond the nurse–patient relationship

Research and policies argue for the importance of nurses learning to see beyond the nurse–patient relationship: to be aware of ethical challenges that arise from dual loyalty, which are potential conflicts between a nurses' professional duties to their patients and their obligations to a third party, like an employer or other authority (Atkinson, 2019; ICN, 2011; IDLWG, 2008; London & Baldwin-Ragaven, 2008).

Health personnel may have to make choices, the effects of which have unwanted consequences for the human rights of the patient (Cohen & Ezer, 2013; Glowa-Kollisch et al., 2015; ICN, 2011). In the context of nursing homes in Norway, the students in this study also experienced challenges related to dual loyalty. Study findings seem to indicate that adopting a human rights perspective in nursing education may increase students' awareness of dual loyalty and their ability to assign responsibilities. In regards to nutritional care, a human rights perspective typically places more emphasis on structural barriers to under- and malnutrition (Valente, Suárez-Franco, & Córdova Montes, 2016) than the traditional emphasis on ethics of care, in which the nurse–patient relationship is emphasized (Peel, 2005; Raustøl, 2010).

A human rights framework defines right-holders and duty-bearers, and places responsibly on the states party and through "nested rings of responsibilities" to support the closest duty-bearers to fulfil their obligations to the rights-holders (Erdman, 2017; Kent, 2005). This is the perspective that Ife (2012) points to in the legal tradition of human rights, and was also addressed in the lectures on campus in the coursework (Dogan et al., 2021). Erdman (2017) concludes that human rights education is about knowledge, change and justice. She argues that human rights is not about realizing rights in heroic and singular moments, but in the transformation of the fundamental institutions of society (Erdman, 2017).

Hixon et al., (2013) point out the importance of supporting students' capacity for systems-level thinking and to see above the clinical setting, since the health system is continuously being transformed by social, political and economic aspects (Hixon, Yamada, Farmer, & Maskarinec, 2013). A human rights framework also addresses root causes, and is appropriate for addressing challenges beyond the nurse–patient relationship (Hixon et al., 2013; McKenzie, Mishori, & Ferdowsian, 2020). In this study, findings suggests that the nursing students recognized and addressed several structural challenges: in particular, the lack of professional chefs to prepare food and meals—a task that was left to the nursing students or

healthcare staff—or the lack of individual choice for residents during mealtimes (Dogan et al., 2020; Dogan et al., 2021). The nursing students also raised a critical eye towards how mealtimes were organized, and questioned the lack of resources (e.g., the food budget); in addition, they found that nutritional care was often dependent upon the caregiver providing that care (Dogan et al., 2020). As other researchers have indicated, caregivers may know how to care appropriately but are constrained by organizational structures hindering their care provision (Hammar et al., 2016).

6.1.4 Enriching the ethical perspectives in nursing education with a human rights perspective

There are similarities between the ethical perspectives in nursing education and a human rights perspective. However, there are also at least two main differences (Peel, 2005). One is that the focus is on the state level (i.e., their legal responsibility) rather than addressing ethical behaviour in the nurse–patient relationship, often seen in moral codes (Easley & Allen, 2007; Erdman, 2017; Gruskin & Dickens, 2006; Peel, 2005). Human rights are correlated with duties or obligations (UN, 1976; OHCHR 1999); in other words, when someone has a right (the right-holders), another person or institution (the duty-bearers) has a duty and obligation to comply with that right (Kent, 2005). The other difference is the issue of benevolence, which is important in the theory of care ethics and bioethics, but it is not central in human rights discourse. Human rights do not depend on the empathy of or mercy from other actors (Peel, 2005). The concept of "human rights in patient care" provides a complementary framework to care ethics and bioethics with a systemic approach, norms and focus on advocacy, duty-bearers and right-holders. While nurses often frame decisions in practice within the context of care ethics and bioethics, the consideration of a human rights perspectives in nursing practice is more recent (Easley & Allen, 2007; Erdman, 2017). Bioethics in nursing is inspired from a combination of the philosophies of two theoretical schools: the utilitarian (consequentialist), which looks into actions from their consequences, and the deontologist and rule-based (non-consequentialist) (Peel, 2005). Based on these two schools, four ethical principles—autonomy, non-maleficence, beneficence and justice—were developed that are central in professional nursing practice and in nursing education (Beauchamp & Childress, 2019; Beauchamp & Childress, 2001). These principles form an often used framework for ethical decision-making in healthcare and nursing education (Ivanov & Oden, 2013), together with care ethics (Gallagher, 2017) and the Code of Ethics for Nurses (ICN, 2012; Vanlaere & Gastmans, 2007).

A human rights perspective in patients care zooms out from the individual nurse–patient relationship towards examining systemic issues and state responsibility (Cohen & Ezer, 2013). A human rights perspective in nursing education is one approach to addressing challenges in healthcare related to dual loyalty, systems and structures, and to teaching student nurses to develop professional values, like advocating for social justice, promoting dignity and respecting patients' rights (Curtice & Exworthy, 2010; Erdman, 2017; Tibbitts, 2017). A human rights perspective addresses challenges both in the interpersonal relationship between patient and health personnel in the delivery of healthcare, but also in regard to the systemic factors and state responsibility that shape healthcare. A human rights framework provides a set of legally recognized and globally accepted norms and procedures for identifying systemic issues and enabling mobilization (Cohen & Ezer, 2013). In this regard, a human rights perspective in nursing care can further complement and work parallel to care ethics and bioethics and involve ethical aspects that move outwards (Cohen & Ezer, 2013; Peel, 2005).

6.2 What can a nursing education perspective bring to human rights education?

Thus far in this thesis, I have been primarily concerned with what a human rights perspective can bring to professional practice in nursing care, as this was the starting point of my journey. However, in the multi-year process of working on my thesis, I increasingly saw the importance of enriching human right education by considering how nursing education can "contribute to broadening human rights thinking and practice" (Mann et al., 1994, p.22).

6.2.1 Learning in a local context and in daily practice of care

In the empirical studies presented in the overview of human rights education for health professionals, the authors highlight the importance of learning human rights education through real-life examples and cases (Mayers, 2007; Reyes et al., 2013). This opens the possibility for students to move beyond an awareness of violations and towards transformation (Erdman, 2017). Here, then, human rights are not seen as abstract violations taking place in some far-off place, but as part of the challenges that can occur in any community that works with patients. This gives students the opportunity to work on human rights challenges in a daily practice of care, and I experienced the benefit by choosing an everyday topic, i.e., first-year nursing students learning to promote the right to food for nursing home residents. In this regard, it was possible for the students to learn about human rights in a daily context of care, as compared to other topics that are seen in human rights

education, such as dual loyalty in prisons (Glowa-Kollisch et al., 2015), rights promotion for asylum seekers and torture survivors (Asgary et al., 2013), or rights at stake due to forced migration (Okenwa-Emegwa & Eriksson, 2020). Although important, these are not generally everyday challenges faced by health personnel (unless working in that particular field).

The findings from this thesis are in line with nursing education's longstanding emphasis on contextual learning: learning in practice and clinical settings is viewed as a crucial component in nursing education (Pollard, Ellis, Stringer, & Cockayne, 2007). As with clinical procedures and practical patient care, knowing the theory about specific policies or human rights conventions does not make one capable of promoting human rights and advocating for social justice in practice. The emphasis on context is not new to human rights education. Several researchers have addressed the need for students to be aware of human rights in daily life, and in a local context (Osler, 2016; Tibbitts, 2017; Vesterdal, 2016). For instance, Tibbits (2017) argues that human rights learning, and accountability develop through participation and socialization. In addition, in this study, I found that human rights need to be contextualized and situated for the learner. As such, human rights education can benefit from being tailored to the students' experiences and own context (Branigan & Ramcharan, 2012). Hopia and Lottes (2018) found in their study on human rights education that students were able to apply human rights principles to their own work and to see the relevance between these principles and providing quality care (Hopia & Lottes, 2018).

A constructivist form of understanding knowledge and learning underscores the importance of involving the learners as active participants; prior knowledge and experiences to the learning process; learning in a sociocultural environment; and a mutuality between the teachers and learners (Peters, 2000). This perspective goes beyond knowledge as objective standards and facts, transferred from teacher to learner. In this study, the module developed towards situated learning about human rights (Dogan et al., 2022; Dogan et al., 2021), and findings show that the students learned from situatedness—as Morley (2016) has also found in the tradition of nursing education—instead of from applying human rights challenges far removed from the learners' own reality or from an exclusively theoretical perspective.

6.2.2 Combining education on campus and in placement

This study combined education on campus and in placement in a nursing home. The students experienced the importance of learning about the right to food on campus since this prepared

them for the reality of their placement (Dogan et al., 2021). The importance of preparedness concerning rights violations in nursing education has been emphasized by others (Malmedal et al., 2014). The students discussed the importance of relevant lectures on campus when they experienced similar situations in practice (Dogan et al., 2021). Study findings indicate that on-campus preparation concerning the right to food seemed to support students in learning about and promoting the right to food in their placement, meaning that placement preparedness and *coherence* helped bridge the boundary between classroom and practice. This kind of boundary crossing is familiar in nursing education, as the outcomes and subjects the students are learning about on campus correspond with preparedness for various placements at hospitals, nursing homes and in the community. Akkerman and Bakker (2011) state that "all learning involves boundaries" (p.132), and that boundary can be seen as "sociocultural differences leading to discontinuities in action and interaction" (p. 152). The concept of boundary crossing usually refers to peoples' transactions and interactions between different sites (Suchman, 1993), such as nursing students when they alternate between campus and various practice fields. The concept of boundary crossing is a part of the theory of communities of practice (Wenger, 1999), which stresses how boundaries carry the potential for learning when moving from legitimate peripheral participation to being a full member of a particular community (Lave & Wenger, 1991; Wenger, 1999). However, the theory does not explore boundary crossing between campus and placement seen in nursing education (Dogan et al., 2021). In this study, coherence was important for the students' development and learning (Dogan et al., 2021).

