Master's Thesis in Health Science

ANALYSING GLOBAL HEALTH POLICY

The importance of having a transparent evidence base

Article I
Getting a grip of White paper 11 (2011-2012) 'Global health in foreign and development policy': The need for a transparent and evidence-based policy?

Article II
A non-academic, evidence-based policy: Insights from actors behind White paper 11 (2011-2012) 'Global health in foreign and development policy'

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Trondheim, May 2015

“Action without vision is only passing time, vision without action is merely day dreaming, but vision with action can change the world”

Nelson Mandela

ACKNOWLEDGEMENTS

The following master's thesis came about due to collaboration between UNICEF Norway and the Norwegian University of Science and Technology (NTNU). NTNU Bridge was one of the main facilitator to this new relationship. Therefore, I would like to give my acknowledgement to NTNU Bridge, and especially project leader Ida Johanne Ulseth, for indirectly giving me the chance to write this thesis. Also, I'm much obliged to UNICEF Norway and particularly my contact person, political advisor Kim Gabrielli. Thank you for the opportunity to work together with you. It has been exciting and very valuable. Moreover, I would like to give appreciation to my supervisor, Professor Geir Arild Espnes. I am grateful for your supervision and enthusiasm and for the opportunities you have given me throughout my master's thesis process. It has made my learning process more meaningful, profound and fun. I would also like to express deep gratitude to Postdoc Courtney McNamara, from the Department of Sociology and Political Science at NTNU, who provided me with some very appreciated feedback. Further, I would like to give my sincere acknowledgement to the employees at the Department of Social Work and Health Science (ISH), whom I have come to know through my two years as a master's student.

A very special thank you, to Margareth Sandvik Alfredsen, master's degree student in political science. I have loved our discussions over lunch and I have really appreciated working together with you. Also, I would like to give my gratitude to my fellow master's degree students at ISH, especially Ida Holm and Tonje Strugstad. Thank you for taking such good care of me. It made it much easier to be a Danish student in Norway.

Some of my deepest acknowledgements is reserved my family and friends in Denmark. Mom and dad, from the bottom of my heart – an enormous thank you for all your love, encouragement and support. I could not have completed this adventure without your help. For that I will always be truly grateful. To all of my friends, I also give a deep and heartfelt thank you. Particularly Stine Bang-Christensen, Daniel Lincoln Thygesen and their lovely daughter, Elina. Thank you for opening up your home, when I was visiting Copenhagen, and thank you for loving support through some tough times. Moreover a

sincere thank you, to Joo Lærke Yerst, who came and visit me on numerous occasions, and not to mention Mai Christensen, Stephanie Christiansen and Ginnie Maya Amor Filstrup. You have all given me love, strength and much needed support in stressful and hard times. Words cannot describe how happy I am to have you girls in my life.

Again, thank you to all of you.

Yours truly,
Eva
Trondheim, May 2015

“When it comes to global health, there is no ‘them’ only ‘us’”

Global Health Council

CONTENT

MAIN INTRODUCTION 9

The short story behind global health policy 10

White paper 11 (2011-2012) 'Global health in foreign and development policy' 12

Why this study is important 12

CLARIFICATION OF THE USE OF 'POLICY' AND 'WHITE PAPER' 13

Policy 13

White paper 14

How white paper and policy is understood in this master's thesis 14

REFERENCES 15

ARTICLE I 19

ABSTRACT IN DANISH 20

ABSTRACT 21

INTRODUCTION 21

The Millennium Development Goals 22

White paper 11 (2011-2012) 'Global health in foreign and development policy' 23

Research question 25

Search of literature 26

GLOBAL HEALTH POLICY 26

THEORETICAL FRAMEWORK 27

The health policy triangle 27

Evidence-based policy 28

Trust and transparency 31

EMPIRICAL FINDINGS 33

Women's and children's health – the impact of malnutrition 33

DISCUSSION 36

The Empirical findings compared with statements in White paper 11 36

Transparent and evidence-based global health policy – why is it important? 39

Limitations 40

CONCLUSION 40

REFERENCES 43

ARTICLE II 53

ABSTRACT IN DANISH 54

ABSTRACT 55

INTRODUCTION **55**

METHOD AND MATERIAL **59**

Participants *59*

Data collection *59*

Analysis procedure *61*

FINDINGS **62**

The process of White paper 11 *62*

White paper 11: a 'gismo' *64*

The knowledge base – a question about culture and trust *66*

DISCUSSION **68**

The making of a non-academic, transparent white paper *68*

Methodical issues *73*

Implications for future study *75*

CONCLUSION **76**

REFERENCES **77**

APPENDIX 83

APPENDIX A: KEYWORDS **85**

APPENDIX B: RESEARCH APPROVAL FROM NSD **87**

APPENDIX C: INFORMATION LETTER **89**

APPENDIX D: THE INTERVIEW GUIDE **91**

APPENDIX E: THE TRANSCRIPTION MANUAL **93**

APPENDIX F: PRIOR UNDERSTANDING **95**

APPENDIX G: EXAMPLE OF TRANSCRIPT – STEP TWO **97**

APPENDIX H: THE CODE MATRIX – STEP THREE **99**

APPENDIX I: EXAMPLE OF TRANSCRIPT – STEP THREE **101**

MAIN INTRODUCTION

Before this master's thesis commence, it's important first to clarify UNICEF Norway's role in the projects process. UNICEF Norway expressed a need for further research on issues associated with their areas of activity. They were not involved in the decision-making of the specific research questions asked in the present thesis' articles. UNICEF Norway only uttered, that they thought the questions were interesting.

This master's thesis consists of two articles and a main introduction. Both articles are written for *Global Policy Journal* and therefore follow this journal's guideline for submission. For instance, the journal allows 8000 words in research papers (Global Policy, 2015). The first article has 7.468 words, excluding abstract, and the second article has 7.779, excluding abstract.

The first article seeks to give insight to *global health policy* and *White paper 11 (2011-2012) 'Global health in foreign and development policy'*. The aim is to answer the research question:

> Do the empirical findings on malnutrition's impact on women's and children's health, match the proposed argumentation in White paper 11 (2011-2012) 'Global health in foreign and development policy'?

This encloses an overview of existing research data and a comparison of these with some selected statements in White paper 11. The intention is to give an illustration as to why a policy should be transparent and based on the best available evidence. It's important to point out, that the found empirical findings are research data from before and up to 2011. The reason for this is, that White paper 11 was presented in the beginning of 2012, which means that the evidence used in the policy was not evidence published after 2011.

The health policy triangle (Walt & Gilson, 1994), evidence-based policy, trust and transparency, will be presented as theoretical framework. The health policy triangle is a model that can explain the interrelationship between different elements in global health policy (Walt & Gilson, 1994). It's comprised of a centre – the *actors* – and three corners – the *context*, *content* and *process*. In article one, it's mainly the *content* of White paper 11, which will be analysed in accordance with evidence-based policymaking. Evidence-based policy is defined as "a set of rules and institutional arrangements designed to encourage transparent and balanced use of evidence in public policy making" (Cookson, 2005, p.119) and transparency refers to the belief, that when used in a policy, it can be a powerful tool in the development of trust and thereby beneficiating an implementation of it.

The purpose with article two is to explore how politicians and policymakers experience different aspects according to White paper 11. Specifically, the second article seeks to answer following research questions:

- What were some of the involved politicians and policymakers experiences of the process of making White paper 11 (2011-2012) 'Global health in foreign and development policy'?
- Which thoughts did some of the involved politicians and policymakers have about the way White paper 11 (2011-2012) 'Global health in foreign and development policy' is and should be used?
- How is the knowledge base within White paper 11 (2011-2012) 'Global health in foreign and development policy' used and how did it come about?

Therefore, the study is a qualitative study using semi-structured interviews as research method. The obtained data were analysed with a step-wise analysis approach. According to the health policy triangle, this article touches the *actors*, *process* and *context* in accordance with evidence-based policymaking.

It's important to point out, that there might occur some repetition of theoretical and empirical aspects in the thesis, due to the flow and logical presentation and answering of the different research questions.

The short story behind global health policy

The processes of globalisation have had a major impact upon policies and the process of making them (Brugha, Bruen & Tangcharoensathien, 2014). Following the founding of

United Nation (UN), international affairs were administered by an arranged set of multilateral institutions, with varying models of national representation and decision-making (Brugha et al., 2014; Muennig & Su, 2013).

International health policy was in the early decades primarily formed through the World Health Organization (WHO) (Buse, Drager, Fustukian & Lee, 2002). Throughout this period, recently become independent countries were finding their place in the emerging international order, with WHO providing an essential arena for them to affect the making of international health policy (Brown, Cueto & Fee, 2006). But from the late 1980s, especially the World Bank, stepped into a vacuum formed by the WHO, whom according to several authors, was becoming unproductive and resource-limited (Abbasi, 1999; Brown et al., 2006; Godlee, 1994). The World Bank utilised their impact on national policymaking, by organising and distributing financial resources to control policy change in the social and health sectors (Brugha et al., 2014).

There has also occurred another transformation in the global health policy arena; the rise of development assistance for health (Brugha et al., 2014; Garrett, 2007). In the beginning of the twenty-first century, the Global Alliance for Vaccines and Immunization (GAVI) was established – mainly due to contribution from the Bill & Melinda Gates Foundation. Following GAVI came the founding of the Global Fund, which significance lies within a noteworthy proportion of its funding is channelled through non-governmental organisations (Brugha et al., 2014; Koivusalo & Ollila, 2014). One reason for the establishment of GAVI and the Global Fund was that many global health policy actors found, that traditional bilateral and multilateral donor agencies was too slow in succeeding global health goals (Brugha et al., 2014). In addition, the rise of GAVI and the Global Fund followed the context of an escalation in new global health partnerships, which created new forms of governance at global and country levels. These new partnerships came to have massive impact on how resources are and were mobilised and distributed, on the procedures for decision-making in policy, and on the implementation of health policies at country and global levels (Brugha et al., 2014).

Besides GAVI and the Global Fund, middle-income countries (e.g. Brazil and India) appeared as, and continue to be, influential global health actors. This is partially reasoned by the shifting geographies of power and by their economic and political motives, due to their emerging economies (Brugha et al., 2014). Although, Brugha et al. (2014) emphasis, that these countries only just started to contribute to financing global health programs, whereas before they were beneficiaries.

Lastly, Marmot (2005) stress, the importance of health status being a concern to policymakers in every sector and not only those involve in health policy. The reason for this, is that broad global inequalities have, among others, influenced a populations' health through the social determinants of health (the conditions in which people live and work, and that affect their opportunities to lead healthy lives), because they are increasingly determined by global commercial interest (Labonté & Schrecker, 2007; Marmot, 2005).

White paper 11 (2011-2012) 'Global health in foreign and development policy'

In early 2012 the Norwegian Government, then led by Jens Stoltenberg, published the first white paper on global health, presented by a Ministry of Foreign Affairs. Outlined through three priority areas, the policy presents the challenges and action areas for the Norwegian global health policy towards 2020 (Utenriksdepartementet, 2012). This encompassed: (1) Mobilising women's and children's rights and health, (2) Reducing the burden of disease with emphasis on prevention and (3) Promoting human security through health (Utenriksdepartementet, 2012).

The former Minister of Foreign Affairs Jonas Gahr Støre said on the launch of the white paper, that one of the policy's purposes was to be better at integrating health goals in foreign and development policies and strategies (Regjeringen, 2012). In addition, it's emphasised in the white paper, that a strong knowledge base and good profound analysis is a fundamental premise for making good decisions around innovation and risk-taking, and also for setting the right goals and criteria for gaining good results (Utenriksdepartementet, 2012).

Why this study is important

White paper 11 is nearly without references to its knowledge base. Numerous reasons argue towards why global health policies should be transparent and also based on the best available evidence:

1. Because there occurs a policy transfer between countries (Brugha et al., 2014), the used evidence should be present so the reader can evaluate and inspect the basis and content of the policy (Innvær, 2009; Oxman, Lavis, Lewin & Fretheim, 2009).
2. Health policies can have an impact on us all and should therefore be based on the best available evidence (Chalmers, 2003, 2005; Yamey & Feachem, 2011).
3. The policy can have a bigger impact because trust increases (Innvær, 2009) and thereby also the likelihood of accurate policy implementation (Naidoo & Wills, 2010).
4. Campaigning organisations can use a transparent policy for partisan purposes (O'Neill, 2006).
5. The reader should have the opportunity to hold the responsible institutions accountable for their policies and performance (Bellver & Kaufmann, 2005).

Knowledge on why policy should be evidence-based and transparent may provide a foundation and recommendation for future governmental policymaking. Hopefully, the present master's thesis can be a contribution in this context.

CLARIFICATION OF THE USE OF 'POLICY' AND 'WHITE PAPER'

The terminological use of policy and white paper will be clarified before the articles are presented. The reason for this is, that it's important to recognise that different actors use the word '*policy*' in different ways (Hill, 2009).

Policy

According to a number of authors, policy is an indistinct term used to describe an organisations locus, a decision to act on a given problem and/or an instruction that guides to the achievement of a concrete goal (Crinson, 2009; Hill, 2009; Howlett, Ramesh & Perl, 2009; Jann & Wegrich, 2007; Naidoo & Wills, 2010; Oliver, Lorenc & Innvær, 2014; Walt et al., 2008). Hill (2009) further state, that policy sometimes may be identified as one decision, but mostly it will either involve more decisions or rather an orientation. Nonetheless, Hill (2009) still believe, that policy as a term has an unclear definition, which he thinks can make the process of identifying occasions where policy is made, complicated and make it difficult handling policy as a precise phenomenon.

Yet, Crinson (2009) and Walt & Gilson (1994) argue, that policies are dynamic and therefore can change in the policymaking process, especially if a problem ensues during the implementation of a decision. Thus, policy can have many functions and degrees of influence depending on the context it takes place in (Crinson, 2009; Howlett et al., 2009; Naidoo & Wills, 2010).

White paper

In Norway, white papers are issues presented and drawn up by the Government to the Storting (Parliament), which they wish to orientate or have a deliberation on (Stortinget, 2014). Furthermore, a white paper is usually a report to the Storting on work carried out in a particular field and/or future policy. These documents and the following discussion in the Storting, normally form the basis of a draft resolution or bill at a later stage (Regjeringen, 2014).

How white paper and policy is understood in this master's thesis

Looking at the description of a policy and a white paper, one could claim that this two can be understood the same. Even though it is argued, that white papers come before an actual policy, it is also stressed that policies operate on multiple levels. Therefore, in this master's thesis, white paper will also be understood as a policy.

