Translation of WHO-policy in Norway and Cuba

Directives from The Word Health Organization in states with different governance systems and economies

PER SCHULTZ-HAUDT

SUPERVISOR
Gro Kvåle

University of Agder, [2022]
Faculty of Social Sciences
Department of Political Science and Management

Acknowledgements

The most important things you can do to succeed in life is to never give up and to never overlook the advice given to you through your gut feeling, your friends and most importantly, those devoted to a greater cause. For me, there is no greater cause than the ever long quest for honest truth. I feel immense gratitude for having had the opportunity to spend five years of my life to expand my knowledge of the how the world functions, an honor that has been bestowed on me largely due to the random artifacts of circumstance that led to me being here in this venerable country at point in history.

Especially, I would like to thank my phenomenal supervisor, Gro Kvåle, for her unwavering patience, guidance, and kind words of encouragement throughout the process of me researching for and writing this thesis. Whenever challenges seemed too large, and times seemed dark you shined a light on my path and showed me what direction to go. I would also like to thank Charlotte Kiland and Dag Olaf Torjesen for their feedback in meetings and seminars, they too guided me through their expert perspectives, and I am very grateful. A large thanks also goes out to all my professors and lecturers throughout my five years at the University of Agder!

I would also like to extend thanks to my parents, family, and friends for giving me the support and motivation I needed to accomplish my educational goals. Nevertheless, my undying gratitude goes to my wife more than any other. Throughout our life together and especially this last year Irina has been incredibly supportive and has motivated me push through the adversity I faced while working on this thesis. Thank you all for lifting my spirits to help me finish my master thesis in Political Science and Management!

Per Schultz-Haudt
02.06.2022

Summary

Transnational governance is governance that takes place across national boundaries and involving a diverse set of actors. One such actor is the World Health Organization which is central to transnational collaboration and policy development globally. Recently the WHO played an integral role in the worldwide battle against the Covid-19 pandemic and the organization has been a central figure in global public health through its declarations and directives that effectively constitute transnational policies. Perhaps the most prevalent of these are the Ottawa Charter and the Health in All Policies that emerged after it.

Norway and Cuba are two public health puzzles that despite their large differences in governance structures and economies both have good results in population health. Both are members of the WHO, but how have the two countries translated transnational policy in the form of WHO-policy into public health measures and policies?

This thesis seeks to answer this question with the help of translation theory as a theoretical framework to interpret how WHO-policy is translated into the Norwegian and Cuban contexts, using a multi-case design. A literature review was conducted to acquire and systematize data that was analyzed through a content analysis of both cases. The aim of this study was to contribute to the literature about the implications and significance of transnational policy on the national levels.

Some central findings are that national Norwegian public health policies that were found to be largely reproduced from WHO-policy elements. However, there is a level of conflict between the overarching policies of the national level and the municipal actors who work with implementing them.

Additionally, Cuban public health work was found to largely be based around community involvement and situationally contingent public health measures that appear to be modified translations of WHO-policy.

The main finding of this thesis as it pertains to transnational governance is that national translations of transnational policy are likely to be reproduced to a much larger degree than regional and local translations that are more likely to be modified by the recipient contexts.