Akkerman and Bakker (2011) reveal how r*eflection* and *transformation* are potential learning mechanisms that can take place through boundary crossing. This was also seen in this study, as findings indicate that the students learned from situations where rights were at risk through reflections with others (Dogan et al., 2021). This seemed to contribute to the students' learning and professional development when determining their own position with regards to different values (Akkerman & Bakker, 2011; Dogan et al., 2021). Findings from another study indicate that, to support students to perceive coherence between theory and practice in nursing education, it is important to develop their reflective skills (Hatlevik, 2012). Moreover, some of the students also experienced changes in their practice. This has also been addressed by Tibbits (2017) in the accountability approach regarding human rights education, which emphasizes the importance for learners to experience an increased capacity to influence their own environment. Some of the students did influence their own practice, and experienced

changes in practice around promoting the residents' human rights (Dogan et al., 2020; Dogan et al., 2021). By engaging in reflections and discussion with others, they also emphasized a constructivist approach to human rights (Ife, 2012), in which the students themselves took responsibility for and contributed to their own learning and professional development and made changes through their own experiences and perspectives. The importance of discussion and reflection in human rights education for health professionals has also been addressed by others (Atkinson, 2019; Jovic Vranes et al., 2015; McGaughey et al., 2019). Hence, if the goal is to support students to develop an awareness of human rights, the curriculum ought to include opportunities for discussion and reflections around rights violations when alternating between campus and practice.

6.2.3 Learning in communities of practice and through socialization and relationships

The findings from the thesis indicate that the students learned through their interactions and relationships. As explored earlier, findings also suggest that learning took place when students talked about and reflected upon their own experiences with other students and with their supervisors, but also in their interactions with the residents (Dogan et al., 2020; Dogan et al., 2021). Further, study findings highlight how the students' learning occurred through sharing their experiences with others (Dogan et al., 2020; Dogan et al., 2021). An important contribution in this regard comes from the theory of learning in communities of practice (Wenger, 1999); the idea that learning is a social process that occurs in communities of practice is important in nursing education (Morley, 2016). In this study, I came to see the importance of understanding learning as something that occurs in a community of practice, involving interaction with both expert practitioners and peers (Dogan et al., 2021). This finding highlights the need to enrich human rights education with other perspectives, as human rights education has been criticized for being decontextualized and addressing violations far removed from the learners' context (Branigan & Ramcharan, 2012; Hahn, 2020; Tibbitts, 2017). The theory of communities of practice can supplement human rights education by emphasizing how learning happens through socialization into and within one's own community (Dogan et al., 2021; Wenger, 1999).

Choosing a topic that would be part of a daily care context was not merely important for the students' learning and professional development but meant that the students would become aware that human rights were at stake in their own country (Dogan et al., 2022). In this regard, the voices of the residents were heard, and their rights were promoted. A study promoting the rights of asylum seekers and torture survivors found a similar benefit to human

rights education taking place in a practice context and community (Asgary et al., 2013); the authors report that many of the patients were moved by the fact that students were interested in their stories and showed empathy (Asgary et al., 2013). Moreover, some studies show the benefit of human rights education when linked to a community (Bakshi et al., 2015; Praschan et al., 2016). This might involve change in that community, which means that human rights education is not limited to the students' learning (Ezer, 2014). This is familiar in nursing education, where throughout the bachelor's programme there is cooperation between the nursing education programme and other institutions in the community, as half of the bachelor programme for the students take place in clinical placements or the community.

In this study, communities of practice (Wenger, 1999) was utilized to understand students' learning in a practice. However, this theory tends not to include patients. As such, an important contribution of this study is its inclusion of patients in students' community of practice. In later work, Wenger argues for extending the theory to patients, since patients form their own communities (Wenger, 2010); however, what is notable here is that the students were also forming a community with the patients. It is well known that students learn from interacting and caring for patients during their clinical placement (Manninen, Henriksson, Scheja, & Silén, 2014). In nursing practice and theory, caring is fundamental and the value base of nursing, and has long been explored and discussed by nursing theorists (Henderson, 1964; Martinsen, 2000; Nightingale, 1861). Patients are in a vulnerable situation and are in need of professionals to care for them—which also was found in this thesis. A human rights perspective that does not include the perspective of care runs the risk of neglect and rights violations. However, the asymmetry of the relationship between patients and health professionals (Parsons, 1969) adds an important aspect regarding the inclusion of patients in a community of practice. Ezer (2014) also addresses the importance of enabling the voices of the socially excluded to be heard, and that human rights education should include these voices (Ezer, 2014). This is not unfamiliar in nursing education and nursing care, and the importance of hearing and giving voice to patients was also addressed by Benner et al., (2008) and Kitson et al., (2013). The patients are of course not only important for the students' learning, but from an HRBA, they are indeed right-holders and should be involved in a community and given the opportunity to participate in social change that concerns themselves.

6.3 Summary

In this chapter, I have explored and discussed what a human rights perspective can contribute to nursing education and what a nursing education perspective can contribute to human rights education. I will now summarize and illustrate the findings in a figure that captures the combination of these two elements. Figure 3 has three main parts, presenting the relevance of a human rights perspective in health profession (as discussed in Chapter 6.1); the contribution of a nursing education perspective for students' learning in regard to human rights (as discussed in Chapter 6.2); and how the students learned when combining both the field of human rights education and nursing education.

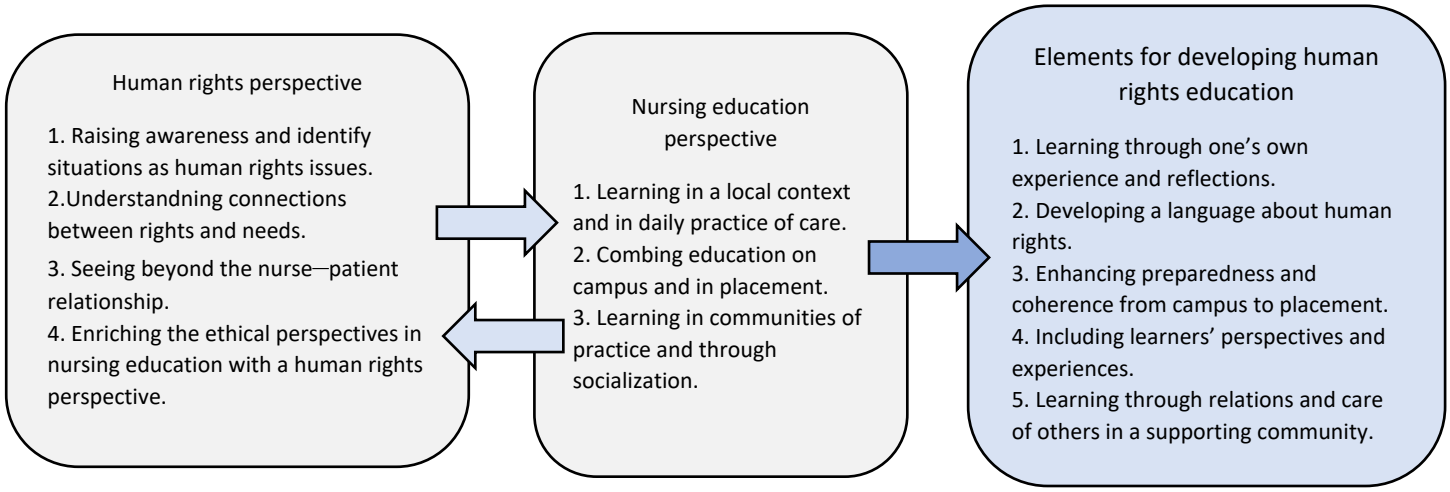

Figure 3 Relevance of human rights and nursing education perspectives and elements for developing human rights education.

From this study I experienced the following elements of importance when developing human rights education when combining a human rights perspective and a nursing education perspective. Firstly, it is important for students to learn through their own experience, real-life challenges and reflections. Secondly, it is important for students to develop a language about human rights. Thirdly, preparedness and coherence from campus to placement is important for students' learning and development. Fourthly, it is important to include the learners' experiences and perspectives to make human rights education relevant and meaningful. Finally, it is important for students to learn through reflection, relationships and caring for others in a supportive community, which relates to both duty-bearers and rights-holders.

6.4 Implications for practice and research

The purpose of this study was to gain more knowledge about how to introduce a human rights perspective in nursing education in the context of nutritional care for older adults in nursing homes. This was done through the development of coursework for first-year nursing students in the area of the right to food for nursing home residents. The students were included through the perspectives and experiences they shared in focus groups and in their written assignments from placement. This thesis also indicates that human rights education in nursing education is a ripe field for providing opportunities to handle ethical and structural challenges and for promoting inclusion and an understanding of nutritional care not only as a basic need, but also as a human right.

I recommend that further research in this field include practice experience, as this may foster both learning for the students and the realization of rights for patients. Facilitating learning in real-life educational contexts in human rights education may also bridge the theory–practice gap. Addressing human rights in a practice context, such as clinical placement, also includes the patients and promotion of their rights. Human rights education can benefit from being contextualized both locally and in practice, enhancing learning through the learners' own experiences and through relations with others when addressing everyday human rights challenges.

The alarming conditions related to nutritional care of older adults in Norwegian institutions seems to demand action and new thinking. Although a human rights perspective cannot be regarded as a quick fix for malnutrition, (and we have learned the importance of respecting the right of not to be fed), it would be interesting to explore the impact of adopting a human rights perspective on the nutritional status of the patients.

Drawing on reflections from this study, I also suggest that human rights education to be addressed throughout nursing students' education. Moreover, as human rights education may complement nursing ethics in the areas of dual loyalty, structural challenges and the human rights of both health professionals and patients, further research should include the human rights perspective for both patients and health professionals, and the nexus between right-holders and duty-bearers.