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ARTICLE I

ABSTRACT IN DANISH

Evidensbaseret policy er fundamental i forbedringen af global sundhed. Meld. St. 11 (2011-2012) 'Global helse i utenriks- og utviklingspolitikken' var den første melding til Stortinget, om global sundhed, præsenteret af et udenrigsministerium. Dog er referencebrugen manglefuld, hvilket betyder at meldingens evidensgrundlag ikke er transparent. En af meldingens topprioriteter er mobilisering af kvinder og børns rettigheder og sundhed. Ved at finde et forskningsgrundlag på kvinder og børns sundhed, særligt med fokus på fejlernærings indvirkning, og sammenligne dette med argumentationen brugt i Meld. St. 11, forsøger artikel at give en illustration på, hvorfor det er essentielt med en transparent evidensbaseret policy. Årsagen er, at når en policy er transparent med den benyttede evidens, så kan læseren vurdere evidensgrundlaget og argumentationen for de valgte prioriteringer. Transparens kan derfor bl.a. gøre, at tilliden til dokumentet og til den implicerede institution stiger. Derudover giver det også læseren mulighed for at holde aktørerne bag meldingen til ansvar for dens udfald, uanset om dette er et positivt eller negativt udfald.

Getting a grip of White paper 11 (2011-2012) 'Global health in foreign and development policy': The need for a transparent and evidence-based policy?

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ABSTRACT

Evidence-based policy is crucial in improvement of global health. White paper 11 (2011-2012) 'Global health in foreign and development policy' was the first white paper on global health, presented by a Ministry of Foreign Affairs. In the policy, the use of references to research evidence is lacking, which means its knowledge base isn't transparent. One of White paper 11's top priorities is mobilising for women's and children's rights and health. The article seeks to illustrate why it is importance to have transparency in a policy. This is tried achieved, by finding evidence, on women's and children's health with focus on the impact of malnutrition and comparing it with the argumentation stated in the white paper. Because, when a policy is transparent, the reader can judge its evidence base and priorities argumentation. Thereby can the trust in the policy and the actors responsible for its making, increase. Furthermore, can transparency give the reader opportunity to hold the actors accountable, whether the policy's outcome has been good or bad.

Keywords: Transparency, Evidence-based global health policy, White paper, Global health, Transparent policy

INTRODUCTION

Global health has become trendy. The reason why is because it rouses interest with a great deal of actors – including media, students and faculty (Beaglehole & Bonita, 2010; Koplan et al., 2009). Even more, global health drives the formation or rearrangement of numerous academic programs and governments support it as a necessary component of foreign affair policies (Koplan et al., 2009). The visibility incline has also led to an increased recognition of the worlds emerging health inequalities and to the poverty and disease burden in developing countries (Clark, 2014). According to Marmot (2005), broader global inequalities have been influenced by social determinants of health, because they are increasingly determined by global commercial interest. Thus Marmot (2005) stress the importance of health status being a concern to all policymakers, no matter sector. Luckily, Garrett (2007) state that there are more money directed toward pressing health challenges today, than ever before.

Global health as a term is commonly used. However, it diverges in, or sometimes has no definition (Koplan et al., 2009). If global health as a notion is without a founded definition, Koplan et al. (2009) argue, that there is a plausibility of different actors not finding agreement about what they are trying to achieve, which kind of resources they should use and in what ways they should use them. In addition Fidler (2009) believes, a common definition is especially important, because of current global crises, such as climate change, food, economic and energy crises, make global health efforts more challenging. Hence, Koplan et al. (2009, p.1995) offer following definition on global health,

> "…an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasises transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care."

Beaglehole & Bonita (2010, p.1) acknowledge and find Koplan & colleagues' definition on global health useful. However, they believe that it is "wordy and uninspiring". Based on Koplan & colleagues' definition, Beaglehole & Bonita (2010) instead propose, that "global health is collaborative trans-national research and action for promoting health for all" as a definition (2010, p.1).

While debates exist regarding a precise definition of global health, the stance adopted in this paper is that of Koplan et al. (2009).

The Millennium Development Goals

The Millennium Development Goals (MDGs) came about in 2000, and are possibly the most important politically pact ever made for international development (UN. General Assembly, 2000; Waage et al., 2010). According to Muennig & Su (2013), the United Nation (UN) set out to create a set of goals, that could be realistically achieve and that could bring global health and development forward. 189 countries endorsed the UN

Millennium Declaration – in which the MDGs are presented (UN. General Assembly, 2000). The MDGs represent an unprecedented global consensus about actions to increase development assistance and poverty eradication in developing countries (Baulch, 2006; Clemens, Kenny & Moss, 2007; Haines & Cassels, 2004; UN. General Assembly, 2000; Waage et al., 2010). Haines & Cassels (2004, p.394) specify that, the MDGs are "framed as a compact that recognises the contribution that developed countries can make through fair trade, development assistance, debt relief, access to essential medicines, and technology transfer".

The MDGs consist of eight goals; MDG 1 'Eradication of extreme poverty and hunger'; MDG 2 'Provision of universal primary education'; MDG 3 'Promotion of gender equality and empowerment of women'; MDG 4 'Reduction of child mortality'; MDG 5 'Reduction of maternal mortality'; MDG 6 'Combating of HIV/AIDS, malaria and other diseases'; MDG 7 'Ensuring of environmental sustainability'; and MDG 8 'Development of global partnership for development' (UN. General Assembly, 2000; Waage et al., 2010, p.994-995).

Health is a central aspect to the attainment of the MDGs. It is emphasised both in its own right (MDG 4,5 and 6) and as a contributor to other goals. But the establishment of the MDGs alone is not enough to successfully address the challenges in global health (Lavis, Wilson, Oxman, Lewin & Fretheim, 2009; Shiffman & Smith, 2007). According to Shiffman & Smith (2007) effective policies, technology and implementation systems, among others, are also essential.

White paper 11 (2011-2012) 'Global health in foreign and development policy'

In early 2012, the Norwegian Government, then led by Jens Stoltenberg, published the first ever white paper on global health, within foreign and development policy (Regjeringen, 2012). Through three priority areas, the paper outlined the challenges and action areas for the Norwegian global health policy towards 2020: (1) Mobilising women's and children's rights and health, (2) Reducing the burden of disease with emphasis on prevention and (3) Promoting human security through health (Utenriksdepartementet, 2012, p.8). This shows, that the MDGs are well founded in the white paper global health priorities.

Mobilising women's and children's rights and health was a top priority for the former Norwegian Government and it was their belief, that health is essential for development and poverty reduction (Utenriksdepartementet, 2012). It was also their intention to promote a policy of health for all. In addition, the white paper emphasis that global health initiatives also embrace regional and bilateral arenas and are far from being limited to the poorest countries. Therefore, the former Norwegian Government recognised the need for a flexible approach to global health challenges and the ability to see how different policy areas are interrelated (Utenriksdepartementet, 2012).

White paper 11 state, that the policy is based on knowledge and evidence. In the document it is argued, that it is a fundamental premise to have a strong knowledge base and good profound analysis for making good decisions around innovation and risk-taking, and furthermore for formulating the correct targets and criteria for gaining good results (Utenriksdepartementet, 2012). To substantiate the orientation on results, the importance of "systematic use of research-based knowledge to evaluate measures (for instance to determine which clinical programmes or measures are most effective and where incentives should be directed for greatest effect)" and routinely viewing the population's health and healthcare services, was also affirmed in the white paper (Utenriksdepartementet, 2012, p.39). White paper 11's proposal of the policy being based on solid evidence can be supported by Bogenschneider & Corbett (2010), whom based on an initiative posted by the Cabinet Office in 1999, committed that using evidence and research in policy, would enhance the possibility of delivering on long-term goals and therefore should play a critical role in policymaking.

Nonetheless, White paper 11, still, recognises that there are several challenges when trying to attain a solid knowledge base (Utenriksdepartementet, 2012). First, the knowledge, that can answer the questions political decision-makers are seeking, needs to be generated. Second, political decision-makers and institutions needs to use this generated knowledge. Thirdly, developing knowledge about new innovative solutions is more difficult than solutions, which are well established and tested. And lastly, not all actors base their arguments on research and evidence when solutions are being discussed (Utenriksdepartementet, 2012).

White papers often build on a Norwegian Official Report (NOU) (Stortinget, 2014). NOUs are government policy documents, that usually have the most references to research evidence (Innvær, 2009). Hence, the evidence used to substantiate a white paper's arguments is usually presented in a NOU. Such NOU was not found to confirm the statements in White paper 11. Looking through the policy, it seems to lack references to research data, substantiating its presented action areas. This does not necessarily mean their claims and action areas are wrong and not evidence-based (Chalmers, 2005), but it makes the white paper less transparent and harder for the reader to go back and find the evidential reports (Innvær, 2009). Further, when transparency is absence, the public and other interested actors are less able to evaluate the content and also less able to hold the institutions accountable for their policies and performance (Bellver & Kaufmann, 2005). And in addition Prior (2010, p.423) argue, that when reading documents "…it always serves us well to ask detailed questions about *how* any such data set has been put together and processed". Even more there's a possibility the reader will answer Locke, Silverman & Spirduso's (2010, p.5) question number 11 in their 'A Dozen Questions to Ask When Reading Research', "Did you find that the report was complete enough for you to form a judgment about each important aspect of the study?", with a no. One could also imagine a low score when using the Index of Scientific Quality (ISQ), which is a scale to evaluate the quality of the evidence used in a document (Oxman et al., 1993). However, it's important to emphasis, that a policy document is of course not a research paper or report and will not serve the function as such, but it is central and decisive for the reader's trust to the document, that it builds on the best available knowledge and shows where this knowledge stems from (Innvær, 2009).

Research question

The aims of this article are three-fold. The first aim is to give a glimpse of what global health policy in general is. The second aim is to present a theoretical framework, describing the health policy triangle, evidence-based policymaking within global health and what lies within a transparent policy. The third aim is to give an overview of existing empirical research, before and up to 2011, on women's and children's health with focus on the impact of malnutrition, and see if the findings match the proposed argumentation in white paper 11. The reason for this is to give an illustration as to why a white paper should be transparent in its knowledge base.

The specific research question this article wishes to investigate is:

- Do the empirical findings on malnutrition's impact on women's and children's health, match the proposed argumentation in White paper 11 (2011-2012) 'Global health in foreign and development policy'?

Search of literature

In order to procure an overview of empirical research on malnutrition's impact on women's and children's health, a search of literature was carried out. The literature was obtained from a number of databases and webpages including Google Scholar, ISI Web of Science, Bibsys ask, UNICEF and Stortinget.no. The main information sources were scientific articles and reports in English. Keywords used in the search are shown in Appendix A. Additionally, citations and list of reference of the found scientific articles, were utilised as stepping-stones in search of further literature.

GLOBAL HEALTH POLICY

Global health policy consists of goals, rules and actions, that address or have an impact on the priorities and health challenges transcending individual countries and regions (Brugha, Bruen & Tangcharoensathien, 2014). Furthermore, joint to most global health policy issues is the political nature of making a policy, where the recognition of actors' power, interests and ability to mobilise resources are central.

Underlying in global health policy are both policy content and policy process (Jenkins referred by Brugha et al., 2014, p.23). By this Jenkins (referred by Brugha et al., 2014, p.23) refer to the policy substance, encompassing rules and guidelines and to the purposeful, deliberated actions, methods and strategies affecting the nature and impact of development and implementation of policy. Compare to the health policy triangle – which will be more thoroughly addressed later in the article – policy *content* and *process* comprise two of the three corners in the triangle. The last corner is the *context* (Walt & Gilson, 1994). The health policy triangle also has a centre, where the *actors* are situated. The actors are, according to Brugha et al. (2014), a complex and dynamic set of individuals, groups and organisations formed of interrelated networks, formulating global health policy. Brugha et al. (2014) argue, that these participants have an major impact on the health of populations, because they are dominant to how priorities in policies are founded and how global health policies are created and implemented (Brugha et al., 2014; Buse, Drager, Fustukian & Lee, 2002). Kruk (2013) emphasis, that understanding policy process is a requirement for achieving global population health goals, and Brugha et al. (2014, p.23) stress, that understanding it is important "for tackling the social and economic determinants of health, where causes and actions go beyond country border."

THEORETICAL FRAMEWORK

According to Nutbeam, Harris & Wise (2010), a fully developed theory explains the major factors influencing the phenomenon of interest, it elaborates the relationship between these factors and also the conditions under which these relationships do or do not occur. As theoretical framework different perspective on evidence-based policy and on transparency and trust, will be clarified. The health policy triangle will, however, first be presented, because it can illustrate and explain the interrelationship between different elements in global health policy (Walt & Gilson, 1994), and because policy processes and factors prompting the policymaking are linked with the interests, influence and actions of policy actors or stakeholders (Brugha et al., 2014; Innvær, Vist, Trommald & Oxman, 2002; Oxman, Lavis, Lewin & Fretheim, 2009).

The health policy triangle

The health policy triangle is comprised of a centre and three corners, Figure 1 (Walt & Gilson, 1994). In the centre are the *actors* and their actions that affect the policy. The corners of the triangle consists of the *context,* wherein policy is developed; the *content* of policy; and the *process* of policy, which is contingent on developing and implementing change (Walt & Gilson, 1994). Actors are influenced by the context they live and work in. The context is affected by factors, e.g. instability or uncertainty, created by major events such as war. The actors and their values and expectations, affect the process of policy. Lastly, the content of policy reflects some or all of the above-mentioned elements. This means they all some how interrelate, even though, it might seem like they could be considered separately (Walt & Gilson, 1994). According to Walt & Gilson (1994), the health policy triangle's simplified framework makes one think systematically about how the complex factors and interrelationships, between the triangles corners and centre, influence policy.

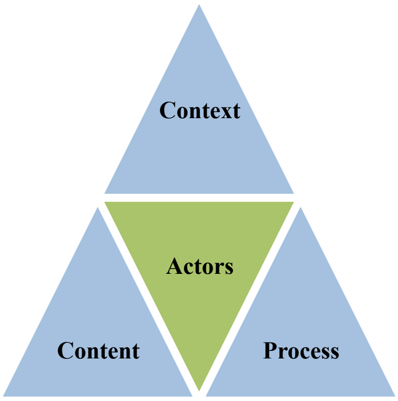

Figure 1: Health Policy Triangle

The health policy triangle can furthermore be used to move beyond a study of the content of policies, to the understanding of how political, historical and cultural contexts impact the course and possibility of policymaking (Brugha et al., 2014). The triangle is also flexible, because it can complement different theories of policymaking to help illuminate, which issues are chosen to get on the policy agenda and also how and why these are formulated and applied (Brugha et al., 2014).

Evidence-based policy

A definition presented by Cookson (2005, p.119) describes evidence-based policy as "a set of rules and institutional arrangements designed to encourage transparent and balanced use of evidence in public policy making." Further, Yamey & Volmik (2014, p.135) define evidence-based policymaking in global health as "the conscientious, explicit, and judicious use of evidence to guide and shape global health policies." Lemer, Cheung, Viner & Wolfe (2014) also state, that the cornerstone of evidence-based policy is ensuring accountability and promoting the conditions for securing improvements in health and well-being.

One could imagine, that it's difficult finding anyone arguing against policy being based on the best available evidence (Marston & Watts, 2003). Nevertheless, in accordance with Bogenschneider & Corbett (2010) will those who believe, that policy and research ought to go hand in hand and that good government should be grounded on solid evidence, face an unpleasant truth. Too often no such bond exists (Bogenschneider & Corbett, 2010). Innvær et al. (2002, p.239) also dispute, that "many researchers are sceptical about the extent to which research is used and many policy-makers are sceptical about the usefulness of research." However, it is still argued, that scientific evidence is an essential tool for improving global public health (Buekens, Keusch, Belizan & Bhutta, 2004; Chalmers, 2003, 2005; Yamey & Feachem, 2011). World Health Organization (2004) and Oxman et al. (2009) also emphasis, that science must help to improve health systems and health systems must collaborate with research to generate knowledge for own improvement.

Yamey & Volmik (2014) attribute two major forces to why global health policy should be evidence-based. The first force is the recognition of the 'know-do gap' – the gap between evidence and policy implementation – as a huge obstacle in the process to achieve the MDGs (Pablos-Mendez, Chunharas, Lansang, Shademani & Tugwell, 2005). The second is the increasing need to minimise uncoordinated and poor utilisation of limited global health resources (Yamey & Volmik, 2014). Some authors believe, that having an evidence-based policymaking approach can help to limit the 'know-do gap' and increase the possibility of ensuring, that resources are not unexploited on ineffective interventions (World Health Organization, 2004; Yamey & Feachem, 2011; Yamey & Volmik, 2014). However, it is still acknowledge, that evidence competes with other inputs such as politics, sociocultural factors and personal expertise (Flitcroft, Gillespie, Salkeld, Carter & Trevena, 2011; Lillefjell, Knudtsen, Wist & Ihlebæk, 2013; Marston & Watts, 2003; Nutbeam & Boxall, 2008; Oxman et al., 2009).

Health policies can have unintended effects by causing more harm than good. Therefore it's important to ensure, that proposed interventions are based on the best available evidence (Chalmers, 2003, 2005). This belief is supported by Yamey & Feachem (2011, p.97) who state, that "improving the flow of evidence between global health researchers and policymakers is an important tool for improving health outcomes". World Health Organization (2004) also accentuates the necessity for policymakers to use evidence to inform decisions. Nonetheless, Buekens et al. (2004, p.2639) argue, that "the effectiveness of many interventions to improve health in poor populations in the developing world remains untested and therefore unproven." In addition, most health research is conducted in developed countries, even though it's the developing countries that bear the biggest burden of disease (Richards, 2004). Richards (2004) believe this is a barrier to evidence-based policymaking in global health. It is also recognised as a problem by Miranda & Zaman (2010) who argue, that health research conducted in developed countries cannot simply be transferred to developing countries, because of the risk of exporting failure. A second barrier to evidence-based policymaking in global health is the absence of basic resources, including lack of funds and information centres in developing countries, which can hinder the distribution and communication of research findings (Petticrew, Whitehead, Macintyre, Graham & Egan, 2004). A third believed barrier is, that even when there is good research evidence available for policymakers, they don’t always use it (Bogenschneider & Corbett, 2010; Yamey & Volmik, 2014). But Oliver, Lorenc & Innvær (2014) believe this assumption is unfair towards the policymakers, who they believe have been shown to use a broad range of information, and also because it oversimplifies the relationship between evidence and policy. By contrary, a systematic review of studies performed by Orton, Lloyd-Williams, Taylor-Robinson, O'Flaherty & Capewell (2011), who examined the use of evidence by health policymakers, identified that policymakers had difficulties understanding and interpreting the presented research evidence, and also the competing influences on decision-making, such as politics, time and resources limitations, which might be plausible reasons as to why policymakers didn’t always use evidence. These identifications are supported by Bogenschneider & Corbett (2010) who dispute, that research and evaluations are often not timely or addressing emerging problems, because the ‘real-world’ changes faster than research can accommodate.

According to Nutbeam & Boxall (2008) and Petticrew et al. (2004), some commentators have argued, that researchers tend to take little account of the needs of policymakers and the reality of the process of making a policy. Even more, researchers have been criticised for their political naivety and for having improbable expectations about what research can accomplish in the policy process (Black, 2001; Oliver et al., 2014). On the other hand, researchers participating in the study by Whitehead et al. (2004) felt, that some policymakers had difficulties understanding research and further had rigid ideas about research methods, which as seen above, can be supported by the study of Orton et al. (2011). However, the researchers still acknowledged, they needed to communicate more understandably and learn to summarise and distribute their research in a more efficient way (Whitehead et al., 2004). Hence, it is proposed that an evidence-based policy could be promoted, if there was a closer engagement between researchers and policymakers at the earliest possible stage of proposals. Further, it's suggested that both should have periods of involvement in each others working fields (Black, 2001; Innvær et al., 2002; Oliver et al., 2014; Whitehead et al., 2004; Yamey & Feachem, 2011). In addition, Orton et al. (2011) also suggest, that it is more likely for policymakers to use evidence if there is a two-way communication and interaction between researchers and policymakers. Bogenschneider & Corbett (2010) agree on this assessment. In fact they believe, that insignificant communication, possibly, is the most discounted aspect affiliated with challenges in evidence-based policy-making. But it is Bogenschneider & Corbett (2010) opinion, that it is the researcher who ought to take the first step to engage in communication.

Trust and transparency

When we say we trust someone/something, or someone/something is trustworthy, it indirectly means, we think of employing in some form of collaboration with the party. On the other hand, when we say that someone/something is untrustworthy, we insinuate that the probability is lower for us to assign from doing so (Gambetta, 2000). Additionally, it also implicitly means, that "when one trusts, one accepts some amount of risk for potential harm in exchange for the benefits of cooperation" (Warren, 1999, p.1). This is also supported by Christensen & Lægreid (2005) who argue, that it is a part of democracy to have a healthy amount of distrust in powerful actors. But according to Hardin (1999), trusting institutions makes little sense for the majority of people most of the time. Citizens simply cannot know enough of what they need to, to be able to trust government. Nonetheless, since decisions are subject to public examination and outcomes directly affect many people, there is still an increasing wish for precise validation of these (Dobrow, Goel & Upshur, 2004; Ham, Hunter & Robinson, 1995; Innvær, 2009; O'Neill, 2006). And as Innvær (2009, Background) state, "A transparent and explicit approach is essential for reliable, valid and rational decision-making."

How scientific advice should be presented and used has concerned both policymakers and academics. One of the reasons is the increasing pressure to open up the process of scientific advise to broader inspection, due to the impact of technology in modern society (Mayer, 2003). Nevertheless, there is still no common agreement on a definition of transparency (Bellver & Kaufmann, 2005; Hood, 2006; Ostry, 2004), but according to Ostry (2004, p.94) it “includes accesses to information as well as the nature of participation in the policy-making process.“ Kaufmann & Kraay (2002), even more, argue that transparency not only should refer to the amount of information, but also to the scope, accuracy and timeline, which should be accessible to all relevant stakeholders. The Organisation for Economic Co-operation and Development (OECD) also emphasis the importance of two-way communication between governments and other interested parties, and/or lobbying groups, if transparency is to be achieved (Bellver & Kaufmann, 2005). Bellver & Kaufmann (2005) argue, that the purpose for requesting transparency is to give different actors and the public opportunity to hold the responsible institutions accountable for their policies and performance. Further they believe it’s crucial to have transparency in the policymaking process, because it allows different social groups to participate in the decision-making (Bellver & Kaufmann, 2005). Oxman et al. (2009) and Innvær (2009) also state, that the process of policymaking should be transparent in order to ensure, that the reader can examine what research evidence was used and to advise and validate policy decisions, as well as the judgements made about the evidence and its implications. Florini et al. (2000) support this notion by saying, that when citizens don’t have enough information, due to the lacking of transparency, they will have difficulties evaluating the quality and efficiency of the given services.

Transparency can be a powerful instrument to develop trust in institutions among society, and also to bring a more democratic policymaking process about (Bellver & Kaufmann, 2005; Mayer, 2003). Stasavage (2006, p.168) also state, that “transparency can have a beneficial effect of ‘disciplining’ representatives.” Pointed out by Birkinshaw (2006), it is, even more, a basic right to know and to be informed about what the government is doing and why. Innvær (2009, Conclusion) propose, that “instead of rejecting out of hand the possibility of writing understandable reports of high scientific quality, committees should focus on writing reports that are accessible to academics and non-academics alike.” However, it is important to emphasis, that this recommendation is targeted NOU, but it is believe to be adaptable to white papers also, as these often are formed on the basis of a NOU.

The Index of Scientific Quality – a question of transparency

A way to evaluate the quality of the scientific evidence used in a policy, is the Index of Scientific Quality (ISQ) (Oxman et al., 1993). The ISQ is grounded on general scientific principles, which is used in all research and which is based on meticulous methods, that aim to answer questions of effect (Innvær, 2009). The index has incorporated a five-point scale, where a score of 5 represents the highest level of scientific quality and 1 the lowest. Question B in the ISQ, "Documentation: Does the presented evidence rely on research, and are references given?", is especially associated with transparency (Innvær, 2009, table 2). According to the ISQ criteria, clear use of references to the evidence used in the report will score 5 or 4, while partly unclear or definitely unclear references to evidence scores 3 or 2 – depending on the degree of vagueness. When the references are possibly misleading, the ISQ score will wither be 2 or 1 (Innvær, 2009).

EMPIRICAL FINDINGS

The references to the evidence base are lacking in White paper 11. As an illustration to why policy should be transparent and based on solid evidence, this article tries to uncover evidence, that support some of the argumentation regarding women's and children's health in developing countries, with focus on the impact of malnutrition, used in the policy.

Women's and children's health – the impact of malnutrition

Renewed interest in strengthening child-health epidemiology, as a basis for enhanced efforts towards a reduction in mortality in children younger than 5, came about due to a boom in attention to evidence-based decision-making in public health and to the global commitment to the MDGs (Bryce, Boschi-Pinto, Shibuya & Black, 2005; Lopez, Mathers, Ezzati, Jamison & Murray, 2006).

The MDG 4 and 5 were about reduction of child and reduction of maternal mortality. Lozano et al. (2011) estimate, that there were 7.2 million deaths in children younger than 5 in 2011. An earlier article by Black et al. (2008) estimated, that in 2004 stunting, severe wasting and intrauterine growth restriction, together, were responsible for 2.2 million deaths in children younger than 5, equivalent with 22 per cent of the deaths and disease burden. In accordance with maternal mortality, a study by Hogan et al. (2010, p.1613) assessed, that there were around 342.900 maternal deaths worldwide in 2008, and “in a counterfactual scenario of a global HIV seroprevalence of zero, this number would be 281.500”.

Apposite care at the youngest age, forms the strongest basis for an individual’s future and for reduction of health inequities within a generation (Irwin, Siddiqi & Hertzman, 2007; Marmot, Friel, Bell, Houweling & Taylor, 2008). The reason for this is, that a mother’s nutrition status, prior and during pregnancy, affects a child’s future nutrition (UNICEF, 2009). Furthermore, children who are undernourished, not optimally breastfed or suffering from micronutrient deficiencies, will have significantly poorer chances of survival than children who are well nurtured.

The risk of serious infection and/or dying from common childhood illnesses – such as diarrhoea, measles, pneumonia and malaria – as well as HIV and AIDS, is also higher when nutrition isn’t ensured (Black et al., 2008). A study by Bryce et al. (2005) estimate that worldwide, 73 per cent of deaths in children younger than 5 are ascribed to six causes: pneumonia (19 per cent), diarrhoea (18 per cent), neonatal sepsis or pneumonia (10 per cent), preterm delivery (10 per cent), malaria (8 per cent) and asphyxia at birth (8 per cent). Furthermore, it is assessed that 53 per cent of deaths in children younger than 5 years-old, had undernutrition as underlying cause (Caulfield, de Onis, Blössner & Black, 2004). Later studies estimated, that more than one third of child deaths are due to maternal and child undernutrition (Bhutta et al., 2008; Black et al., 2008; Victora et al., 2008). This decline can be explained by different base years, with a modest reduction in child mortality and illness (Black et al., 2008). In addition, there is a risk that those children, who survive an insufficient nutrition starting point, become locked in a cycle of frequent illness and wavering development, with permanent damage to their growth and cognitive abilities (Bhutta et al., 2008; Black et al., 2008; Irwin et al., 2007; Victora et al., 2008).

According to Victora et al. (2008) and Marmot et al. (2008), chronic undernutrition in early childhood can have impact on adult life, where an adult may be less productive and even face a higher risk of diseases, compared with adults that were not undernourished as child. Irwin et al. (2007) estimate, that 219 million children worldwide are not achieving their full development potential. According to Grantham-

McGregor et al. (2007) and Jolly (2007), this is due to poverty, poor health, poor nutrition and underprovided care. So, for national development and public health, it is imperative to increase children's development and health (Grantham-McGregor et al., 2007; UNICEF, 2009).

In accordance to numbers from a UNICEF report, 16 per cent of infants in developing countries – equivalent with 19 million new-borns – weigh less than 2.500 grams at birth (UNICEF, 2009). Asia has the highest incidence of infants with a low birth weight – 18 per cent of all infants. This number can be even higher, because of the low proportion of new-borns who are weighed at birth in developing countries – which also indicates, that there is an absent of appropriate obstetric care (UNICEF, 2009). A cause related to low birth weight is maternal undernutrition. Maternal undernutrition is prevalent and evident as a serious problem in many regions. For instance, in Sub-Saharan Africa, South-Central and South-Eastern Asia, and in Yemen, more than 20 per cent of women have a body-mass index of less than 18.5 kg/m2. However, in India, Bangladesh and Eritrea, the prevalence is as much as around 40 per cent (Black et al., 2008).