7 Conclusion

Today, there are broad international discourses on the importance of human rights education for developing sustainable practices, promoting human rights, ensuring social justice and protecting human dignity. Although human rights are an important part of nursing care and practice, few studies have investigated human rights education in nursing education. The aim of this study was to explore the experience of introducing a human rights perspective in nursing education. This was done in the context of nursing education in Norway, focusing on the right to food for older adults in nursing homes. By adopting an HRBA, coursework on the right to food was introduced and developed, combining education on campus and in placement, where nursing students had their first placement in a nursing home/long-term care facility. This study is likely the first to explore human rights education in nutritional care in nursing education.

The three papers each address different parts of the overall aim. In Paper I, I explore nursing students' perspective and experiences of the right to food throughout placement in a nursing home, and how they constructed human rights throughout placement. In Paper II, I explore how the students learned about the right to food, combining coursework on campus and in placement. In Paper III, I draw upon reflections from the studies and the development of the coursework that led to theoretical understanding and lessons learned when developing education in nursing education from a human rights perspective.

The findings from the thesis highlight that nursing students' learning about human rights can be enriched by integrating learning on campus with learning in practice, using other theories and concepts of learning beyond human rights education. Key to students' learning and professional development were their relationships with nursing home residents, other students and nurses and health personnel. This underscores the importance of the role of patients and communities of practice in nursing education in human rights education. The thesis findings indicate that human rights education addressing the students' own context made human rights both meaningful and relevant. In this study, when addressing a human rights issue in a daily context of care, the students became aware of human rights at stake in their own country. Awareness of human rights also seemed to make the students make autonomous decisions regarding care in accordance with values related to social justice, but they were also dependent on a good learning environment in which they felt included. The ability to draw on the language of human rights also seemed to enhance students' accountability and support their navigation when they experienced rights violations during placement. This study

underscores the necessity of integrating the language of human rights into nursing education in local contexts. Doing so may increase nursing students' awareness of and commitment to promoting patients' rights. The findings also suggest the importance of strengthening nursing students' ability to handle the complexity of the organizational structures in which they will provide nutritional and nursing care. This can be achieved by adding a human rights framework in nursing education and through supporting the students to benefit from the learning environment during placement.

A human rights perspective in nursing education is one approach to addressing challenges in healthcare related to dual loyalty, systems and structures—and for teaching student nurses to develop professional values like advocating for social justice, promoting dignity and respecting patients' rights. A human rights perspective in patients' care "zooms out" from the individual patient–provider relationship towards examining systemic issues and state responsibility. In this regard, a human rights perspective in nursing care can further complement and work parallel with care ethics and bioethics and involve ethical aspects that move outwards: from the individual as the professional who must make ethical decisions towards systems and structural challenges. Incorporating human rights in nursing education supported nursing students and nurses in recognizing and addressing both ethical and structural challenges and to be able to fulfil the right to food for patients. It is my hope that this dissertation can contribute to knowledge regarding introducing a human rights perspective in health profession and nursing education, and to the field of human rights education.

References

Aagaard, H. (2010) "Ærlig talt": mat og måltider i sykehjem: en undersøkelse blant beboere i somatiske sykehjem i Østfold. Oppdragsrapport. Vol. 2010:1. Høgskolen i Østfold: Halden. Retrieved from: http://hdl.handle.net/11250/147795

Aagaard, H., & Grøndahl, V. A. (2015). Mat og måltid i sykehjem 2. Oppdragsrapport.Vol. 2015:1. Høgskolen i Østfold. Retrieved from: http://hdl.handle.net/11250/278769

Adresseavisen. (2021). Dårlig og for lite mat er en av grunnene til at stadig flere eldre på sykehjem blir underernærte. *Adresseavisen*. Retrieved from: https://www.midtnorskdebatt.no/meninger/leder/2021/09/30/Eldre-fortjener-og-trenger-bra-mat-24647803.ece

Amnesty International (2005). Amnesty International Urges a Stronger Human Rights Role for Nurses and Midwives, 12, Amnesty International Pub. L. No. 6 649-650 (2005). Retrieved from: https://www.amnesty.org/en/wp-content/uploads/2021/08/act750022005en.pdf

Akkerman, S. F., & Bakker, A. (2011). Boundary crossing and boundary objects. *Review of educational research, 81*(2), 132-169. https://doi.org/10.3102/0034654311404435

Allen, D. G., Bowers, B., & Diekelmann, N. (1989). Writing to learn: A reconceptualization of thinking and writing in the nursing curriculum. *Journal of Nursing Education, 28*(1), 6-9. https://doi.org/10.3928/0148-4834-19890101-04

Alves, P., Oliveira, C. S., & Lima-Basto, M. (2019). Food: A Challenging and Complex Fundamental Care. *Mediterranean Journal of Social Sciences, 10*(3), 36-36. https://www.richtmann.org/journal/index.php/mjss/article/view/10419

Andrew, N., Tolson, D., & Ferguson, D. (2008). Building on Wenger: Communities of practice in nursing. *Nurse education today, 28*(2), 246-252. https://doi.org/10.1016/j.nedt.2007.05.002

Arda, B. (2004). Human rights in medical ethics education. *Journal of the International Association of Medical Science Educators, 14*(1), 5-7. http://www.iamse.org/mse-article/human-rights-in-medical-ethics-education/

Asgary, R., Saenger, P., Jophlin, L., & Burnett, D. C. (2013). Domestic global health: a curriculum teaching medical students to evaluate refugee asylum seekers and torture survivors. *Teaching and learning in medicine, 25*(4), 348-357. https://doi.org/10.1080/10401334.2013.827980

Atkinson, H. G. (2019). Preparing physicians to contend with the problem of dual loyalty. *Journal of Human Rights, 18*(3), 339-355. https://doi.org/10.1080/14754835.2019.1617121

Backman, G., & Fitchett, J. R. (2010). Health and human rights education: time to act. *The Lancet, 375*(9718), 894. https://doi.org/10.1016/S0140-6736(10)60389-3

Bajaj, M. (2017). Introduction. I: M. Bajaj. (Eds.) *Human rights education*. *Theory, Research, Praxis* (pp. 1-16). USA: University og Pennsylvania Press.

Bakker, A. (2018). What is design research in education? I: A. Bakker (Eds.) *Design Research in Education. A Practical Guide for Early Career Researchers* (pp. 3-22). New York: Routledge.

Bakshi, S., James, A., Hennelly, M. O., Karani, R., Palermo, A.-G., Jakubowski, A., . . . Atkinson, H. (2015). The Human Rights and Social Justice Scholars Program: a collaborative model for preclinical training in social medicine. *Annals of global health, 81*(2), 290-297. http://doi.org/10.1016/j.aogh.2015.04.001

Barab, S., & Squire, K. (2004). Design-based research: Putting a stake in the ground. *The journal of the learning sciences, 13*(1), 1-14. https://doi.org/10.1207/s15327809jls1301_1

Beauchamp, T., & Childress, J. (2019). Principles of biomedical ethics: marking its fortieth anniversary. *The American Journal of Bioethics,*(19(11): 9–12). https://doi.org/10.1080/15265161.2019.1665402

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. (5th edition). Oxford: Oxford University Press.

Benner, P., Sutphen, M., Leonard-Kahn, V., & Day, L. (2008). Formation and everyday ethical comportment. *American Journal of Critical Care, 17*(5), 473-476. https://doi.org/10.4037/ajcc2008.17.5.473

Bollo, M., Terzoni, S., Ferrara, P., Destrebecq, A., & Bonetti, L. (2019). Nursing students' attitudes towards nutritional care of older people: A multicentre cross-sectional survey incorporating a pre post design. *Nurse education today, 78*, 19-24. https://doi.org/10.1016/j.nedt.2019.03.016

Borchsenius, C., Mortensen, T., & Husevåg, E. (2021). Når skal underernæring blant eldre tas alvorlig? *Dagens Medisin.* Retrieved from: https://www.dagensmedisin.no/artikler/2021/10/21/nar-skal-underernaring-blant-eldre-tas-alvorlig/

Borglin, G., & Fagerström, C. (2012). Nursing students' understanding of critical thinking and appraisal and academic writing: A descriptive, qualitative study. *Nurse education in practice, 12*(6), 356-360. https://doi.org/10.1016/j.nepr.2012.04.009

Bovill, C., Cook-Sather, A., & Felten, P. (2011). Students as co-creators of teaching approaches, course design, and curricula: implications for academic developers. *International Journal for Academic Development, 16*(2), 133-145. https://doi.org/10.1080/1360144X.2011.568690

Branigan, E., & Ramcharan, P. (2012). Human rights education in Australia: Reflections on the meaningful application of rights and values in practice. *Journal of Human Rights Practice, 4*(2), 233-252. https://doi.org/10.1093/jhuman/hus007

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101. http://doi.org/10.1191/1478088706qp063oa

Brenner, J. (1996). Human rights education in public health graduate schools: 1996 survey. *health and human rights, 2*(1), 129-139. https://doi.org/4065239

Buxton, C., & Davies, A. (2013). Nutritional knowledge levels of nursing students in a tertiary institution: Lessons for curriculum planning. *Nurse education in practice, 13*(5), 355-360. https://doi.org/10.1016/j.nepr.2012.09.014

Cardenas, D., Bermudez, C., & Echeverri, S. (2019). Is nutritional care a human right? *Clinical Nutrition Experimental, 26*, 1-7. https://doi.org/10.1016/j.yclnex.2019.05.002

Cardenas, D., Correia, M. I. T. D., Ochoa, J. B., Hardy, G., Rodriguez-Ventimilla, D., Bermúdez, C. E., . . . Ungpinitpong, W. (2021). Clinical nutrition and human rights.