Black et al. (2008) argue, that unless malnutrition is severe, maternal undernutrition has little effect on the volume or composition of breast milk. But according to UNICEF (2009), it's important to state, that optimal infant and young child feeding can have a major influence on child-survival and on the mother's risk of mortality. However, a study by Nduati et al. (2001) showed, that breastfeeding could have adverse outcome for HIV-1 infected mothers and their children. Therefore, the study recommended, that women were tested during pregnancy. If they were found to have HIV-1, they should receive counselling in infant feeding-choices, including a discussion of potential risks on their own health, as well as the risk of transmitting HIV-1 to the their baby, if they chose to breastfeed.

In accordance with UNICEF (2009), an approximated 129 million children under 5 years in developing countries are underweight and 10 per cent of them are severely underweight. Jones, Steketee, Black, Bhutta & Morris (2003) estimated, that 19 per cent of all deaths of children under 5 in the developing world in 2000 (of a total of 10.8 million deaths) could be prevented with correct nutrition – with breastfeeding standing for 13 per cent and complementary foods for 6 per cent. Numbers from Black et al.

(2008) show, that insufficient breastfeeding, results in 1.4 million deaths and 10 per cent of disease burden in children younger than 2 years, especially for non-exclusive breastfeeding in the first six months of life [exclusive breastfeeding is defined as where an infant receives breast milk and nothing else (UNICEF, 2009)]. In addition Victora et al. (2000) state, that breastfed children are six times more likely to survive infectious diseases in the first two months, compared to non-breastfed children in the conditions that normally exist in developing countries. This is due to the protective antibodies and essential nutrients in the breast milk, produced by the mother the first days after birth (Huffman, Zehner & Victora, 2001).

A study by Desai & Alva (1998) also showed, that there in 22 developing countries consist negative relationship between maternal education and the probability of infant death. Children of mothers with a secondary-school education, where the least likely to die, compared to children of mothers with primary school education or no education at all – with children of mothers with no education having the highest risk of infant death.

As shown, undernutrition has directed discussions on the nutritional situation in developing countries, but it is important to recognise, that overweight among children and adults is also developing as a public health issue, especially in countries undergoing a so-called nutrition transition (Kelishadi, 2007; Wang & Lobstein, 2006) [transition refers to changes in traditional diets, with increased consumption of high-calorie, high-fat and processed foods (UNICEF, 2009)]. In these countries, overweight is caused primarily by economic insufficiency and by poor infant and young child feeding practices (UNICEF, 2009). Furthermore, some of these countries are facing a ‘double burden’ of malnutrition, having high rates of both stunting and underweight and of overweight (Kelishadi, 2007; UNICEF, 2009).

DISCUSSION

The Empirical findings compared with statements in White paper 11

As stated above, the MDGs increased the attention and renewed the interest in strengthening child-health epidemiology, as a basis for enhanced efforts toward a reduction in mortality within children younger than 5 (Bryce et al., 2005; Lopez et al., 2006). MDG 4 focus exactly on reduction of child mortality and it is an argument for one of White paper 11's priorities (Utenriksdepartementet, 2012). As shown previously, several authors believe, that apposite care at the youngest age forms the strongest basis for an individual's future and reduces health inequities within a generation (Irwin et al., 2007; Marmot et al., 2008). This seems to be equivalent with White paper 11's statement, "Early childhood is the most important period for all development. (…) Investing in the first years of life is one the most important ways of reducing health inequalities" (Utenriksdepartementet, 2012, p.18). The policy argues, that early childhood is where the foundation for future education and work is laid and where it is possible to reduce the risk of malnutrition, obesity, mental problems, heart disease and social problems later in life.

In accordance with UNICEF (2009), undernourished, insufficiently breastfed children or children suffering from micronutrient deficiencies have significantly poorer chances of survival, than well-nurtured children. Further, there is a risk that those children who survive an insufficient nutrition starting point, become locked in a cycle of frequent illness and wavering development with permanent damage to their growth and cognitive abilities (Bhutta et al., 2008; Black et al., 2008; Irwin et al., 2007; Victora et al., 2008). Therefore, it can be argued, that White paper 11's argumentation to focus on early childhood is founded in empirical evidence. Even more, White paper 11 state that it is crucial for society as a whole and for the individual child, that it develops its full potential. The earlier mentioned study by Grantham-McGregor et al. (2007) could substantiate this notion, because they believe it is fundamental to increase children's development and health for the national development and the public health.

The article of Jones et al. (2003) estimated, that 19 per cent of all deaths of children under 5 in the developing world, could be prevented with correct nutrition – with breastfeeding standing for 13 per cent and complementary foods for 6 per cent. The white paper 11 state, that "infant mortality would be reduced by 13 % if the WHO guidelines on breastfeeding were followed" (Utenriksdepartementet, 2012, p.18). Again it seems, that the argumentation in White paper 11 correlate with scientific evidence.

In the white paper, the former Norwegian Government emphasised the importance of integrated health services. Especially sexual health services, which should include services related to HIV and AIDS, were stressed as essential (Utenriksdepartementet, 2012). The study of Nduati et al. (2001) showed, that breastfeeding could have adverse outcome for HIV-I infected mothers and their children. Thus, the study recommended, that women were tested for HIV during pregnancy and were counselled in infant feeding-choices. Nduati et al. (2001) study could have been used to support the emphasised significance of sexual health services in the policy.

“At least 200 million children under the age of five fail to develop to their full potential, with severe consequences both for the individuals concerned and for society as a whole” (Utenriksdepartementet, 2012, p.18). Even though the number is slightly lower, this statement can be supported by the study of Irwin et al. (2007) who estimated, that 219 million children worldwide are not achieving their full development potential.

One of the few articles White paper 11 refers to is the study of Lozano et al. (2011). This article estimated, that there in 2011 were 7.2 million deaths in children younger than 5. However, in White paper 11 it is written, that 3.5 million children younger than 5 died due to low birth weight, acute malnutrition, or inconsistent breastfeeding, which is subscribed to be one third of all deaths in this age group. If one uses simple math, one would see, that 3.5 million is not one third of 7.2 million; it is near half, which could indicate that the number in White paper 11 isn’t the one from the Lozano et al. (2011) study. Neither is it conform with the study by Black et al. (2008), who estimated that in 2004 stunting, severe wasting and intrauterine growth restriction together were responsible for 2.2 million deaths in children younger than 5, equivalent with 22 per cent of the deaths and disease burden. According to Black et al. (2008, p.254), that result is lower than their earlier estimate, which indicated that “35 % of child deaths could be attributed to childhood underweight and maternal low body-mass index operating through intrauterine growth restriction to affect low birthweight”. Together with an study by Bryce et al. (2005) who estimated, that 10.6 million children younger than 5 died in 2000-2003 each year, the study referred to in the Black and colleagues article from 2008, is more corresponding with White paper 11’s statement. This could imply, that the number of mortality within children younger than 5, used in White paper 11 is of older date, even though the paper actually refers to a newer article (Lozano et al., 2011) with different numbers.

Transparent and evidence-based global health policy – why is it important?

Pointed out by several authors, global health policies should always be based on the best available evidence (Chalmers, 2003; Lozano et al., 2011; Yamey & Feachem, 2011). Even though many of the statements presented in White paper 11, seems to be originated from research data, there is uncertainty if the located evidential reports with the empirical findings, is the ones used in the white paper. Without references to the specific knowledge base, the reader cannot be sure to have found, or even find, the correct report to a given statement. This makes it impossible to evaluate the policy and the policy's evidence base and also to hold the responsible actors accountable (Bellver & Kaufmann, 2005; Innvær, 2009; Lemer et al., 2014; Oxman et al., 2009; Tjora, 2012). Therefore, White paper 11 might be judged as untrustworthy. This could lead to relevant actors not participating in achieving the priorities stated in the policy. To substantiate this notion, Naidoo & Wills (2010) argue, that lacking of transparent use of evidence can have implications for the policy implementation, which is usually an unproblematic and straightforward affair. And as argued by Mayer (2003) and Bellver & Kaufmann (2005), a transparent policy might increase the trust towards an institution and boost a more democratic policymaking. Further, when there is an explicit and transparent use of references, it does not complicate the identification of eventual bias ingrained in special interest (Innvær, 2009), and according to Prior (2010) it is always a good idea to ask detailed questions about how data has been collected and put together, when reading documents. On the contrary Stasavage (2006) dispute, that having transparency in policy can have important costs. For example, when the involved actors know, that their individual negotiating positions will become part of the public record, they can have a greater inducement to take positions, that will demonstrate loyalty to a constituency, even if this could means taking an action, that they know is less likely to create the policy outcome, they think is most favourable (Stasavage, 2006).

There is a possibility that some of the numbers, from the found evidential articles, are too old or too new. For instance, when comparing White paper 11's statement – 3.5 million children younger than 5 died due to low birth weight, acute malnutrition or inconsistent breastfeeding, subscribed as one third of all deaths in this age group – to the study of Lozano et al. (2011), Bryce et al. (2005) and the earlier study mentioned in Black et al. (2008), there is an inconsistency with the white paper's number and the Lozano & colleagues' study, but more accuracy with the two latter. The lacking of transparency makes it difficult to assess this probability. Chalmers (2003), among others, also argue that a health policy's action areas needs to be supported by the best available evidence, because of the risk of unintended effects. When you don't have the references to the correct evidence, there is no possibility of judging this. Further, if the stated numbers are from what seems like an old article, it's imaginable that there is a risk, that the paper gives a too negative, or even too positive image, of the actual situation. Conversely, it could perhaps be argued, that it is good enough if there is linkage from the presented argumentation to some sort of evidence, old or new.

Limitations

It can be seen as a limited scope only to look at one policy and state that all Norwegian white papers need to be more transparent. The degree of transparency could be different in other white papers.

Even more, formulation of a policy is more complicated than the discussion if the policy is evidence-based and transparent or not. In addition to use of evidence, factors such as politics, value of stakeholders and politicians, and budgets need to be taking into consideration when analysing a policy process (Flitcroft et al., 2011; Innvær, 2009; Lillefjell et al., 2013; Marston & Watts, 2003; Nutbeam & Boxall, 2008; Oxman et al., 2009).

In accordance with the literature search of empirical evidence on the malnutrition's impact on women's and children's health, there is a high possibility that not all of the evidence was located. However, it would have been a massive assignment to investigate the entire research database on malnutrition's impact on women's and children's health. Hence, it could be argued, that this emphasises why transparency in the evidence base is important when writing white papers or other types of reports.

CONCLUSION

Global health policy should be based on the best available evidence. Looking at the definition on evidence-based policy presented by Cookson (2005, p.119), which was "a set of rules and institutional arrangements designed to encourage transparent and balanced use of evidence in public policy making", it's possible to claim that White paper 11 (2011-2012) 'Global health in foreign and development policy' only has a part of the definition; the ‘balanced use of evidence’. The reason is, that even though the comparison between the empirical findings and the argumentation in the white paper indicates, that the policy does have a balanced use of evidence, one cannot be sure to have found the actual research evidence used in the policy. Hence, a question arises: “Can you have an evidence-based policy if there is no transparency?”, and in extension of this question, is White paper 11 therefore an evidence-based policy? It is difficult answering this, however, one of the cornerstones in evidence-based policy was ensuring accountability and promoting the conditions for securing improvements in health and well-being and having an explicit use of evidence. Having Cookson’s definition in mind and the cornerstone of evidence-based policy, one could therefore, al though perhaps very harshly and according to Oliver et al. (2014) very unfair towards policymakers, claim that White paper 11 is in fact not an evidence-based policy. However, this hypothesis cannot be completely concluded in this study.

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ARTICLE II

ABSTRACT IN DANISH

Introduktion: I 2013 dødede hver dag i nærheden af 17.000 børn under fem år. Dette var primært af årsager som kunne forebygges og sygdomme som kunne behandles af kendte livreddende behandlingstiltag. Meld. St. 11 (2011-2012) 'Global helse i utenriks- og utviklingspolitikken' var den første melding til stortinget omhandlende global sundhed, præsenteret af et udenrigsministerium. Da meldingen bl.a. kan have stor indflydelse på, hvordan den politiske sfære og global sundhedsinteressenter arbejder, er det vigtigt at undersøge dens tilblivelsesproces og kundskabsgrundlaget. **Formål:** At undersøge politikere og policy-arbejderes erfaringer med tilblivelsesprocessen af Meld. St. 11., og høre deres tanker om hvordan melingen og dens evidensgrundlag bliver brugt og blev til. **Metode:** Kvalitativt semi-struktureret interview studium med fem deltagere, bestående af politikere og policy-arbejdere. **Fundene:** Studiets deltagere beskrev samarbejdet med Global Alliance for Vaccines and Immunization (GAVI) og programmet om at vaccinere verdens børn, som Meld. St. 11's flagskib. Processen blev beskrevet som åben og involverende. Evidensgrundlaget blev brugt til at vise den politiske retning, fremfor at godtgøre prioriteterne. Dog blev der fundet en kulturforskel mellem de involverede ministerier i forhold til meldingens design. Yderligere blev Meld. St. 11 forklaret og set som et værktøj for både politikere og policy-arbejdere, og som et politisk dokument, fremfor akademisk. **Konklusion:** Evidens er bare en del af de forskellige faktorer, som påvirker en policy proces. På trods af det, fandt dette studie, at det er essentielt, at have en transparent evidensbase, når man skriver meldinger til Stortinget, da det kan have adskillige konsekvenser, hvis man ikke har.

A non-academic, evidence-based policy: Insights from actors behind White paper 11 (2011-2012) 'Global health in foreign and development policy'

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ABSTRACT

Introduction: In 2013, proximately 17.000 children under five died every day around the world. They died mostly by preventable causes and diseases that can be treated by well-known knowledge and technologies for lifesaving interventions. White paper 11 (2011-2012) 'Global health in foreign and development policy' was the first white paper on global health presented by a ministry of foreign affairs. Therefore, it's important to investigate the process behind the policy, since it, among other things, can have big impact on how the political sphere and global health interest work. **Aim**: To investigate politicians' and policymakers' view and experiences with the process of making the white paper, their thoughts on how it should be used, how the policy's knowledge base is used and how it came about. **Method**: Qualitative semi-structured interview study with five participants, consisting of politicians and policymakers. **Findings**: The participants described the collaboration with Global Alliance for Vaccines and Immunization (GAVI) and the program of vaccinating the children of the world as flagship for White paper 11. The process was seen as open and involving and the knowledge base was used to show direction of the policy, rather than stating the reasons. There was found a difference in culture between the involved ministries in accordance with the design of the policy. Further, White paper 11 was seen as a tool both for politicians and policymakers and also as a political paper, rather than an academic one. **Conclusion**: Evidence is just a part of different contributing elements in the process of making evidence-based policy. Nevertheless, this study found that it's crucial to have a transparent knowledge base, when writing white papers, because it can have multiple consequences if not enforced.

Keywords: White paper, Policy, Transparency, Evidence-based, Qualitative methods, Global health

INTRODUCTION

In 2013, proximately 17.000 children under five died every day around the world (UNICEF, 2014). They died mostly by preventable causes and diseases that can be treated by well-known knowledge and technologies for lifesaving interventions (UNICEF, 2014). Furthermore, maternal mortality numbers show that in 2013, 292.982 women died, many of them also by treatable conditions (Kassebaum et al., 2014).

Before White paper 11 (2011-2012) ‘Global health in foreign and development policy’ was written, it was estimated that 7.2 million children under 5 died in 2011 (Lozano et al., 2011), and in 2008 approximately 342.900 women died due to maternal complications (Hogan et al., 2010). Even though there has been a decrease in the child and maternal mortality ratio, the numbers are still far from reaching the goal of reducing child mortality ratio with two-thirds and maternal mortality ratio with three-quarters, as stated in the Millennium Development Goals (MDGs) (Bryce, Black & Victora, 2013). This emphasises why global health is a crucial area of focus.

White paper 11 was the first white paper on global health, presented by a Ministry of Foreign Affairs (MFA) (Regjeringen, 2012). In the summery of the policy, following is stated:

> “Health is a global public goal. Through political leadership, diplomacy and economical support, Norway will be at the forefront of efforts to mobilise a strong and broad global consensus on cooperation to address national health needs. (…) One of the objectives of Norway‘s global health policy is a better integration of health objectives into foreign and development policy. (…) The promotion of women’s and children’s rights and health is one of the main themes of political mobilisation efforts, both internationally and in our dialogue with national authorities. (…) Norway’s global health policy will be knowledge based.” (Utenriksdepartementet, 2012, p.5-6)

There were different actors involved in the making of White paper 11; from politicians to policymakers to lobbying organisations. The health policy triangle’s simplified framework can illustrate the complex factors and interrelationships, between the triangles corners and centre, which influence a policymaking process (Walt & Gilson, 1994), Figure 1.

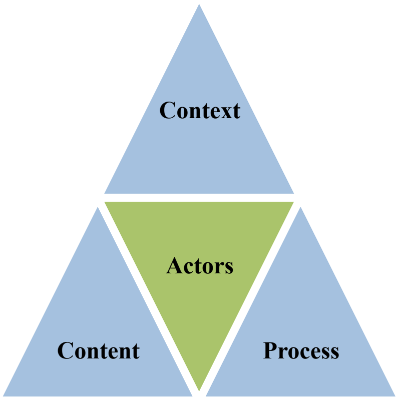

Figure 1: Health Policy Triangle

In the centre are the *actors* and their actions that affect the policy. The corners of the triangle consists of the *context* where policy is developed; the *content* of policy; and the *process* of policymaking, which is contingent on developing and implementing change (Walt & Gilson, 1994). They all some how interrelate, even though, it might seem like they could be considered separately. The actors and their beliefs have an impact on the policy process; the context, which can be affected by factors such as instability caused by for instance war, has an influence on the actors; and the policy content reflects some or all of the above elements (Walt & Gilson, 1994).

Since policy decisions are subject to public examination and outcomes affect many people directly, there is an increasing wish for their precise validation (Dobrow, Goel & Upshur, 2004; Ham, Hunter & Robinson, 1995; Innvær, 2009; O'Neill, 2006). As Innvær (2009, Background) state, "A transparent and explicit approach is essential for reliable, valid and rational decision-making." Even though the following statement by Tjora (2012) is argued in accordance with presentation of research, one can argue that it substantiates Innvær (2009)'s previous argument, since several authors claim the same thing, in the context of policy work (Bellver & Kaufmann, 2005; Florini et al., 2000; Kaufmann & Kraay, 2002; Mayer, 2003; Ostry, 2004; Oxman, Lavis, Lewin & Fretheim, 2009). Tjora (2012) state, that one of the most important requirement with research and presentation of it, is transparency. Transparency gives the reader a chance to evaluate the research quality. If the probability to evaluate the quality of a policy is present, it can improve the trust towards the paper and the responsible institution (Bellver & Kaufmann, 2005; Florini et al., 2000; Innvær, 2009; Oxman et al., 2009). However, Christensen & Lægreid (2005) state, that it's a part of democracy to have some amount of distrust in the powerful actors. This supports why it's crucial, for a paper's trustworthiness, that it builds on the best available knowledge and evidence and also refers to where it stems from (Bellver & Kaufmann, 2005; Chalmers, 2003, 2005; Dobrow et al., 2004; Florini et al., 2000; Ham et al., 1995; Innvær, 2009; Kaufmann & Kraay, 2002; Mayer, 2003; O'Neill, 2006; Ostry, 2004; Oxman et al., 2009; Tjora, 2012; World Health Organization, 2004; Yamey & Feachem, 2011).

Acknowledging that white papers are of course not research papers and will not serve the functions as such, and therefore do not have the same strict presentation rules as academic papers (Innvær, 2009; Tjora, 2012), it is still suitable to ask the question, why is this so? Because, it's decisive that policies, within the global health area, are based on solid and transparent evidence, as it can have a big impact on how the political sphere and global health actors work (Ham et al., 1995). Therefore, it is crucial for a document's affect, that the reader, no matter what background he or she has, can go back and evaluate the evidence quality on which its recommendation are based (Innvær, 2009; Lemer, Cheung, Viner & Wolfe, 2014; Oxman et al., 2009).

Therefore, by using existing literature as a basis and semi-structured interview as method of data collection, this study sets out to explore and investigate relevant politicians' and policymakers' view on the knowledge base behind White paper 11 and the process of making it.

In particular the present article address the following research questions:

- What were some of the involved politicians and policymakers experiences of the process of making White paper 11 (2011-2012) 'Global health in foreign and development policy'?
- Which thoughts did some of the involved politicians and policymakers have about the way White paper 11 (2011-2012) 'Global health in foreign and development policy' is and should be used?
- How is the knowledge base within White paper 11 (2011-2012) 'Global health in foreign and development policy' used and how did it come about?

METHOD AND MATERIAL

The objective of the present article was to explore how politicians and policymakers experienced different aspects according to White paper 11. Therefore, this study is a qualitative study involving semi-structured interviews. Prior to the interviews, the study procured approval from The Norwegian Social Science Data Services (NSD) to carry out the project, c.f. Appendix B. The individual interviews took place in a city in Norway in 2015. All participants signed a consent agreement and were told they at anytime could withdraw their consent to participate.

Participants

To recruit participants for the study, invitations with an information letter and a consent agreement were mailed out to a sample of strategically chosen persons, and if possible their personal advisor, whom it was thought had a connection to White paper 11; see Appendix C for invitation letter. From the beginning the ambition was to get in contract with central individuals around the white paper. In total, there were sent out thirty-eight emails (not including mails sent to the personal advisors). Fifteen of the invited persons forwarded the invitation to whom they believed had more knowledge of this study's objective and seventeen declined or didn't respond to the invitation. In all six individuals agreed to participate, however, one participant cancelled in the last second due to illness. Therefore, five participants contributed to the study with their experiences and thoughts about the policy. They had varying connections to White paper 11, since the motive was to get a broad understanding of the process behind the policy (Tjora, 2012). The group of participants was composed of a former politician (active during the work with the white paper), three policymakers and a current politician. It was assessed not to give a further description of the participants, as it could enable an indirect identification and thereby affect their promised anonymity. In addition, it was concluded, that a further description was not required, as it would not have affected the findings.

Data collection

An interview guide was developed prior to the data collection, c.f. Appendix D. Questions varied slightly according to the participant's role as either politician or policymaker. The interview guide was a guideline of areas and questions for the interviewer to ask the interviewee. The questions were connected to the study's focus and aims. This consisted of questions relating to the background of white paper 11, the process of making White paper 11, the evidence-use and how this was collected, pro and cons of the process of making White paper 11 and also explanations why they wrote it the way they did. In the beginning the questions were open and broad and then later in the interview, narrowed towards the focus of this study. Follow-up questions were also used to obtain further information or clarity, of what was told.

One of the interviews was a phone interview, the rest were face-to-face interviews. The interviews lasted an average of 25 minutes, where the longest was 50 minutes and the shortest 15 minutes. They were all recorded on tape. The interviews were performed in Norwegian and Danish, since the interviewer is Danish and the participants Norwegian. The interviews were transcribed shortly after each interview, because then the information and impressions were still fresh. The reason for this was to minimise the loss of mimics, expressions, tone of voice and body language, which are not caught on tape (Kvale & Brinkmann, 2009; Malterud, 2011; Silverman, 2005). Further, when the interview is transcribed right after it has been conducted, it enables the researcher to make slight adjustments, if necessary, to the style of future interviews (Malterud, 2011; Silverman, 2005). To enhance the validity of the study, a transcription manual with codes and guidelines was prepared (Malterud, 2011); the manual is shown in Appendix E. Further, Slightly Modified Verbatim Mode was used, because the method, if necessary, allows editing of the transcribed text, so the spoken words are more coherent (Malterud, 2011). The different quotes, which were chosen as illustrations, were in the writing process translated to English. Since there were several translations – from Norwegian and Danish spoken during the interviews, rewritten only in Danish in the transcriptions and again rewritten into English – there is a possibility of loosing significant meaning. However, to be sure the translations of the quotes were done correctly, the transcripts were validated with a supervisor. Lastly, the participant, whom the chosen quote was attributable to, was referred to by a letter, e.g. *Participant-A*. The letter was given in a random order according to when the interviews were held, so their confidentiality was maintained.

In addition to the interviews, the author had a meeting with a researcher, who had written an article about transparency in Norwegian governmental documents. The reason for the meeting was to get some comprehensive ideas and maybe new perspectives to the study's objective. The meeting was not recorded, as it was used to contribute with knowledge and information to the article's author.

Analysis procedure

A step-wise approach was taken to analyse the interviews. The first step was to write down personal experiences and knowledge with the process of making a policy and with evidence-based and transparent policy, as recommended by Cresswell (2013), c.f. Appendix F. This was an attempt to set aside personal views, so the focus was on the participants' – although it is recognised that this cannot be done completely (Cresswell, 2013; Kvale & Brinkmann, 2009; Malterud, 2011).

The second step was to read the transcribed material and writing down themes that seemed significant for the objective of this study, c.f. Appendix G. Ten themes were identified: *Process*, *Background*, *actors*, *sub-actors*, *knowledge*, *responsibility*, *politics, difference in culture*, *a tool* and *documentation*.

Third step was to give each theme a code, and then to find significant meaningful units – quotes – that could illustrate the code. During this process, the ten codes were adjusted, because some of them seemed to illustrate the same aspect. This is known as categorisation (Kvale & Brinkmann, 2009; Tjora, 2012). The adjustments lead to three new categories – where *process*, *background*, *actors*, *sub-actors* and *responsibility* became one category – 'process'; *tool* and *documentation*, the second category – 'tool'; and *difference in culture* and *knowledge* the third – 'knowledge'. In addition to this, each category was given a colour and the quotes were treated equally (Burnard, 1991; Cresswell, 2013; Kvale & Brinkmann, 2009; Malterud, 2011). The quotes were then listed in a matrix with their line number, c.f. Appendix H. For an example of the colour coding in the transcripts, see Appendix I.

Step four was to portray the categories, using the participants' experiences and thoughts; the matrix was used as a map. This step is called "textural description" and according to Cresswell (2013, p.193) "includes verbatim examples". This is also the essence of the described findings presented in the next section. According to numerous authors, using quotes from the interviews can help elaborate the participants' voice (Burnard, 1991; Cresswell, 2013; Postholm, 2010; Tjora, 2012), which is why these are used multiple times. Lastly, each category was given a new title, which enlightened what it comprised.

FINDINGS

Three major categories presented as "*The process of White paper 11*", "*White paper 11: a 'gismo'*" and "*The knowledge base – a question about culture and trust*", were found to answer this article's objectives. Each will in the following be described in more details.

The process of White paper 11

Global health has been a big concern and priority for various Norwegian Governments. Especially, the collaboration with Global Alliance for Vaccines and Immunization (GAVI), in connection with vaccinating the children of the world was enhanced as being one of the main factors for the development of the white paper. As *Participant-A* describes:

> *Global health has been an important priority and commitment in Norwegian development and foreign policy, since it's dealt within the same ministry. (...) It was Millennium Development Goal 4 and 5 that was the main priority for the commitment. Efforts towards the health of women and children and especially the vaccine program and collaboration with GAVI, was the flagship.*

In the Ministry of Foreign Affairs (MFA) a section was founded, because there was a desire to have a structured approach to the field of global health, and because global health was an important focus area for Norway. When heavier actions were initiated, there, however, came a need to document the work done in the ministry. Stated by *Participant-C*:

> *(...) After the section started to work more with global health, we saw a need to write down the basis and reasons for the things we did. You can say... the foundation was there, but my co-workers and I experienced in the work, that there wasn't a lot which explained what it was we were to achieve, what the object was and how we should work in the field [global health]. (...)*

The initiative to write a white paper on global health came from MFA. In addition to the members from MFA, *Participant-B* explained, that a group from the Ministry of Health and Care Services (MHCS), The Norwegian Agency for Development Cooperation (NORAD) – an affiliation under MFA – and other relevant academic environments, were also invited to participate in the development of the policy. These actors formed a reference group, who could give counselling, advise and academic knowledge on different relevant issues. The reason for their invitation was explained as three-fold. First, White paper 11 was seen as a broad commitment on health. Secondly, MHCS had and still has a close collaboration with World Health Organization, and both MHCS and NORAD had a profound academic environment connected to them. Thirdly, there were joint interests' between MFA and MHCS, within the area of global health.

Before and during the writing of White paper 11, the policymakers and politicians had meetings with different humanitarian organisations, philanthropies and academia. These affiliates supplemented with knowledge and views on what the priorities should be in the policy. In addition to these actors, members within MFA also used their individual networks. As *Participant-E* describes:

> *Also, we had meetings with scientists… a lot of different people… Further we had people in the ministry [MFA] who had enormous networks, who also contributed to the discussion.*

It was stressed, that the academic environments and relevant stakeholders should present their data in a way that made it easy for the policymakers to understand the knowledge and thereby the possibility to translate the data into priorities in the policy. Further, there was a desire for the white paper to be short, precise and easy for all to read. Yet, one challenge, which was accentuated by a couple of the participants, was a shift in personnel during the process of making White paper 11. Here, however, there was expressed slightly ambiguity. One participant meant that it was positive, that there was a break, because when MFA wished to have the policy done quickly, there was a risk of loosing important views and thematic'. Another participant, however, expressed that the shift in personnel gave a problem with the policy's textual flow.