An International position paper. *Clinical nutrition*. 40(6):4029-4036. https://doi.org/10.1016/j.clnu.2021.02.039

Cederholm, T., Barazzoni, R., Austin, P., Ballmer, P., Biolo, G., Bischoff, S. C., . . . Holst, M. (2017). ESPEN guidelines on definitions and terminology of clinical nutrition. *Clinical nutrition, 36*(1), 49-64. https://doi.org/10.1016/j.clnu.2016.09.004

Chamberlain, M. (2001). Human rights education for nursing students. *Nursing ethics, 8*(3), 211-222. https://doi.org/10.1177/096973300100800306

Chao, A. M., Luong, V., Dowd, M., & Compher, C. (2020). A National Survey of Faculty Perceptions of Nutrition in Nursing Education. *Journal of Nursing Education,* 59(10), 566-569. https://doi.org/10.3928/01484834-20200921-05

Chapman, C., Barker, M., & Lawrence, W. (2015). Improving nutritional care: innovation and good practice. *Journal of Advanced Nursing, 71*(4), 881-894. https://doi.org/10.1111/jan.12571

Chastonay, P., Zesiger, V., Ferreira, J., & Mpinga, E. K. (2012). Training medical students in human rights: a fifteen-year experience in Geneva. *Canadian medical education journal, 3*(2), e151. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4563630/

Chaudoir, S., & Trepanier, M. (2016). Writing assignments: A relatively emotional experience of learning to write in one baccalaureate nursing program. *Quality Advancement in Nursing Education-Avancées en formation infirmière,* 2(2), 3. https://qane-afi.casn.ca/journal/vol2/iss2/3/

Chen, W., & Reeves, T. C. (2020). Twelve tips for conducting educational design research in medical education. *Medical teacher, 42*(9), 980-986. https://doi.org/10.1080/0142159X.2019.1657231

Chepulis, L. M., & Mearns, G. J. (2015). Evaluation of the nutritional knowledge of undergraduate nursing students. *Journal of Nursing Education, 54*(9), S103-S106. https://doi.org/10.3928/01484834-20150814-19

Chilisa, B., & Kawulich, B. (2012). Selecting a research approach: Paradigm, methodology and methods. I: C. Wagner, B. Kawulich. and M. Garner (Eds.) *Doing social research: A global context* (pp.51-61). Maidenhead, Berkshire : McGraw-Hill Higher Education.

CoE. (2003). *Food and Nutritional Care in Hospitals: How to Prevent Undernutrition.* Strasbourg: Council of Europe. Retrieved from: https://book.coe.int/en/health-protection-of-the-consumer/2570-food-and-nutritional-care-in-hospitals-how-to-prevent-undernutrition.html#

Cohen, J., & Ezer, T. (2013). Human rights in patient care: a theoretical and practical framework. *Health Hum Rights, 15*(2), 7-19. https://www.hhrjournal.org/2013/12/human-rights-in-patient-care-a-theoretical-and-practical-framework/

Cope, P., Cuthbertson, P., & Stoddart, B. (2000). Situated learning in the practice placement. *Journal of advanced nursing, 31*(4), 850-856. https://doi.org/10.1046/j.1365-2648.2000.01343.x

Cotter, L. E., Chevrier, J., El-Nachef, W. N., Radhakrishna, R., Rahangdale, L., Weiser, S. D., & Iacopino, V. (2009). Health and human rights education in US schools of medicine

and public health: current status and future challenges. *PloS one, 4*(3), e4916. https://doi.org/10.1371/journal.pone.0004916

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice,* 39(3), 124-130. https://doi.org/10.1207/s15430421tip3903_2

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches*. (4th edition). Sage publications.

Curtice, M. J., & Exworthy, T. (2010). FREDA: a human rights-based approach to healthcare. *The Psychiatrist,* 34(4), 150-156. https://doi.org/10.1192/pb.bp.108.024083

Dahlgren, M. A., Solbrekke, T. D., Karseth, B., & Nyström, S. (2014). From University to professional practice: Students as journeymen between cultures of education and work. I: S. Billett, C. Harteis and H. Gruber (Eds.) *International Handbook of Research in Professional and Practice-based Learning* (pp. 461-484). Springer.

Dang, T. M., & Maggio, L. A. (2017). Supporting the call to action: a review of nutrition educational interventions in the health professions literature and MedEdPORTAL. *Academic Medicine,* 92(3), 403-416. https://doi.org/10.1097/acm.0000000000001532

Dembour, M.-B. (2010). What are Human Rights-Four Schools of Thought. *Hum. Rts. Q., 32*, 1. https://www.jstor.org/stable/40390000

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research*. (4th edition). Thousands Oaks: Sage.

DiMaria-Ghalili, R. A., Mirtallo, J. M., Tobin, B. W., Hark, L., Van Horn, L., & Palmer, C. A. (2014). Challenges and opportunities for nutrition education and training in the health care professions: intraprofessional and interprofessional call to action. *The American journal of clinical nutrition, 99*(5), 1184S-1193S. https://doi.org/10.3945/ajcn.113.073536

Dogan, E. I. K., Raustøl, A., & Terragni, L. (2020). Student nurses' views of right to food of older adults in care homes. *Nursing ethics, 27*(3), 754-766. https://doi.org/10.1177/0969733019884614

Dogan, E. I. K., Terragni, L., & Raustøl, A. (2021). Student nurses' experience of learning about the right to food: Situated professional development within clinical placement. *Nurse education today, 98*, 104692. https://doi.org/10.1016/j.nedt.2020.104692

Dogan, E. I. K., Terragni, L., & Raustol, A. (2022). Human rights and nutritional care in nurse education: lessons learned. *Nursing ethics*. https://doi.org/10.1177/09697330211057226

Dong, X. Q. (2015). Elder abuse: systematic review and implications for practice. *Journal of the American Geriatrics Society, 63*(6), 1214-1238. https://doi.org/10.1111/jgs.13454

Donnelly, J. (2013). *Universal human rights in theory and practice*. (3rd edition). Ithaca: Cornell University Press.

Donnelly, J., & Whelan, D. J. (2020). *International human rights*. (6th edition). Routledge.

Easley, C. E., & Allen, C. E. (2007). A critical intersection: Human rights, public health nursing, and nursing ethics. *Advances in nursing science, 30*(4), 367-382. https://doi.org/10.1097/01.ANS.0000300185.94595.6c

Eglseer, D., Halfens, R. J., Schüssler, S., Visser, M., Volkert, D., & Lohrmann, C. (2018). Is the topic of malnutrition in older adults addressed in the European nursing curricula?

A MaNuEL study. *Nurse education today, 68*, 13-18. https://doi.org/10.1016/j.nedt.2018.05.015

Eide, A. (1996). Human rights requirements to social and economic development. *Food Policy, 21*(1), 23-39. https://doi.org/10.1016/0306-9192(95)00057-7

Eide, H. D., Aukner, C., & Iversen, P. O. (2013). Nutritional status and duration of overnight fast among elderly residents in municipal nursing homes in Oslo. *Vård i norden, 33*(1), 20-24. https://doi.org/10.1177/010740831303300105

Eide, H. D., Halvorsen, K., & Almendingen, K. (2015). Barriers to nutritional care for the undernourished hospitalised elderly: perspectives of nurses. *Journal of Clinical Nursing, 24*(5-6), 696-706. https://doi.org/10.1111/jocn.12562

Elton, L. (2010). Academic writing and tacit knowledge. *Teaching in higher education, 15*(2), 151-160. https://doi.org/10.1080/13562511003619979

Englert, D. M., Crocker, K. S., & Stotts, N. A. (1986). Nutrition education in schools of nursing in the United States. Part 1. The evolution of nutrition education in schools of nursing. *Journal of Parenteral and Enteral Nutrition, 10*(5), 522-527. https://doi.org/10.1177/0148607186010005522

Erdman, J. N. (2017). Human rights education in patient care. *Public health reviews,38*(1), 14. https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-017-0061-8

Evju, A. S., & Lindgren, S. J. (2017). Ernæring hos eldre: Hvorfor svikter ernæringsoppfølgingen? *Sykepleien*. Retrieved from: https://sykepleien.no/meninger/innspill/2017/01/hvorfor-svikter-ernaeringsoppfolgingen

Ezer, T. (2014). Four Key Lessons from Teaching Human Rights for Health.(nd). Retrieved from: https://www.opensocietyfoundations.org/voices/four-key-lessons-teaching-human-rights-health-0

Ezer, T., & Overall, J. (2013). Advancing human rights in patient care through higher education in eastern europe and central asia. *Health and human rights, 15*(2). https://www.hhrjournal.org/2013/12/advancing-human-rights-in-patient-care-through-higher-education-in-eastern-europe-and-central-asia/

FAO (2012) The right to food and global strategic frameworks: The Global Strategic Framework for Food Security and Nutrition (GSF) and the UN Comprehensive Framework for Action (CFA). Retrieved from: http://www.fao.org/3/a-ap556e.pd

Farmer, P., & Gastineau, N. (2002). Rethinking health and human rights: time for a paradigm shift. *The Journal of Law, Medicine & Ethics, 30*(4), 655-666. https://doi.org/10.1111/j.1748-720X.2002.tb00433.x

Feo, R., & Kitson, A. (2016). Promoting patient-centred fundamental care in acute healthcare systems. *International Journal of Nursing Studies, 57*, 1-11. https://doi.org/10.1016/j.ijnurstu.2016.01.006

Fields, A. B., & Narr, W.-D. (1992). Human rights as a holistic concept. *Hum. Rts. Q., 14*, 1. https://www.jstor.org/stable/762549?origin=crossref&seq=1#metadata_info_tab_contents

Fitchett, J. R., Ferran, E., Footer, K., & Ahmed, N. (2011). Health and human rights: an area of neglect in the core curriculum? *Journal of medical ethics, 37*(4), 258-260. http://dx.doi.org/10.1136/jme.2010.037556

Fjellström, C. (2009). The social significance of older people's meals. I: M. Raats, L. de Groot and W. van Staveren (Eds.). *Food for the ageing population* (pp. 95-109): Elsevier. https://doi.org/10.1533/9781845695484.1.95

Flick, U. (2004). Triangulation in qualitative research. I: U. Flick, E. von Kardorff and I. Steinke (Eds.). *A companion to qualitative research* (pp.178-183). London-Thousands Oak-New Dehli: Sage Publications.

Florencio, C. (2001). Rights-based food and nutrition perspective: 21st century challenge for dietetics. *Journal of Human Nutrition and Dietetics, 14*(3), 169-183. https://doi.org/10.1046/j.1365-277X.2001.00286.x

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., . . . Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC health services research, 18*(1), 1-11. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2915-2

Forman, L. (2011). Making the case for human rights in global health education, research and policy. *Canadian Journal of Public Health, 102*(3), 207-209. https://doi.org/10.1007/BF03404898

Forman, L., Brolan, C., & Kenyon, K. (2019). Global health, human rights, and the law. *Lancet, 394(10213), 1987*. https://doi.org/10.1016/S0140-6736(19)32604-2Freidson, E. (2001). *Professionalism, the third logic: On the practice of knowledge*: University of Chicago press.

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Herder and Herder.

Gallagher, A. (2017). Care ethics and nursing practice. I: A. Scott (Eds.). *Key concepts and issues in nursing ethics* (pp. 55-68). Springer.

Gastmans, C. (1998). Meals in nursing homes. *Scandinavian Journal of Caring Sciences, 12*(4), 231-237. https://pubmed.ncbi.nlm.nih.gov/10067649/

Glowa-Kollisch, S., Graves, J., Dickey, N., MacDonald, R., Rosner, Z., Waters, A., & Venters, H. (2015). Data-driven human rights: using dual loyalty trainings to promote the care of vulnerable patients in jail. *Health & Hum. Rts. J., 17*, 124. https://www.hhrjournal.org/2015/03/data-driven-human-rights-using-dual-loyalty-trainings-to-promote-the-care-of-vulnerable-patients-in-jail/

Goff, W., & Getenet, S. (2017). Design-based research in doctoral studies: adding a new dimension to doctoral research. *International Journal of Doctoral Studies, 12*, 107-121. https://doi.org/10.28945/3761

Gostin, L. O., Huffstetler, H., & Meier, B. M. (2020). Human Rights Education Must Become Central to the Health Curriculum. *Health and human rights journal*. https://www.hhrjournal.org/2020/01/human-rights-education-must-become-central-to-the-health-curriculum/

Gostin, L. O., Monahan, J. T., Kaldor, J., & Friedman, E. A. (2019). Global health, human rights, and the law–Authors' reply. *The Lancet, 394*(10213), 1988. https://doi.org/10.1016/S0140-6736(19)32616-9

Graves, J., Boyal, A., Shields, T., Newham, R., Hewison, A., & Terry, L. (2021). Human rights education in palliative care–an evaluation of a national training programme. *International Journal of Human Rights in Healthcare*. Vol. 14 No. 5, pp. 437-451. https://doi.org/10.1108/IJHRH-08-2020-0066

Greenhalgh, T. (2019). I: *How to read a paper: the basics of evidence-based medicine and healthcare* (6th edition). Wiley-Blackwell

Gruskin, S., & Dickens, B. (2006). Human rights and ethics in public health. In: American Journal of Public Health Association. November; 96(11): 1903–1905.10.2105/AJPH.2006.099606

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin and Y. S. Lincoln (Eds.). Handbook of qualitative research (pp. 105-117). London: Sage

Gubrium, J. F., & Holstein, J. A. (2008). The constructionist mosaic. I: J. F. Gubrium and J. A. Holstein (Eds.). *Handbook of constructionist research* (pp. 3-10). New York: Guilford Press.

Hahn, C. L. (2020). Human rights teaching: Snapshots from four countries. *Human Rights Education Review, 3*(1), 8-30. https://doi.org/10.7577/hrer.3724

Hall, P. (2010). Health and human rights education: time to act. *Lancet, 375*, 894. https://doi.org/10.1016/S0140-6736(10)60388-1

Halvorsen, K., Eide, H. K., Sortland, K., & Almendingen, K. (2016). Documentation and communication of nutritional care for elderly hospitalized patients: perspectives of nurses and undergraduate nurses in hospitals and nursing homes. *BMC nursing, 15*(1), 1-10. https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-016-0193-z

Hammar, L. M., Swall, A., & Meranius, M. S. (2016). Ethical aspects of caregivers' experience with persons with dementia at mealtimes. *Nursing ethics, 23*(6), 624-635. https://doi.org/10.1177/0969733015580812

Hanssen, I., & Kuven, B. M. (2016). Moments of joy and delight: the meaning of traditional food in dementia care. *Journal of Clinical Nursing, 25*(5-6), 866-874. https://doi.org/10.1111/jocn.13163

Hatlevik, I. K. R. (2012). The theory-practice relationship: reflective skills and theoretical knowledge as key factors in bridging the gap between theory and practice in initial nursing education. *Journal of Advanced Nursing, 68*(4), 868-877. https://doi.org/10.1111/j.1365-2648.2011.05789.x

Henderson, V. (1964). The nature of nursing. *The American journal of nursing*, Vol 64 (8)62-68. https://doi.org/10.2307/3419278

Herrington, J., McKenney, S., Reeves, T., & Oliver, R. (2007). *Design-based research and doctoral students: Guidelines for preparing a dissertation proposal.* University of Wollongong Research Online.Retrieved from: https://ro.uow.edu.au/cgi/viewcontent.cgi?referer=https://www.google.no/&httpsredir=1&article=1942&context=edupapers

Hixon, A. L., Yamada, S., Farmer, P. E., & Maskarinec, G. G. (2013). Social justice: The heart of medical education. *Social Medicine, 7*(3), 161-168. https://www.socialmedicine.info/index.php/socialmedicine/article/view/671/1380

HOD. (2017). *Nasjonal handlingsplan for bedre kosthold (2017–2021). Sunt kosthold, måltidsglede og god helse for alle! Norwegian National Action Plan for a Healthier Diet.* Retrieved from: https://www.regjeringen.no/no/dokumenter/nasjonal-handlingsplan-for-bedre-kosthold-20172021/id2541870/

HOD. (2019). *Meld. St. 19 (2018 –2019). Folkehelsemeldinga. Gode liv i eit trygt samfunn. A Good Life in a Safe Society.* Retrieved from: https://www.regjeringen.no/no/dokumenter/meld.-st.-19-20182019/id2639770

HOD. (2020). Oppfølging av ernæring hos beboere på sykehjem. Retrieved from: https://www.helsedirektoratet.no/statistikk/kvalitetsindikatorer/kommunale-helse-og-omsorgstjenester/oppf%C3%B8lging-av-ern%C3%A6ring-hos-beboere-p%C3%A5-sykehjem

HOD. (2021). *God og riktig mat hele livet. National strategy for good diet and nutrition for the elderly in nursing homes and who receive home care services.* Ministry of Healt and Care Service. Retrieved from: https://www.regjeringen.no/no/dokumenter/god-og-riktig-mat-hele-livet/id2849251/

Holmberg, C., Klingberg, S., & Brembeck, P. (2021). The food diary as a pedagogical strategy in undergraduate nursing nutrition education: A student evaluation. *Nurse education today, 98*, 104737. https://doi.org/10.1016/j.nedt.2020.104737

Hopia, H., & Lottes, I. (2018). Human rights education for nurses: An example from Finland. *Journal of Nursing Education and Practice. 8(3), 116-125.* https://doi.org/10.5430/jnep.v8n3p116

Huisman-de Waal, G., Feo, R., Vermeulen, H., & Heinen, M. (2018). Students' perspectives on basic nursing care education. *Journal of Clinical Nursing, 27*(11-12), 2450-2459. https://doi.org/10.1111/jocn.14278

Hummelvoll, J. K. (2008). The multistage focus group interview: A relevant and fruitful method in action research based on a co-operative inquiry perspective. *Norsk tidsskrift for sykepleieforskning.* 10(1), p. 3-14, https://brage.inn.no/inn-xmlui/handle/11250/134226

Hunt, P. (2008). The health and human rights movement: Progress and obstacles. *Journal of law and medicine, 15*(5), 714-724.

ICN. (2011). Nurses and human rights. Position Statement. Adopted in 1988. Retrieved from: https://www.icn.ch/nursing-policy/position-statements

ICN. (2012). The international code of ethics for nurses. Retrieved from https://www.icn.ch/nursing-policy/position-statements

IDLWG (2008). Dual loyalty& human rights in health professional practice, proposed guidelines & institutional mechanisms. I: F. Allhoff (Eds.). *Physicians at War. The Dual-Loyalties Challenge*. Dordrecht: Springer. https://doi.org/10.1007/978-1-4020-6912-3

Ife, J. (2012). *Human rights and social work: Towards rights-based practice*. (3rd edition) Cambridge University Press.

Iheanacho, P. N., Mbadugha, C. J., Anetekhai, C. J., Ubah, C. I., Obiekwu, A. L., & Chukwujama, N. A. (2021). Human rights of people with mental illness: determining knowledge and attitude of nursing students in Enugu state Nigeria. *International Journal of Human Rights in Healthcare*. https://www.emerald.com/insight/content/doi/10.1108/IJHRH-11-2020-0101/full/html

Ivanov, L. L., & Oden, T. L. (2013). Public health nursing, ethics and human rights. *Public health nursing, 30*(3), 231-238. https://doi.org/10.1111/phn.12022

Jovic Vranes, A., Mikanovic, V. B., Vukovic, D., Djikanovic, B., & Babic, M. (2015). Education on human rights and healthcare: evidence from Serbia. *Health promotion international, 30*(1), 101-105. https://doi.org/10.1093/heapro/dau093

Kaplan, D. M. (2012). Introduction: The Philosophy of Food. I: D. M. Kaplan (Eds.). *The philosophy of food* (pp.1-32). University of California Press.