The responsibility of making White paper 11 appears to be within the MFA, even though it, for some, might seem surprising that global health wasn't under MHCS. But as *Participant-E* explains, "*There isn't one area on the international agenda, discussed by foreign ministers, where health isn't important at some point*."

In all, the process of making White paper 11 was experienced to be an open and including process, and also an interesting and a fun way to work. Exemplified by *Participant-C*:

> *Even though we were busy, it's a fun and exciting area to work with. I believe there is much to learn about that way of working with global health, where you try to combine knowledge and politics.*

White paper 11: a 'gismo'

In addition for the need to document what was done and why, White paper 11 became a 'gismo' to navigate around priorities and politics associated with global health for the employees of MFA. As *Participant-A* explains:

> *For us, it's still a steering document, because it summarises what we did and what we have kept on with. (...) For example, we can still refer to it and --- Every year we make business plans and there the policy is an essential document that gives us directions. (...)*

To amplify this, the white paper instructions on health priorities were also explained to be a guide for the governmental budgets on where to place money, targeted aid.

White paper 11 is also seen as a sort of 'gismo' for politicians and the Storting. Yet it is only picked up when the present theme is discussed. Exemplified by *Participant-D*:

> *Like it is with those type of white papers, they are picked up when that type of thematic is up for debate (...) so in a way ... as a new committee you simply don't read the old white papers (...) Maybe it should be different (haha)*

Also stated by some of the participants, there are still a lot of things done in MFA and in the Storting, that hasn't been described in the policy. Clarity in the central priorities is therefore believed to be crucial. Quoting *Participant-C*:

> *(...) The information load is often big, and very quickly it can be too much and then it [the white paper] wouldn't be read ... your message wouldn't be apparent [if you are not clear in your priorities] (...)*

Not only is the white paper a tool to guide the work done in MFA and the Storting, the policy was also described as being a sort of communication instrument; a 'voice'. When politicians and policymakers went out advocating for the Norwegian priorities and politics on global health, they would bring the white paper to meetings, as an illustration. This was also one of the reason why it was decided, that White paper 11 should be short, written in a language that was readable for all – and not just for experts – and also why it was translated into English. For example, from *Participant-E's* point of view:

> *It's also because, I think, a white paper should draw up what the political priorities are, and I think… it depends on the document, but if it becomes big with massive writings… then it's my experience that sometimes what's important will be hard to see… it will be hard to se the political endeavour.*

Even more, it was important to get a formal approval of the priorities from the political sphere, so the involved actors in the long run, could work along the same path. So if there is a new Government, the administration in MFA can and will still use the policy as a guideline. As *Participant-C* state, "*Even though there would be an election and a shift in government, the administration could say that they follow the white paper*." In addition to this statement, *Participant-A* believe, that although the present Government considers global health as an important priority, they won't be so committed to refer to the white paper and feel ownership over it, because it was the former Government who wrote it.

So, White paper 11 is a document written for all relevant stakeholders, including the different humanitarian organisations, the political environment and bilateral partners.

The most important factor was that the policy was a non-academic, political document, written so everyone could read and understand it.

The knowledge base – a question about culture and trust

In the interviews it was stated that it was difficult finding evidence saying a given action was better than another. However, it was believed that there was not a need to substantiate the chosen actions, because the policy should indicated the directions, rather than justify them. Nevertheless, the importance of the policy being based on profound and solid evidence was still a crucial factor; exemplified by *Participant-B*:

> *(...) This is so you don't make a decision in a vacuum of political spinal reflex, but also on a base of knowledge… for MFA it's a lot about money and being sure that they are administrated and spent on actions, which gives the results they wish. (...) I believed, inherently when it comes to aid, very often it could seem like we just throw money at countries. This is another reason why the priorities should be based on knowledge.*

During the process of making White paper 11, numbers and statements were double-checked, so everything that was written down was correct and based on good research. *Participant-E* trusted this process completely and was glad the bureaucracy was there to check, that what was advocated, was correct. It was experienced like a quality assurance of the white paper.

In addition it was stressed, that the MFA did not make its own research and evaluation. The MFA used what was given to them and what they knew from before. Several of the participants highlighted, that they sat in a lot of boards in different humanitarian organisations, where they also got information and reports. *Participant-A* gave this example:

> *Lets say you work and have responsibility within the field of maternity health. Then you know something about this, because it's a part of your job. You know the basics (...) But you still need to gather evidence, because there of course is development in the field. ... But this is something that's discussed in executive boards in for example UN organisations. ... So if you work within maternity*

> *health, then you'll get… in some way, the information flows your way all the time. You are somehow part of the environment.*

Therefore, a lot of the knowledge and evidence used in White paper 11 is based on knowledge and experience from experts, research from academic environment and from different organisations, who worked within the field of global health. In addition, when politicians need an elucidation of a given topic, they had and still have access to the 'Section of Elucidation'. Portrayed by *Participant-D*:

> *(…) The Storting has it's own 'Section of Elucidation', that is a department where politicians or counsellors can require…lets say a comparative comparison of the EU and Norway's approach to global health, then they will come back… they do the research for us. And this is a service for all parties in the Storting.*

The process of gathering evidence was not to sit and read reference books and analyse the data. Like *Participant-A* said, "*That's not the way we work.*" Instead, a lot of the background and material used in the policy was based on notes and knowledge present in the ministry. Nonetheless, one could claim, that it's difficult being certain of the profoundness of this knowledge base, because of the small number of references in the policy. This was a topic that was discussed in the interviews. As an answer to this question, *Participant-D* for example believed, that most white papers do refer to where a number [e.g. on child mortality] is taken, because "*It would be quite hopeless just to throw out numbers, because then you [as a reader] in reality don't know who or what the background are for them [the numbers]*". It was also explained that the white paper was a political paper and not an academic and there therefore wasn't any need for references. According to *Participant-C* it was a deliberate choice not to make the white paper too academic, even though they had discussions between the actors involved in the writing process. Some participants also explained, that the use of references would exert the wished length of the white paper. A fourth explanation was the wish for the policy to be short and clear; by clear meaning the priorities should stand out strong. It was also believed, that it wasn't normal to have a list of references, when writing white papers and lastly it was more important to get a formal approval, by giving precise priorities, rather than documenting and giving massive descriptions of everything. On these encounters, a difference in culture was expressed. Illuminated by *Participant-B*:

> *This is where you see the difference between the ministries. (...) Especially the Norwegian Knowledge Centre for the Health Services [NOKC] and Norwegian Institute of Public Health was very insisting on this [the use of references]. (...) Nearly every sentence NOKC delivered had a reference and then of course the list of references gets long… this way of writing, wasn't in the current interest of MFA, because a white paper usually isn't a research paper. (...) NOKC thought this was odd and in fact had difficulties accepting this. They [NOKC] believed it had to stand out clearer, what the actually evidence was.*

Another example of difference in culture can be seen in the pace the ministries worked and chose their priorities. The MFA had a culture where it was important to prioritise tight and narrow and to have a quick process. For example illustrated by the phrase, by *Participant-B*, "*MFA with their confined determined glasses, working speedy*". MHCS, on the other hand, was seen as a bigger institution that 'walks' slower, illustrated by *Participant-B* as "*a big waddling troll [said with a smile]*".

To summarise, White paper 11's knowledge base consists of reports and evaluations from different organisations, a previous knowledge base within the ministry and of expert knowledge. The knowledge base was there to make sure, that the priorities presented in the policy, wasn't solely built on politics and also to show, that the priorities was situated on solid evidence. Further, in accordance with referring to an evidence base, there was expressed a difference in culture among the ministries.

DISCUSSION

The making of a non-academic, transparent white paper

Three categories were elicited from the interviews, to answer the objective of this study; "*The process of White paper 11*", "*White paper 11: a 'gismo'*" and "*The knowledge base – a question about culture and trust*". It's reasonable of the reader to wonder what the results of this study can offer. One could ask, "What can knowledge about the making of a white paper give?", "Shouldn't we just trust, that what is presented in a white paper is based on solid evidence?" and "Why is it relevant to know how white papers are used or should be?" These are all good questions. Hopefully this discussion gives an answer.

There were different actors involved in the process of making White paper 11; policymakers from MFA and MHCS, employees from academia, lobbying organisations, philanthropies and politicians. The framework of the health policy triangle can help illuminate and explain complex factors and interrelationship, between the different components in global health policy (Brugha, Bruen & Tangcharoensathien, 2014; Walt & Gilson, 1994). In accordance with the health triangle model, the actors are influenced by their context, for instance work environment (Walt & Gilson, 1994). If one takes, a lobbying organisation as an example; they are influenced by the environment, values and goals connected to the organisation. These factors will have an affect on which basis the organisation advocates and lobbies and thus explains the actors' actuation on the policymaking process, and thereby the possibility of their perspective being reflected in the content of a policy. Substantiating this, Otjes & Rasmussen (2015, p.1) say that "the pattern of collaboration between groups and parties shapes both the character of public policies as well as the quality of democracy." This illustrates how the different elements interrelate with each other and how the elements can have a domino effect (Brugha et al., 2014; Walt & Gilson, 1994). Also, it could be argued, that it illustrates the complexity of policymaking, where different elements compete with each other in gaining influence in the policy formulation.

The domino effect, which can be present in the health policy triangle, can be seen as a positive and negative feature. On the positive note, important issues may come on the political and public agenda, and politicians, policymakers and the society can thereby develop required knowledge about a matter of international and/or national relevance. By contrast, if one of the elements in the triangle is affected by, for instance a poor evidence base or personal agenda, it can influence the rest of the policy process. This could result in a policy of low quality or a policy based on personal agendas and beliefs. Pedersen, Halpin & Rasmussen (2014) substantiate this. They argue, that the different actors, that interact with each other, are all interested in influencing public policy, however, the actors' degree of focus may vary. A consequence of this is according to Pedersen et al. (2014, p.5), that "they may not be equally eager to spend their resources

– time and/or money – on providing information to parliamentary committees.” White paper 11 acknowledges this challenge. In the paper it’s written, that “not all actors base their arguments on research and evidence when solutions are being discussed” (Utenriksdepartementet, 2012, p.40). This could indicate, that the depth of the presented evidence has been inspected and evaluated, since they are aware of the issue. However, when the policy lacks transparency in the knowledge base, there is a lesser chance of evaluating and inspecting its profoundness, but also a lower possibility of assessing the inter-relationship between the different elements in the policymaking process.

Cookson (2005, p.119) defined evidence-based policy as “a set of rules and institutional arrangements designed to encourage transparent and balanced use of evidence in public policy making.” Looking through White paper 11 it could be argued, that the policy is without transparency in use of references and thereby one of the cornerstones in evidence-based policy. This seems consistent with the expressed concern of NOKC. NOKC had difficulties accepting MFAs minor use of references, because NOKC use them thoroughly in their own reports. Even more, this way of using references was expressed as difference in culture between MFA and MHCS. The MFA saw no necessity to refer to the knowledge base, because the policy was a political paper and not academic and should be easy for all to read. However, one could question the argument that use of references might make it harder for non-academic people to read and understand the paper, because arguably transparency has nothing to do with the comprehension of the content. And, as shown by several authors, when the reader knows where the evidence stems from, trust will increase (Bellver & Kaufmann, 2005; Chalmers, 2003, 2005; Dobrow et al., 2004; Florini et al., 2000; Innvær, 2009; Kaufmann & Kraay, 2002; Mayer, 2003; O'Neill, 2006; Ostry, 2004; Oxman et al., 2009; Pawson, 2006; World Health Organization, 2004; Yamey & Feachem, 2011). Further, when a reader, whom e.g. works within global health, has the opportunity to see where the presented priorities originate from, will theoretically know that the priorities they work after, are based on a solid evidence base – or at least they get the chance to evaluate it. Also, when the priorities are based on knowledge and referred to where they originate from, it could arguably increase the public beliefs, that the politicians don’t just throw money at different aid actions in other countries, which was believed to be an evident issue by one of the participants.

In accordance with O'Neill (2006), it hasn’t become less demanding communicating with intended audiences about complex matters. Those who aim to communicate still have to design their acts of speech with care; they still have to take into account, the actual capacities and beliefs of their intended audiences; and they still have to meet a range of epistemic and ethical norms that are constitutive of adequate communication. According to O'Neill (2006), if these norms are met, transparency may extend communication by making information available to audiences, who otherwise wouldn’t be included. However, if they are not meet, transparency can worsen communication by spreading confusion, uncertainty, false beliefs and poor information (O'Neill, 2006). Nevertheless, if there is absence of transparency in the evidence base in a white paper, and thereby where the knowledge disseminates from, the probability of achieving the policy’s targets can decrease. An explanation might be, that transparency strengthens the trust (Innvær, 2009) and it facilitates the policy implementation (Naidoo & Wills, 2010). However, there is a broad political collaboration within global health in Norway, and there has been a reduction in MDG 4 and 5 (UNICEF, 2014), so it could be claimed that this hasn’t been an issue – all though it is acknowledge that White paper 11 was not the sole reason for the reduction in the MDGs. Other actions have, of course, also beneficiated towards the reduction.

Transparency requirements can benefit expert ‘outsiders’ by giving them access to information about the performance of institutions and their corporate office-holders (O'Neill, 2006). Supplementary, transparency is also especially useful to campaigning organisations, which may use the evident information for partisan purposes (O'Neill, 2006). Transparency can facilitate to secure trust, when it’s tied to communication with an audience with relevant expertise. However, transparency cannot give most members of the public (who don’t have the expertise, assess or time to understand the information made present for them, or sometimes don’t have the interest in doing so) a profound basis to judge whether or not to place their trust in the policy and thereby the government (O'Neill, 2006). In addition, Hardin (1999) believes, that for the majority of people, most of the time it makes little sense trusting the institutions, because they cannot know enough of what they need to, to be able to trust government. Therefore, for the sake of the public, it could be argued to be of little importance, that White paper 11 is transparent in its knowledge base. However, Saint-Arnaud & Bernard (2003) argue, that in social democratic welfare states (like Norway), citizen involvement in politics is much higher, than in liberal welfare regime, which on the other hand could emphasis the importance of having a transparent evidence base.