Karlsen, E. I., Stray Aurdal, K., Terragni, L., Barth Eide, W., & Iversen, P. O. (2013). A Human Rights-Based Approach to Challenges and Opportunities in the Process of Fulfilling Nursing Home Residents' Right to Adequate Food. *Nordic J. Hum. Rts.,* 31(3), 401-426. https://doi.org/10.18261/ISSN1891-814X-2013-03-08

KD. (2008) Rammeplan for sykepleieutdanning. Retrieved from: https://www.regjeringen.no/globalassets/upload/kd/vedlegg/uh/rammeplaner/helse/rammeplan_sykepleierutdanning_08.pdf

Keller, A. S., Horn, S. K., Sopheap, S., & Otterman, G. (1995). Human rights education for Cambodian health professionals. *Health and human rights*, 256-271. https://www.jstor.org/stable/4065138?seq=1#metadata_info_tab_contents

Kent, G. (2005). *Freedom from want: The human right to adequate food*. Washington, D. C: Georgetown University Press.

Kerstetter, K. (2012). Insider, outsider, or somewhere between: The impact of researchers' identities on the community-based research process. *Journal of rural social sciences, 27*(2), 7. https://egrove.olemiss.edu/jrss/vol27/iss2/7/l

Kirkevold, M., Brodtkorb, K., and Ranhoff, A. H (2020). *Geriatrisk sykepleie: god omsorg til den gamle pasienten*. (3rd edition). Gyldendal.

Kitson, A., Conroy, T., Kuluski, K., Locock, L., & Lyons, R. (2013). Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs. Adelaide: School of Nursing.

Kitzinger, J. (1995). Qualitative research: introducing focus groups. *Bmj, 311*(7000), 299-302. https://doi.org/10.1136/bmj.311.7000.299

Klug, F. (2000). *Values for a godless age: the history of the Human Rights Act and its political and legal consequences.* London: Penguin

Koivisto, J.-M., Hannula, L., Bøje, R. B., Prescott, S., Bland, A., Rekola, L., & Haho, P. (2018). Design-based research in designing the model for educating simulation facilitators. *Nurse education in practice, 29*, 206-211. https://doi.org/10.1016/j.nepr.2018.02.002

Kourkouta, L., & Papathanasiou, I. V. (2014). Communication in nursing practice. *Materia socio-medica, 26*(1), 65. https://doi.org/10.5455/msm.2014.26.65-67

Kris-Etherton, P. M., Akabas, S. R., Bales, C. W., Bistrian, B., Braun, L., Edwards, M. S., . . . Palmer, C. A. (2014). The need to advance nutrition education in the training of health care professionals and recommended research to evaluate implementation and effectiveness. *The American journal of clinical nutrition, 99*(5), 1153S-1166S. https://doi.org/10.3945/ajcn.113.073502

Kris-Etherton, P. M., Akabas, S. R., Douglas, P., Kohlmeier, M., Laur, C., Lenders, C. M., . . . Pratt, C. A. (2015). Nutrition competencies in health professionals' education and training: a new paradigm. *Advances in Nutrition, 6*(1), 83-87. https://doi.org/10.3945/an.114.006734

Krueger, R. A., & Casey, M. A. (2001). Designing and conducting focus group interviews. I: A. Kruger, M.A. Casey, J. Donner, S. Kirch and J. N. Mack (Eds.) *Social Development Papers. Social Analysis. Selected Tools and Techniques* (pp. 4-23). Social Development Family of the World Bank.

Kvale, S. (1995). The social construction of validity. *Qualitative inquiry,* 1(1), 19-40. https://doi.org/10.1177/107780049500100103

L Berger, P., & Luckmann, T. (1966). *The social construction of reality.* USA: Penguin Books.

Laing, B. B., & Crowley, J. (2021). Is undergraduate nursing education sufficient for patient's nutrition care in today's pandemics? Assessing the nutrition knowledge of nursing students: An integrative review. *Nurse education in practice, 54*, 103137. https://doi.org/10.1016/j.nepr.2021.103137

Lake, L. (2014). Children's rights education: An imperative for health professionals. *Curationis, 37*(2), 1-7. https://doi.org/10.4102/curationis.v37i2.1268

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge university press.

Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, P. C., & Graham, I. D. (2009). Use of communities of practice in business and health care sectors: a systematic review. *Implementation science, 4*(1), 27. https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-4-27

Lilleskare Lunde, A. (2021). Stadig flere eldre på sykehjem får i seg for lite næring: – Når maten er dårlig over lengre tid, venner du deg til å spise lite. *Aftenposten*. Retrieved from: https://www.aftenposten.no/oslo/i/bGLQVq/stadig-flere-eldre-paa-sykehjem-faar-i-seg-for-lite-naering-naar-maten

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New directions for program evaluation, 1986*(30), 73-84. https://doi.org/10.1002/ev.1427

Livne, N. (2018). Need for Nutrition Education in Health Professional Programs: A Review of the Literature. *Internet Journal of Allied Health Sciences and Practice, 17*(1), 5. https://nsuworks.nova.edu/ijahsp/vol17/iss1/5/

London, L. (2008). What is a human-rights based approach to health and does it matter? *Health and human rights*, 65-80. https://www.hhrjournal.org/2013/09/what-is-a-human-rights-based-approach-to-health-and-does-it-matter/

London, L., & Baldwin-Ragaven, L. (2008). Human rights and health: challenges for training nurses in South Africa. *Curationis, 31*(1), 5-18. https://doi.org/10.4102/curationis.v31i1.898

Malmedal, W., Hammervold, R., & Saveman, B.-I. (2014). The dark side of Norwegian nursing homes: factors influencing inadequate care. *The Journal of Adult Protection, 16*(3), 133-151. https://doi.org/10.1108/JAP-02-2013-0004

Malterud, K. (2017). *Kvalitative forskningsmetoder for medisin og helsefag*. (4th edition). Oslo: Universitetsforlaget.

Mann, J. M., Gostin, L., Gruskin, S., Brennan, T., Lazzarini, Z., & Fineberg, H. V. (1994). Health and human rights. *Health & Hum. Rts., 1*, 6. https://www.hhrjournal.org/archives/volume-1-issue-1/

Manninen, K., Henriksson, E. W., Scheja, M., & Silén, C. (2014). Patients' approaches to students' learning at a clinical education ward-an ethnographic study. *BMC medical education, 14*(1), 131. https://bmcmededuc.biomedcentral.com/articles/10.1186/1472-6920-14-131

Marks, S. P. (2002). The evolving field of health and human rights: issues and methods. *Journal of Law, Medicine & Ethics, 30*(4), 739-754. https://doi.org/10.1111/j.1748-720X.2002.tb00440.x

Martínez Sainz, G. (2017). Building Professional Agency in Human Rights Education: Translating Policy Into Practice. *International Journal of Human Rights Education, 1*(1), 12. https://repository.usfca.edu/ijhre/vol2/iss1/14/

Martinsen, K. (2000). Øyet og kallet. (4th edition). Fagbokforlaget.

Mayers, P. (2007). Introducing human rights and health into a nursing curriculum. *Curationis, 30*(4), 53-60. https://doi.org/10.4102/curationis.v30i4.1117

McGaughey, F., Hartley, L., Banki, S., Duffill, P., Stubbs, M., Orchard, P., . . . Kerdo, P. P. (2019). 'Finally an academic approach that prepares you for the real world': simulations for human rights skills development in higher education. *Human Rights Education Review*. https://doi.org/10.7577/hrer.3093

McHale, J., & Gallagher, A. (2004). *Nursing and human rights*. Butterworth-Heinemann. Elsevier Limited.

McKenney, S., & Reeves, T. C. (2018). *Conducting educational design research*. New York: Routledge.

McKenney, S., & Reeves, T. C. (2020). Educational design research: Portraying, conducting, and enhancing productive scholarship. *Medical Education*. https://doi.org/10.1111/medu.14280

McKenzie, K. C., Mishori, R., & Ferdowsian, H. (2020). Twelve tips for incorporating the study of human rights into medical education. *Medical teacher, 42*(8), 871-879. https://doi.org/10.1080/0142159X.2019.1623384

McMillan, L. R., & Raines, K. (2010). Headed in the "write" direction: Nursing student publication and health promotion in the community. *Journal of Nursing Education, 49*(7), 418-421. https://www.proquest.com/docview/598372737

Mercer, J. (2007). The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas. *Oxford review of education, 33*(1), 1-17. https://doi.org/10.1080/03054980601094651

Merton, R. K. (1972). Insiders and outsiders: A chapter in the sociology of knowledge. *American journal of sociology, 78*(1), 9-47. https://doi.org/10.1086/225294

Merry, S. E. (2006). *Human rights and gender violence: Translating international law into local justice*. The University of Chicago Press.

MFA (1999). *Menneskeverd i sentrum - Handlingsplan for menneskerettigheter.* Ministry of Foreign Affairs. Retrieved from: https://www.regjeringen.no/no/dokumenter/stmeld-nr-21-1999-2000-/id192704/?ch=1

Miller, L. C., Russell, C. L., Cheng, A.-L., & Skarbek, A. J. (2015). Evaluating undergraduate nursing students' self-efficacy and competence in writing: Effects of a writing intensive intervention. *Nurse education in practice, 15*(3), 174-180. https://doi.org/10.1016/j.nepr.2014.12.002

Mitchell, H., Lucas, C., Charlton, K., & McMahon, A. (2018). Models of nutrition-focused continuing education programs for nurses: a systematic review of the evidence. *Australian Journal of Primary Health, 24*(2), 101-108. https://doi.org/10.1071/PY17088

Mitchell, K. M. (2018). Constructing writing practices in nursing. *Journal of Nursing Education, 57*(7), 399-407. https://doi.org/10.3928/01484834-20180618-04

Molander, A. & Terum, L. I. (2008). Profesjonsstudier: en introduksjon. I: A. Molander og L. I. Terum (Eds.). *Profesjonsstudier* (pp. 13-27). Oslo: Universitetsforlaget.

Molander, A. (2016). *Discretion in the welfare state. Social rights and professional judgment*. Routledge.

Molander, A., Grimen, H., & Eriksen, E. O. (2012). Professional discretion and accountability in the welfare state. *Journal of Applied Philosophy, 29*(3), 214-230. https://doi.org/10.1111/j.1468-5930.2012.00564.x

Molesworth, M. (2017). Nursing students' first placement: Peripherality and marginality within the Community of practice. *Journal of Nursing Education, 56*(1), 31-38. https://doi.org/10.3928/01484834-20161219-07

Morgan, D. L. (1996). *Focus groups as qualitative research* (Vol. 16): Sage publications.

Morley, D. (2016). Applying Wenger's communities of practice theory to placement learning. *Nurse education today, 39*(April), 161-162. https://doi.org/10.1016/j.nedt.2016.02.007

Mpinga, E. K., Verloo, H., London, L., & Chastonay, P. (2011). Health and human rights in scientific literature: A systematic review over a decade (1999-2008). *Health and human rights, 13*(2), 102-129. https://www.hhrjournal.org/2013/08/health-and-human-rights-in-scientific-literature-a-systematic-review-over-a-decade-1999-2008/

Newham, R., Hewison, A., Graves, J., & Boyal, A. (2021). Human rights education in patient care: A literature review and critical discussion. *Nursing ethics, 28*(2), 190-209. https://doi.org/10.1177/0969733020921512

Nightingale, F. (1861). Notes on nursing. London: Harrison, 59, Pall Mall.

NIM. (2018). *Stakeholder report from the Norwegian National Human Rights Institution in relation to the UPR 3rd cycle review of Norway in 2019*. Retrieved from: https://www.nhri.no/en/2019/universal-periodic-review-upr-of-norway-may-2019/

NIM. (2019) *Temarapport 2019 – Eldres menneskerettigheter: syv utfordringer*. Retrieved from https://www.nhri.no/2019/temarapport-2019-eldres-menneskerettigheter-syv-utfordringer/

NIM. (2021). *Menneskerettighetene i Norge 2019*. Retrieved from: https://www.nhri.no/arsmelding/arsmelding2019/

NSF. (2019) Yrkesetiske retningslinjer for sykepleiere. Retrieved from: https://www.nsf.no/etikk-0/yrkesetiske-retningslinjer

Okenwa-Emegwa, L., & Eriksson, H. (2020). Lessons learned from teaching nursing students about equality, equity, human rights, and forced migration through roleplay in an inclusive classroom. *Sustainability, 12*(17), 7008. https://doi.org/10.3390/su12177008

Orem. (2001). *Nursing: Concepts of practice.* (6th edition). St. Louis*: Mosby*

Orend, B. (2002). *Human rights: Concept and context*. Broadview Press.

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

Osler, A. (2016). *Human rights and schooling: An ethical framework for teaching for social justice*. J. Banks (Eds.). Teachers College Press.

Parsons, T. (1969). Research with Human Subjects and the" Professional Complex". *Daedalus*, 98(2), 325-360.

Peel, M. (2005). Human rights and medical ethics. *Journal of the Royal Society of Medicine, 98*(4), 171-173. https://doi.org/10.1177/014107680509800412

Perry, M. J. (2000). *The idea of human rights: Four inquiries*. Oxford University Press, USA.

Peters, M. (2000). Does constructivist epistemology have a place in nurse education? *Journal of Nursing Education, 39*(4), 166-172. https://doi.org/10.3928/0148-4834-20000401-07

Pfendt, K. (2018). Minding the Gap Regarding Human Rights Education—a Renewed Call to Integrate Human Rights Education into All Levels of Professional Nursing Programs in the US. *J Nurs Patient Care. 3 (1)*, 1-3. https://www//doi.org/10.4172/2573-4571.1000e104

Phelan, A. (2015). Protecting care home residents from mistreatment and abuse: on the need for policy. *Risk management and healthcare policy,* 2015, 215–223. https://doi.org/10.2147/RMHP.S70191

Polit, D., & Beck, C. (2012). *Nursing research. Generating and assessing evidence for nursing practice*. (9th edition). Philadelphia: Lippincott, Williams & Wilkins.

Pollard, C., Ellis, L., Stringer, E., & Cockayne, D. (2007). Clinical education: A review of the literature. *Nurse education in practice, 7*(5), 315-322. https://doi.org/10.1016/j.nepr.2006.10.001

Prasad, M. N., & Theodore, D. D. (2016). Knowledge of nursing students regarding human rights of mentally ill. *Asian Journal of Nursing Education and Research, 6*(2). https://www//doi.org/151-155. 10.5958/2349-2996.2016.00028.8

Praschan, N., Mishori, R., & Stukel, N. (2016). A student-run asylum clinic to promote human rights education and the assessment and care of asylum seekers. *Journal of Student-Run Clinics, 2*(2). https://journalsrc.org/index.php/jsrc/article/view/18

Premkumar, A., Barker, A., DeLoureiro, A., Sarathy, L., & Dworkis, D. A. (2013). A call from below: Why deeper education in health and human rights is crucial for medical students. *Journal of Health and Human Rights*. https://www.hhrjournal.org/2013/04/a-call-from-below-why-deeper-education-in-health-and-human-rights-is-crucial-for-medical-students/

Raustøl, A. (2010). *Impartiality and partiality in nursing ethics.* The University of Reading. Doctoral Thesis.

Reyes, H., Padilla Zuniga, K., Billings, D. L., & Blandon, M. M. (2013). Incorporating human rights into reproductive health care provider education programs in Nicaragua and El Salvador. *Revista Panamericana de Salud Pública, 34*, 54-59. https://iris.paho.org/handle/10665.2/9153

Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing, 53*(3), 304-310. https://doi.org/10.1111/j.1365-2648.2006.03727.x

Rosales, C. B., Coe, K., Ortiz, S., Gámez, G., & Stroupe, N. (2012). On Academics; Social Justice, Health, and Human Rights Education: Challenges and Opportunities in Schools of Public Health. *Public Health Reports, 127*(1), 126-130. https://doi.org/10.1177/003335491212700117

Rubenstein, L. S., & Amon, J. J. (2019). Global health, human rights, and the law. *The Lancet, 394*(10213), 1987-1988. https://doi.org/10.1016/S0140-6736(19)32468-7

Rugås, L., & Martinsen, K. (2003). Underernæring er vanlig på sykehjem. *Tidsskriftet Sykepleien, 6*(109), 34-37. Retrieved from: https://sykepleien.no/forskning/2009/03/underernaering-er-vanlig-pa-sykehjem

Sacks, G. S. (2017). The shrinking of formalized nutrition education in health professions curricula and postgraduate training. *Journal of Parenteral and Enteral Nutrition, 41*(2), 217-225. https://doi.org/10.1177/0148607116685049

Saldaña, J. (2014). Coding and analysis strategies. I: P. Leavy (Eds). *The Oxford handbook of qualitative research* (*pp. 581–685).* Oxford: Oxford University Press.

Scammell, J. (2017). Food for thought: delivering effective nutritional care. *British Journal of Nursing, 26*(5). https://doi.org/10.12968/bjon.2017.26.5.300

Schonholz, S. M., Edens, M. C., Epié, A. Y., Kligler, S. K., Baranowski, K. A., & Singer, E. K. (2020). Medical Student Involvement in a Human Rights Program: Impact on Student Development and Career Vision. *Annals of global health, 86*(1), 130-139. http://doi.org/10.5334/aogh.2940

Schou, P. (2021). Det skal lukte fårikål på sykehjemmet! *Aftenposten*. Retrieved from: https://www.aftenposten.no/meninger/debatt/i/1OV97J/det-skal-lukte-faarikaal-paa-sykehjemmet

Shea, A., Brophy, L., Nininger, J., Abbott, M., & Wilson, L. (2021). Nutrition Integration Across the Nursing Curriculum: A Novel Teaching Model within a Pre-Licensure Program. *Journal of Professional Nursing*. 37(6), 1162-1166. https://doi.org/10.1016/j.profnurs.2021.10.006

Smith, R., & Smith, L. (2018). Qualitative methods. I: L. McConnel and R. Smith (Eds.) *Research methods in human rights* (pp. 70-93). New York: Routledge.

Smith, R. (2018). Human rights based approach to research. I: L McConnell and R. Smith (Eds.). Research methods in human rights (pp. 6-23): Routledge.

SMR (2014). *Menneskerettigheter i norske sykehjem*. Temarapport fra Norsk senter for menneskerettigheter. Oslo: UiO Juridisk fakultet.

Sodjinou, R., Bosu, W. K., Fanou, N., Déart, L., Kupka, R., Tchibindat, F., & Baker, S. (2014). Nutrition training in medical and other health professional schools in West Africa: the need to improve current approaches and enhance training effectiveness. *Global health action, 7*(1), 24827. https://doi.org/10.3402/gha.v7.24827

Sonis, J., Gorenflo, D. W., Jha, P., & Williams, C. (1996). Teaching of human rights in US medical schools. *JAMA, 276*(20), 1676-1678. https://jamanetwork.com/journals/jama/article-abstract/411065

SSB. (2018). *Menneskerettighetssituasjonen til beboere i sykehjem. Operasjonalisering og tallfesting ved hjelp av SSBs statistikk over kommunale omsorgstjenester*. Statistisk Sentrabyrå. Otnes, B. Retrieved from: https://www.ssb.no/helse/artikler-og-publikasjoner/menneskerettighetssituasjonen-til-beboere-i-sykehjem

Stewart, D. W., & Shamdasani, P. N. (2014). *Focus groups: Theory and practice* (3rd edition). Sage Publications.