In addition, Stasavage (2006) claims, when transparency is absent from a policy, it eliminates outsiders possibility to trace back to where a policy choice stems from. This means that the reader can't hold the institutions responsible for their actions, whether good or bad (Bellver & Kaufmann, 2005; Innvær, 2009; Lemer et al., 2014; Oxman et al., 2009). Conversely, Stasavage (2006, p.168) dispute, that when the involved actors know, that their positions will become evident "they may have a greater incentive to take positions that will demonstrate loyalty to a constituency, even if this means taking an action that they know is less likely to produce the policy outcome they think is best." On the other side, Pedersen et al. (2014, p.5) state, that all though members of a parliamentary committee may favour information that substantiate their policy position, they still "have an interest in being as fully informed as possible when developing arguments or making a final decision about their position." Further Pedersen et al. (2014) believe, that it would reflect badly on the involved actors, whether it's the committee's members or the parliament, if they abstain from taking evidence from central stakeholders linked to the discussed topic.

Politicians have access to the 'Section of Elucidation' and therefore have employees finding the evidence for them. However, students and 'outsiders', like humanitarian organisations and the general public, have to try and find the evidence, which could substantiate the policy's presented arguments and thus their work, themselves. Hence, it could be recommended, that policy committees write documents, that are accessible and also understandable, to academics and non-academics alike (Ham et al., 1995; Innvær, 2009). A possible solution could therefore be to formulate separate reports for different audiences (Innvær, 2009). In addition to this, Attanasio (2014, p.29) stress, that "it is important that the institutional design of policy making is such that policy-making institutions are incentivised to use rigorous evaluation in the process of designing policies and allocating resources to alternative options.".

The findings indicate that White paper 11 is a working tool for the MFA, regardless of which government is situated in the Storting. This was, because the policy had a broad political accept. However, it's believed that the new government probably will not refer to it as often as the former, who composed it. Hence, the feeling of ownership seems to be an important dimension when working with white papers. Nonetheless, White paper 11 is still seen as a trademark for Norwegian global health policy. First, it's the only white paper on global health within foreign and development policy in Norway. Second, because the policy was brought to different meetings, as an illustration of the Norwegian priorities on global health. Since the policy is seen as a trademark of Norwegian global health policy, it arguably needs to be trustworthy and thereby transparent. It could be argued, that this will substantiate Norway's position as an alluring partner within the global health arena, because other relevant cooperate partners will see, that Norway's priorities stems from profound evidence. However, it is important to highlight the complexity of the distinctive factors affecting the evidence-based policymaking process. Because as Lillefjell, Knudtsen, Wist & Ihlebæk (2013), among others, argue, evidence is just one contributor.

The findings also show, that politicians only read white papers when the given topic is up for discussion. This suggests that they don't fully know the content of the white papers. It cannot be concluded in this study, that this is an issue for all Norwegian white papers, but it raises the question whether this actually is the fact. Hence, a question arise, "Can and should one presume politicians know the entire content of white papers?" Because society delegates their sovereignty to the political and administrative institutions and actors and trust, that this authorisation will be handled in an adequate way (Christensen & Lægreid, 2005). Shouldn't it thus be anticipated, that the politicians at least know the latest versions of a white paper, within their political area? This could emphasis why "an inherent part of any democracy, is a 'healthy distrust' in or skepticism toward the interests of powerful actors" (Christensen & Lægreid, 2005, p.487-488).

Methodical issues

Malterud (2011) utters, that you shouldn't say you use phenomenology, if you don't have profound knowledge about the approach. This is one of the reasons why the present study didn't state to have such an analytical view. However, it could be reasoned that this is a study that has a phenomenology approach, because the author's prior understanding has been described as part of the analysis procedure, the participants' voice is the most important feature and the participants' experiences is seen as valid knowledge (Malterud, 2011). Nonetheless, it was assessed, not to define the study as a phenomenological. Yet, it is still acknowledging that 'some' would believe it could be harder to recreate the study, when such approach isn't described further. Even more, there is a possible that the prior understanding and status as a novice researcher has biased and influenced the extent of the analysis and thereby the presented findings.

When interviewing strategically chosen actors, the present study got the chance to get below the surface of official and conventional knowledge (Malterud, 2011) and therefore towards a better understanding of thoughts and experiences behind the process of making White paper 11. However, when recruiting participants through the snowball method, there occurs an ethical issue, because information of the participants could be exposed (Tjora, 2012). By refraining from using a continuous order when referring to the interviews, and by not mentioning the gender of the participants, this issue was tried addressed.

There could also be some methodical issues when carrying out a phone interview. This type of interview increases the risk of misinterpretation of what's said, because of the missing possibility of seeing the participant's body language. Body language is an important aspect when analysing interview data (Malterud, 2011). To try and overcome this obstacle, questions of explanatory nature was asked (Tjora, 2012). However, it has been argued, that a positive aspect of having interviews over phone is the fact, that the interviewee can't see the tape recorder and thereby won't be reminded of the interview is being recorded (Pettersen, 2009). A phone interview can therefore, for some, make the interview situation more relaxing.

When semi-structured interviews use an interview guide, there might be a lack of consistency in the way the research questions are asked. The reason for this is, that the researcher can be divergent in the way he or she ask them (Turner, 2010). The consequence being, that the participants are not answering the same questions. This could therefore also be seen as an issue of methodical character.

The transcriptions was done in Danish, even though there was spoken a mix of Norwegian and Danish in the interviews. Hereafter, the chosen quotes were translated into English. Consequently, there is a risk of eliminating the essences of what it was the participants' actually meant. However, by recording the interviews, there was an opportunity to listen to them multiple times and thereby helped ensure that the meaning was understood correctly (Silverman, 2005). Further, the findings were discussed with a supervisor, who is Norwegian. Hereby it was verified, if the spoken word was understood correctly. This also contributed to new perspectives on the data, which according to several authors strengthens the validity of the study (Kvale & Brinkmann, 2009; Malterud, 2011; Silverman, 2005). Another way would be to get the participants to look through the transcriptions and thereby give their approval of the written. However, this wasn't opted.

Implications for future study

The present study did not illuminate how the policymakers and politicians evaluated the profoundness of the knowledge they were presented. It could have been interesting to hear how they did that, because theoretically if the policymakers and politicians didn't find the evidence behind the presented data, and hereby ensuring if it's based on a solid ground, there is the risk that the statements are not accentuated from solid research evidence. This hypothesis can be substantiated by the findings in the study of Innvær (2009, Discussion), which found that "both policy-makers and experts tend to prioritise summaries and recommendations, rather than the hard science underlying them, since experts' participation on committees did not seem to influence the strategy used to gather research information." However, this proposition cannot fully be answered in this study, since it wasn't clarified in the interviews. It might therefore be something that is illuminated in a future study.

Another aspect a future research project could investigate is whether a general design template would minimise the differences between the ministries, when writing white papers, and if this could be a beneficial way of designing and working with policies. One could imagine, that it gave more systematic to the writing process and perhaps eliminated the challenges in accordance with for instance possible change in personnel.

Lastly, it could be argued, that it's hard to conclude, that all Norwegian white papers are lacking transparency, based on this study alone. It could therefore be relevant in a future study, to compare different white papers and see whether this is a trend in them all.

CONCLUSION

In White paper 11 (2011-2012) ‘Global health in foreign and development policy’ it’s emphasised, that the policy seeks out to be based on profound knowledge. Findings from this study indicate, that the knowledge base was used so the policy wasn’t just based on political spinal reflex, but also solid evidence. Further, the knowledge base was there to show, that the aid provided to the field of global health, was directed towards priorities, which had a profound evidence base. The article’s findings also show, that the process of making White paper 11 was experienced, as an open and including process, where different relevant stakeholders gave information and reports to support the policy’s knowledge base. More, the policy was seen as a communication tool and as a tool that indicated the direction of the priorities, rather than justifying them. This was also one of the reasons why it was believed, that there was no need for transparent use of references in the white paper. On this account, the study found a difference in culture among the ministries. Thus, an idea could be to have a more systematic process, a general template, when writing white papers. Still, pointed out by e.g. Lillefjell et al. (2013), evidence is just a part of different contributors in the process of making evidence-based policy. Nevertheless, this study found, that a transparent knowledge base is an important feature when writing evidence-based white papers, as it can have consequences if not enforced. A consequence is the possibility of a decrease in trust with the paper, which could affect the policy implementation. Second, campaigning organisations can have difficulties using the evident information for partisan purposes. Thirdly, the reader can’t evaluate the quality of the document and thereby hold the responsible institutions accountable for their actions; or at least it takes more time in doing so.

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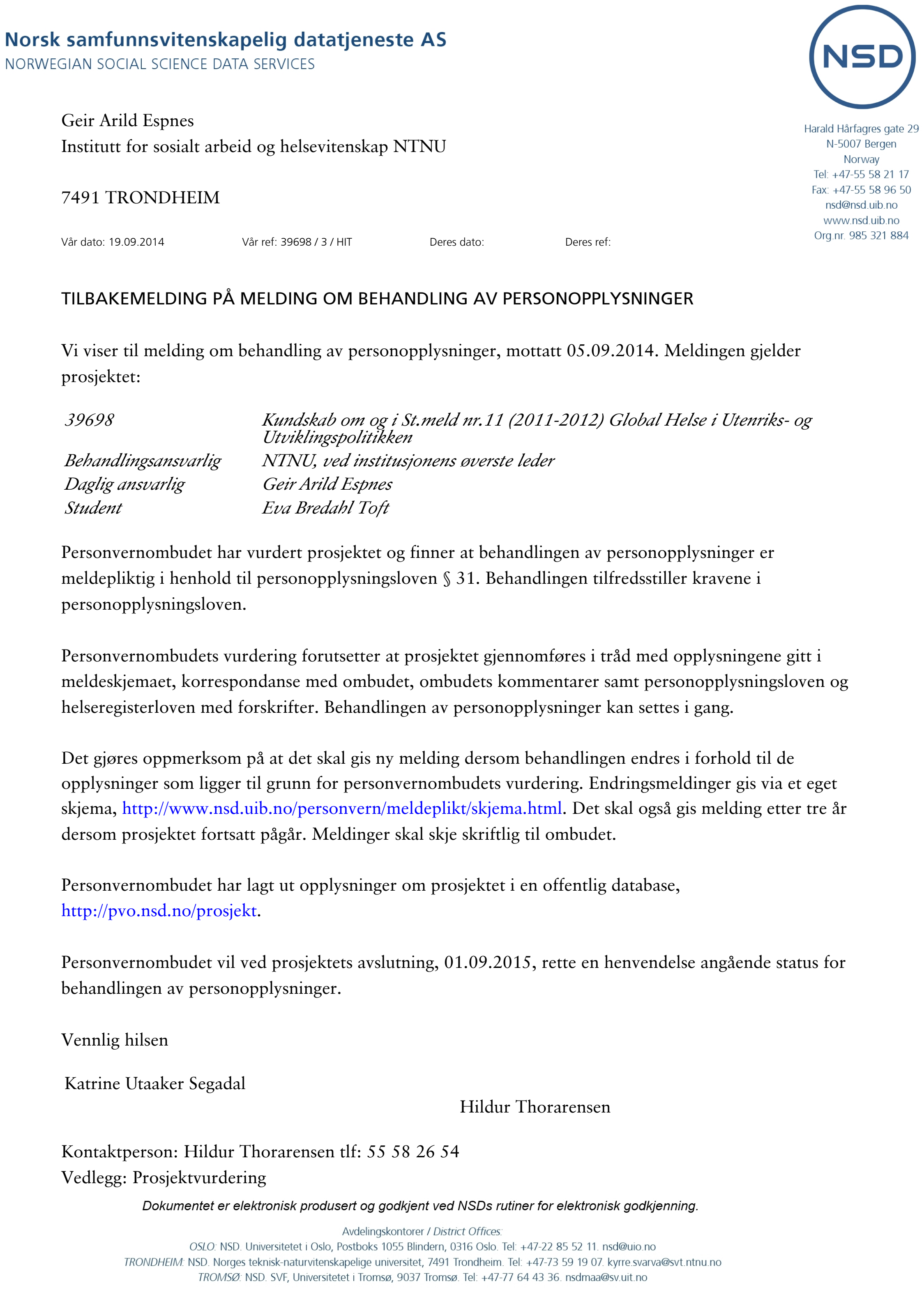
APPENDIX

APPENDIX A: KEYWORDS

Policymaking
Health Promotion
Mortality
Policy
Global Health
Child mortality
Maternal mortality
Malnutrition
Undernutrition
MDGs
Millennium Development Goals
Evidence-based policy
Transparency
Transparent
Transparent policy
Government programmes
Government documents
Developing countries
Child health
Women’s health
Global health policy
Evidence
Health policy

APPENDIX B: RESEARCH APPROVAL FROM NSD



Norsk samfunnsvitenskapelig datatjeneste AS
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Geir Arild Espnes
Institutt for sosialt arbeid og helsevitenskap NTNU

7491 TRONDHEIM

Vår dato: 19.09.2014 Vår ref: 39698 / 3 / HIT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 05.09.2014. Meldingen gjelder prosjektet:

39698	*Kundskab om og i St.meld nr.11 (2011-2012) Global Helse i Utenriks- og Utviklingspolitikken*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*Geir Arild Espnes*
Student	*Eva Bredahl Toft*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 01.09.2015, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / *District Offices:*
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
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TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 39698

Prosjektet gjennomføres i samarbeid med UNICEF Norge. NTNU er behandlingsansvarlig institusjon. Personvernombudet forutsetter at ansvaret for behandlingen av personopplysninger er avklart mellom institusjonene. Vi anbefaler at det inngås en avtale som omfatter ansvarsfordeling, ansvarsstruktur, hvem som initierer prosjektet, bruk av data og eventuelt eierskap.

Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet, såfremt følgende endres:
- delsetningen "men selv de knytter dem ikke sammen med svarene" slettes, da det fremgår av meldeskjema at koblingsnøkkel vil bli benyttet.

Personvernombudet legger til grunn at forsker etterfølger NTNU sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på privat pc /mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 01.09.2015. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette lydopptak

APPENDIX C: INFORMATION LETTER

Forespørsel om å delta i forskningsprosjektet

"Kunnskap om og i Meld.st. 11 (2011-2012) Global Helse i Utenriks- og Utviklingspolitikken"

Bakgrunn og formål

Med grunn i din bakgrunn i Utenrikskomiteen eller som administrativ policy-medarbeider i Utenriksdepartementet forespørres herved om å delta i et masterprosjekt i helsevitenskap, ved NTNU, Institutt for Sosialt arbeid og helsevitenskap i samarbeid med UNICEF Norge. Formålet med masterprosjektet er å undersøke og kartlegge kunnskapsgrunnlaget for Meld.st. 11 (2011-2012) Global Helse i Utenriks- og Utviklingspolitikken. Videre ønsker vi å finne svar på, hvordan denne kunnskapen blir anvendt i policydokumentet samt å intervjue politikkere i Utenrikskomitéen og administrasjonen i Utenriksdepartementet om hvordan de oppfatter sin kunnskap og dermed beslutningsgrunnlaget for Norsk global helsearbeidspolitikk.
Hva innebærer deltakelse i studien?
Prosjektet skal inneholde en dokumentanalyse av Meld.st. 11 (2011-2012) Global Helse i Utenriks- og Utviklingspolitikken, samt personlige intervju med en rekke intervjuobjekter. Hver på ca. 30.min. Intervjuet vil bli tatt opp på lydfil og det vil bli skrevet notater underveis. Spørsmålene vil blant annet omhandle Stortingsmeldingens temaer og om hvordan meldingen blir benyttet i praksis.