Struthers, A. E. (2015). Human rights education: Educating about, through and for human rights. *The International Journal of Human Rights, 19*(1), 53-73. https://doi.org/10.1080/13642987.2014.986652

Suárez, D. (2006). Education professionals and the construction of human rights education. *Comparative Education Review, 51*(1), 48-70. https://www.journals.uchicago.edu/doi/10.1086/508638

Suchman, L. (1993). Working relations of technology production and use. *Computer supported cooperative work, 2*(1), 21-39. https://link.springer.com/article/10.1007/BF00749282

Sullivan, W. M. (1995). *Work and integrity: The crisis and promise of professionalism in America*. New York: HarperBusiness..

Sydner, Y. M., & Fjellström, C. (2005). Food provision and the meal situation in elderly care–outcomes in different social contexts. *Journal of Human Nutrition and Dietetics, 18*(1), 45-52. https://doi.org/10.1111/j.1365-277X.2004.00577.x

Tarantola, D., & Gruskin, S. (2006). Health and human rights education in academic settings. *Health and human rights, 9*(2), 297-300. https://doi.org/4065412

Tarantola, D., Gruskin, S., Brown, T. M., & Fee, E. (2006). Jonathan Mann: founder of the health and human rights movement. *American Journal of Public Health, 96*(11), 1942-1943. https://ajph.aphapublications.org/doi/10.2105/AJPH.2006.098079

Thrysoe, L., Hounsgaard, L., Dohn, N. B., & Wagner, L. (2010). Participating in a community of practice as a prerequisite for becoming a nurse–Trajectories as final year nursing students. *Nurse Education in Practice, 10*(6), 361-366. https://doi.org/10.1016/j.nepr.2010.05.004

Tibbitts, F. (2005). Transformative learning and human rights education: Taking a closer look. *Intercultural Education.* 16(2), 107-113. https://doi.org/10.1080/14675980500133465

Tibbitts, F. (2017). Evolution of human rights education models. I: M. Bajaj (Eds.). *Human rights education: Theory, research, praxis* (pp. 69-95). USA: University og Pennsylvania Press.

Tibbitts, F., & Kirchschläger, P. G. (2010). Perspectives of research on human rights education. *Journal of human rights education, 2*(1), 8-29.

Tibbitts, F. L. (2018). Human rights education: the good surf and reclaiming human rights. *Netherlands Quarterly of Human Rights, 36*(1), 64-74. https://doi.org/10.1177/0924051917752419

Ulrich, G. (2017). Research ethics for human rights researchers. I: B. Andreassen, H. O. Sano and S. McInerney-Lankford. *Research Methods in Human Rights. A handbook* (pp. 192-221). Edward Elgar Publishing.

UN. (1948) Universal declaration of human rights. Retrieved from: https://www.un.org/en/about-us/universal-declaration-of-human-rights

UN. (1976). International Covenant on Economic, Social and Cultural Rights. Retrieved from: https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

UN. (1999). General Comment No. 12: The Right to Adequate Food (Art. 11) (1999). Retrieved from: https://www.ohchr.org/En/Issues/ESCR/Pages/food.aspx

UN. (2005). First phase (2005-2009) of the World Programme for Human Rights Education. Retrieved from: https://www.ohchr.org/EN/Issues/Education/Training/WPHRE/FirstPhase/Pages/Firstphaseindex.aspx

UN. (2010). Second phase (2010-2014) of the World Programme for Human Rights Education. Retrieved from: https://www.ohchr.org/EN/Issues/Education/Training/WPHRE/SecondPhase/Pages/Secondphaseindex.aspx

UN. (2011). United Nations Declaration on Human Rights Education and Training. Retrieved from: https://www.ohchr.org/en/issues/education/training/pages/undhreducationtraining.aspx

UN. (2014). Third phase (2015-2019) of the World Programme for Human Rights Education. Retrieved from: https://www.ohchr.org/en/issues/education/training/wphre/thirdphase/pages/thirdphaseindex.aspx

UN. (2019). Fourth phase (2020-2024) of the World Programme for Human Rights Education. Retrieved from: https://www.ohchr.org/EN/Issues/Education/Training/WPHRE/Fourthphase/Pages/FourthPhaseIndex.aspx

UN. (2020). *Concluding observations on the sixth periodic report of Norway:* Committee on Economic, Social and Cultural Rights. Geneva. Retrieved from https://digitallibrary.un.org/record/3865967

UN. (2021). Status of ratification. Retrieved from: https://indicators.ohchr.org/UN. (2021). Status of ratification. Retrieved from: https://indicators.ohchr.org/

UNSDG. (2003). *The human rights based approach to development cooperation towards a common understanding among UN agencies.* New York: United Nations. Retrieved from: https://unsdg.un.org/resources/human-rights-based-approach-development-cooperation-towards-common-understanding-among-un

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences, 15*(3), 398-405. https://doi.org/10.1111/nhs.12048

Valente, F. L., Suárez-Franco, A., & Córdova Montes, R. (2016). Closing protection gaps through a more comprehensive conceptual framework for the human right to adequate food and nutrition. I: A. C. Bellows, F. L.S. Valente, S. Lemke, M. D. N. Burbano de

Lara (Eds.). *Gender, nutrition, and the human right to adequate food: Toward an inclusive framework* (pp.341-408). Routledge.

Vanlaere, L., & Gastmans, C. (2007). Ethics in nursing education: learning to reflect on care practices. *Nursing ethics, 14*(6), 758-766. https://doi.org/10.1177/0969733007082116

Ventura, C. A. A., Mendes, I. A. C., De Godoy, S., Fumincelli, L., Souza, M. C., & Junior, V. D. S. (2019). Perceptions of brazilian nursing faculty members regarding literacy of human rights related to health in nursing undergraduate programs. *BMC international health and human rights,19*(1),1-7.https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/s12914-019-0213-7

Vesterdal, K. (2016). The roles of human rights education in Norway: A qualitative study of purposes and approaches in policy and in upper secondary schools. NTNU. Doctoral thesis. http://hdl.handle.net/11250/2390573

Vesterdal, K. (2019). Championing human rights close to home and far away: Human rights education in light of national identity construction and foreign policy in Norway. *Human Rights Education Review*, 01-19. https://doi.org/10.7577/hrer.2907

Watson, J. (2008). *Nursing: The philosophy and science of caring.* Boulder: University Press of Colorado.

Wenger, E. (1999). *Communities of practice: Learning, meaning, and identity*: Cambridge University Press.

Wenger, E. (2010). Communities of practice and social learning systems: the career of a concept. I: C. Blackmore (Eds.). *Social learning systems and communities of practice* (pp. 179-198). London: Springer.

Wenger, E. (2018). A social theory of learning. I: K. Illeris (Eds.). *Contemporary Theories of Learning* (2nd edition). New York, Routledge

Wenger, E., McDermott, R. A., & Snyder, W. (2002). *Cultivating communities of practice: A guide to managing knowledge*. Harvard Business Press.

Wenger, E. C., & Snyder, W. M. (2000). Communities of practice: The organizational frontier. *Harvard business review, 78*(1), 139-146. https://hbr.org/2000/01/communities-of-practice-the-organizational-frontier

Wesselborg, B., Hoenen, M., Adam-Paffrath, R., Kuske, S., Schendel, L., Grünewald, M., . . . Rotthoff, T. (2019). Interprofessional nutrition management–implementation and evaluation of a course for medical and nursing students using research-based learning method. *GMS journal for medical education, 36*(6). https://doi.org/10.3205/zma001276

Williams, C., & Hunt, P. (2019). Health rights are the bridge between law and health. *The Lancet, 393*(10183), 1782-1784. https://doi.org/10.1016/S0140-6736(19)30809-8

Yfanti, E., Tsiriga, S., Yfantis, A., Tiniakou, I., & Mastrapa, E. (2011). Nutrition knowledge in students of a Nursing School. *Health science journal, 5*(2), 118. https://www.hsj.gr/medicine/nutrition-knowledge-in-students-of-a-nursing-school.php?aid=3421

Yildiz, I., Yildiz, F. T., Yimaz, E. A., & Dogan, S. A. (2018). Attitudes of Nursing Students towards Children's Rights: A Sample from Turkey. *International Journal of Caring Sciences, 11*(2), 1059. https://doi.org/10.33457/ijhsrp.949874

Yuste, S., Zarandona, J., Arrue, M., & Gravina, L. (2021). Exploring the effect of two different teaching strategies on first-year nursing students' understanding of nutritional concepts: A mixed-method approach. *Nurse education in practice, 56*, 103193. https://doi.org/10.1016/j.nepr.2021.103193

Ziegler, J., Golay, C., Mahon, C., & Way, S. A. (2011). The Definition of the Right to Food in International Law. I: J. Ziegler, C. Golay, C. Mahon and S. Way (Eds.).*The Fight for the Right to Food. Lessons Learned* (pp. 15-22). Springer. London: Palgrave Macmillan. https://doi.org/10.1057/9780230299337

Özdemir, M. H., Can, İ. Ö., Ergönen, A. T., Hilal, A., Önder, M., & Meral, D. (2009). Midwives and nurses awareness of patients' rights. *Midwifery, 25*(6), 756-765. https://doi.org/10.1016/j.midw.2008.01.010

Appendix

Paper I

Dogan EIK, Raustøl A, Terragni L. Student nurses' views of right to food of older adults in care homes. *Nursing Ethics.* 2020;27(3):754-66. https://doi.org/10.1177/0969733019884614

Paper II

Dogan EIK, Terragni L, Raustøl A. Student nurses' experience of learning about the right to food: Situated professional development within clinical placement. *Nurse Education Today*. 2021;98:104692. https://doi.org/10.1016/j.nedt.2020.104692

Paper III

Dogan EIK, Terragni L, Raustøl A. Human rights and nutritional care in nurse education: lessons learned. *Nursing Ethics*. Article first published online: February 7, 2022. https://doi.org/10.1177/09697330211057226

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