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidensielt hele prosjektet igjennom, og ved eventuell skal det ikke være mulig å identifisere enkeltsvar eller personer. Det er kun masterstudenten og prosjektansvarlig, som har tilgang til personopplysningene. Opplysningene og lydfilen med intervjuet vil blev oppbevart efter datatilsynets forskrifter.

Masteroppgaven skal leveres 15.mai 2015 med et påfølgende forsvar. Prosjektet skal etter planen avsluttes 1.september 2015. Data i prosjektet slettes ved prosjektets avslutning.

Frivillig deltakelse.
Det er frivillig å delta i prosjektet, og du kan når som helst trekke fra deltagelse uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg og som du har gitt bli slettet.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Professor Geir Arild Espnes på telefon +47 90165153 eller masterstudent Eva Bredahl Toft på telefon +47 94484703

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Samtykke til deltakelse i prosjektet

Jeg har mottatt informasjon om studien, og er villig til å delta i masterprosjektet med arbeidstittelen ”*Kunnskap om og i Meld.st. 11 (2011-2012) Global Helse i Utenriks- og Utviklingspolitikken*” og samtykker i følgende:

☐ ***Jeg samtykker til å delta i intervju***

(Sted og dato, Prosjektdeltaker)

APPENDIX D: THE INTERVIEW GUIDE

Interviewguide

Interviewguiden er vejledende. Guiden giver nogle retningslinjer for hvilke temaer interviewet skal berøre.

Indledning

Samtykkeerklæringen underskrives og der informeres og at deres deltagelse til enhver tid kan trækkes tilbage.

Briefing

Tusind tak, fordi du vil deltage i mit projekt. Hensigten med interviewet er at indsamle data til mit masterprojekt. Interviewet vil blive optaget på diktafon, så vigtige oplysninger ikke går tabt. Jeg vil også skrive lidt notater undervejs. Dine udtalelser vil blive anonymiseret efter datatilsynets retningslinjer. Det vil kun være min vejleder og jeg, der har adgang til materialet.
Har du nogle spørgsmål inden vi starter?
Hvis du får nogle spørgsmål undervejs i interviewet, så husk på dem, så tager vi dem når vi har afsluttet selve interviewet.

Båndoptageren tændes. Dato, tidspunkt og tilstedeværende præciseres – OBS på at opretholde anonymitet.

Forskningsspørgsmål

1) **Kan du starte med at fortælle lidt om baggrunden for Meld. St. 11 (2011-2012) global helse i udenrigs- og udviklingspolitikken?**
   a) Årsag til den blev lavet
   b) Baggrunden for prioriteringerne

2) **Hvordan blev meldingen udarbejdet?**
   a) Hvilke aktører var med til at udarbejde den?
   b) Processen

3) **Hvem er den tiltænkt til?**
   a) Befolkningen?
   b) Relevante aktører?
   c) Forskningsverden?

4) **Hvis vi tager første prioritering om at mobilisere kvinder og børns helse, hvilken kundskab bygger dette på, og hvordan og hvorfra blev den indhentet?**
   a) Hvilken type evidens?

5) **Hvordan forsøgte i at vise hvor kundskaben/evidensen kommer fra? Og var det et ønske?**
   a) Tilgængelighed
   b) Sådan at folk kunne vurdere indholdet

6) **- Driver man som politiker med at anskaffe sig sin egen viden eller forholder man sig kun til den viden der står i policy-dokumentet? (Til politikere)**
   - **Tror du at politikere indhenter og vurdere egen viden? (Policy-arbejdere)**

7) **Hvordan bruger du kundskaben/evidensen og dermed meldingen til dagligt?**

8) **Mener du der noget der burde ændres i måden at arbejde med en melding på?**
   a) Hvis ja – hvilke?
   b) Hvis nej – hvorfor?

Op-følgende spørgsmål (Til interviewer)
Hvordan tænkte du det? Hvordan gjorde du det? Kan du uddybe det? Så det jeg hører dig sige er...

Debriefing

Jeg har ikke flere spørgsmål. Er der noget du gerne vil tilføje?

Tusind tak for din hjælp

APPENDIX E: THE TRANSCRIPTION MANUAL

I:	Interviewer
Pa:	Participant A
Pb:	Participant B
Pc:	Participant C
Pd:	Participant D
Pe:	Participant E
Pf:	Participant F
…	Small thinking pause
---	Long thinking pause
(Haha)	Laughter
Word	A word with an underline is a word that is emphasised
(?)	A question mark in a bracketed is unclear, recorded material
(…)	Some of the quote is taken out
[]	If a word needs an elaboration, the explanation will stand in the bracket.

Words like ohm, hmm, cough and repetition is omitted in the transcription, if they don't have a subsidising effect or is relevant for the meaning.

APPENDIX F: PRIOR UNDERSTANDING

I have had a guided self-chosen course, where my topic was on the making of the Norwegian public health policy. Here, I learned about the process of making an evidence-based policy from literature and a meeting with a policymaker within health. Further, I had meetings with different relevant stakeholders about the issue of reference use in white papers and also issued the problem myself, when reading different white papers. For instance when I needed a reference, when writing exams.

APPENDIX G: EXAMPLE OF TRANSCRIPT – STEP TWO

arbejder med dette fagfelt, så får du.. der flyder sådan information til dig hele tiden. Du er ligesom en del af et miljø.

KUN
AKT
ANS
UAK

I: Det forstår jeg.

Pa: Det betyder jo ikke, at man er ekspert, når man arbejder her. Man er sådan lidt på overfladen, man tolker informationen, og så tager man beslutninger på grundlag af det.

SP/AP
KUN
AKT

I: Så man tager selv, ja man fortolker selv det man får ind, og så…

Pa: Og så tager man det op til udenrigsministeren, med en tilrådning.

I: Okay … Tror du at, når i så har lavet den her melding, og den er kommet ud til Stortinget. Tror du at, politikere de driver med at indhenter mere information eller tror du de …

Pa: Ja, det gør de kan du sige. Nu er det Utenrikskomitéen, som behandler denne type meldinger. Der er sidder jo personer, som arbejder meget med lignende ting. Det vil sige at de har også en sådan tilsig af information. De kan en del. Det må vi regne med. … Så skal de jo også give en indstilling… fra komitéen. Den må jo bygger på noget. Bygger på politik og sikkert på kundskab, som de har indhentet, hvis der er noget de er misfornøjet med f.eks., så kan det hænde at de laver en undersøgelse og tænker hvorfor har i ikke set på akkurat det eller hvorfor prioriterer i ikke dette højere, når det er så vigtigt. F.eks. det der kom ind på den helse melding nu, er jo psykisk helse, mental health. Hvorfor er det ikke en prioritering i den melding f.eks. Det var sådan en lobby som var interesseret i det. Da kan jeg tænke mig, at de prøvede at indhente data, på hvor stort er omfanget af psykisk problemer i verden og hvorfor gør Norge ikke noget ved det. Sådan gør det nok. Men det ser vi jo ikke.

AP/SP
KUN
ANS
DOK

I: Nej nej. Det var også bare hvad du tænkte hvad de gjorde.

Pa: Jeg tror at de læser og opdaterer sig og indhenter og.

I: Så bra. Hvordan bliver meldingen brugt til dagligt? Nu er det et stykke tid siden. Og nu er der kommet en ny regering. … hvordan bliver brugt i det daglige?

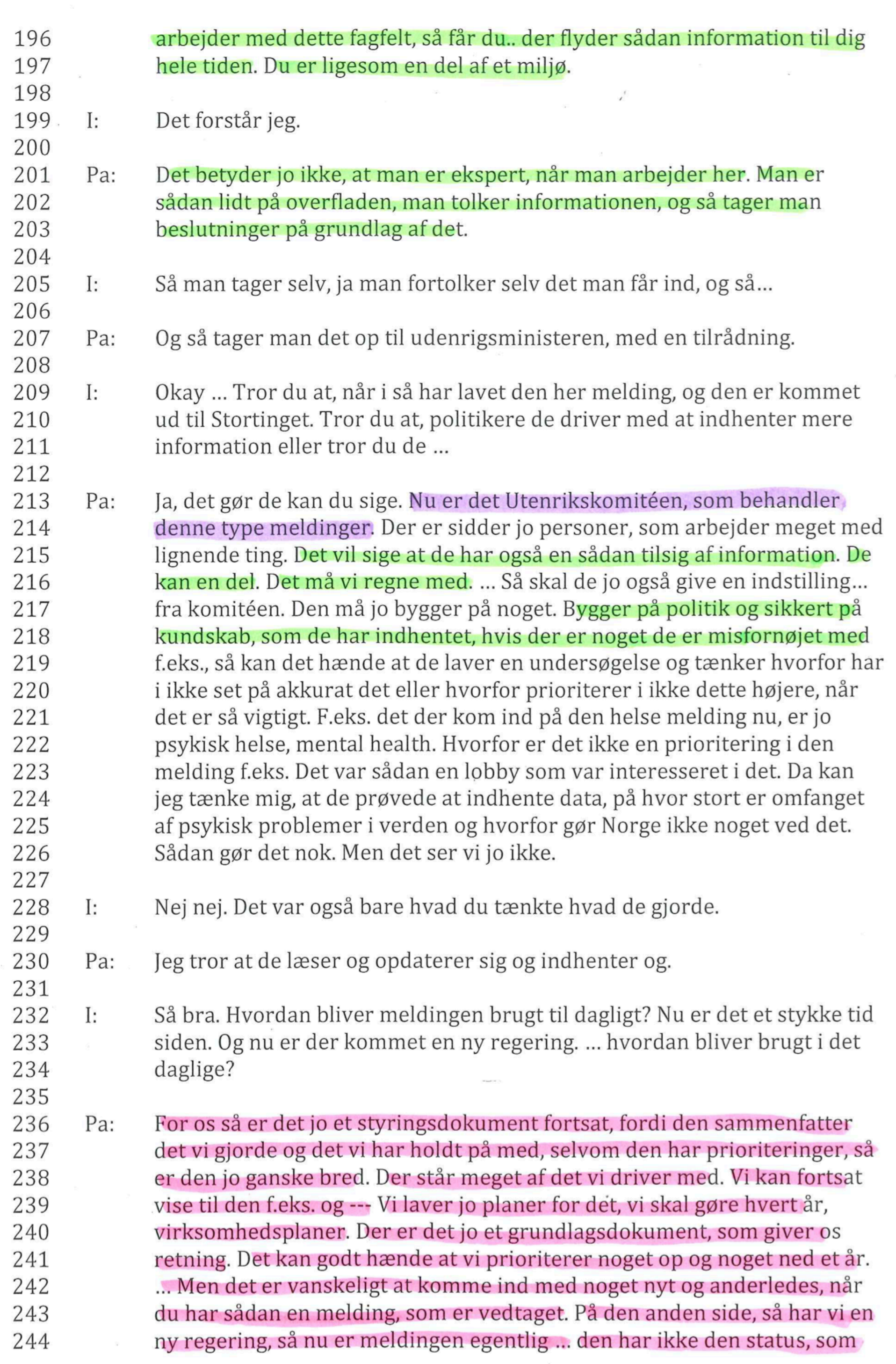
Pa: For os så er det jo et styringsdokument fortsat, fordi den sammenfatter det vi gjorde og det vi har holdt på med, selvom den har prioriteringer, så er den jo ganske bred. Der står meget af det vi driver med. Vi kan fortsat vise til den f.eks. og --- Vi laver jo planer for det, vi skal gøre hvert år, virksomhedsplaner. Der er det jo et grundlagsdokument, som giver os retning. Det kan godt hænde at vi prioriterer noget op og noget ned et år. … Men det er vanskeligt at komme ind med noget nyt og anderledes, når du har sådan en melding, som er vedtaget. På den anden side, så har vi en ny regering, så nu er meldingen egentlig … den har ikke den status, som

DOK
ANS
VÆRK
POL
AKT

APPENDIX H: THE CODE MATRIX – STEP THREE

Participant **Code**	*P-A*	*P-B*	*P-C*	*P-D*	*P-E*
Process **Sub:** Background Actors Sub-actors Responsibility	8-37, 42-51, 53-55, 59-63, 67-70, 75-77, 82-84, 213	10-11, 20-30, 34-45, 50-56, 61-66, 72-79, 87-94, 154-156, 261, 293-296, 329-333	13-43, 46-58, 75-82, 84-86, 111-113, 126-127, 215-223, 239-244	9-12, 47-50, 55-71, 77, 81-83, 89-93	10-17, 24-28, 42-46, 51-54, 70-89, 102-104, 108-115, 130-136, 152, 174-176, 180, 184-186, 195-197, 232-264, 322-325, 332-333, 387-398, 405-408, 424-430, 567-575
Tool **Sub:** Documentation Tool	77-79, 111-118, 236-256	142-144, 244-249	43-46, 106-107, 144-150, 189-199, 205, 227-229	17-21, 25-27, 41-43, 83-85, 179-180, 230-235, 242-248, 252-254	84-86, 254-264, 315-328, 332-333, 348-349, 405-408, 434, 450-455, 501-502, 515-516, 521-524, 532-536, 551-562
Knowledge **Sub:** Knowledge Difference in culture	79-82, 84-92, 103-107, 137-144, 161-163, 170-173, 186-203, 215-216, 217-218	94-99, 103-105, 109-110, 132-142, 168-181, 188-193, 197-209, 224-230, 250-253, 257, 263-264, 282-283, 287, 300-304, 342-345	86-88, 113-119, 124-126, 130-135	98-99, 103-115, 149-159, 171, 180-183, 195-196, 200-204, 208-219, 224	277-281, 301-304, 460-461, 501-502

APPENDIX I: EXAMPLE OF TRANSCRIPT – STEP THREE



arbejder med dette fagfelt, så får du.. der flyder sådan information til dig hele tiden. Du er ligesom en del af et miljø.

I: Det forstår jeg.

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”If your actions inspire others to dream more, learn more, do more and become more, your are a leader”

John Quincy Adams