Contents

1 Introduction

In this thesis I investigate the impact of transnational governance on the national governance levels of two very different countries. Governance is increasingly seen as taking place across and beyond national boundaries (Djelic, 2011, p. 36). This phenomenon is referred to as transnational governance and represents the notion of governance and rule-making taking place outside of the traditional state structures and involving diverse sets of actors (Djelic, 2011, pp. 38-39). One aspect of transnational governance is nations and various other actors such and international organizations, public organizations and non-governmental organizations forming various networks of collaborations and interactions that take form according to what governance challenge they are interested in (Djelic, 2011, p. 39). One such actor is the World Health Organization (WHO) which is central to transnational collaboration and policy development globally and who's primary field of interest is health. Recently the WHO played an integral role in the worldwide battle against the Covid-19 pandemic (Gostin, 2020) and the organization has been a central figure in global public health through its declarations and directives. For instance, having a broad perspective on the public health challenge, involving all factors of health and not solely healthcare providers, has been on the global health agenda since 1986, when the WHO launched the Ottawa Charter. The Ottawa Charter was the result of the first Global Conference on Health Promotion and built on the prior Alma Ata Declaration on Primary Health Care from 1978 and a debate at the World Health Assembly on intersectoral work for health the same year (WHO, 1987, p. 5). Last year the WHO celebrated the 35th anniversary of the Ottawa Charter and the hosted the 10th Global Conference on Health Promotion (WHO, 2021a). The Ottawa Charter layed the foundation for the development of a trend called HiAP (Health in all Policies) (Kvåle, Kiland, & Torjesen, 2020, p. 150). HiAP places the responsibility of public health work across all sectors as a strategy to contend with the complex problem of public health by taking into account the implications on health that follow from all policy-making decisions (Synnevåg, Amdam, & Fosse, 2018, p. 983). This aspect of transnational WHO policy will be discussed in more depth later in this thesis. Transnational governance and policies, especially in the field of public health, are interesting research topics for political scientists and arguably more relevant now than ever. To be able to investigate the significance of transnational governance on the national governance levels translation theory is used since it is concerned with the travel of ideas from contexts to contexts. This theory serves as a tool to examine how transnational policy has been implemented into national policies and public health measures within countries. Additionally, when used as a

theoretical framework for analyzing case data, it allows for informed discussion of what factors determine transnational policy translations and to what degree the policy has any impacted the countries in question.

This thesis consists of a multiple case study of two countries with drastically different governance systems and economies, but with similar and high-ranking population health results. As discussed later in this chapter, Cuba and Norway are two distinct, puzzling, and interesting cases of public health and so they provide much nuance to the analysis if this thesis. This is advantageous to the academic contribution this thesis as it explores transnational policy implementation in countries that are similar in their good results in population health, but that have likely achieved their results using very different political methods. Instead of merely providing a one-sided story this thesis provides two varieties of manifestation of the studied phenomenon providing greater understanding of possible, relevant factors of transnational policy translations and thus, possibly more generalizable knowledge.

1.1 Transnational policy

The transnational level of governance is one that reaches, not only across a particular national border, but across many national borders with a certain degree of authority. Abbott (2012, p. 572) classifies organizations as being transnational if "…they operate in more than one country and include private actors and/or subnational units of government as well as, or rather than, states and interstate organizations (IOs)." And as engaging in governance if they "… possess the authority and undertake to steer the conduct of target actors toward collective goals".

One way these organizations steer the conduct of other actors is through the spread of reform packages that lead to changes in policy on the national level (Djelic, 2011, p. 55). Stone, Porto de Oliveira, and Pal (2020, p. 5) describe the European Union, the World Bank, the OECD (Organization for Economic Co-operation and Development) and the United Nations (UN (of which the WHO is a part of)) as forceful agents of transnational policy transfer that facilitate development of policy ideas, generate consensus regarding global policymaking and circulate policy models. As will be discussed later in this chapter, the WHO has played a large role as a facilitator of public health policies globally.

1.2 Research question and time restriction

Member states of the WHO are plenty (194 nations total (WHO, 2021b)) and are also diverse in their administrative, economic, cultural and political compositions. I expect the national translations, transfers, or implementations of WHO-policy to reflect that diversity. In this thesis I seek to illuminate how the directives from the WHO, in the form of WHO-policy, are incorporated into or in other ways are translated by countries with especially different governance systems and economies. The main research question in this thesis is:

> **How have countries with different governance systems and economies translated transnational policy in the form of WHO-policy into public health measures and policies?**

Regarding the time restriction of the project, I considered that the WHO has a long-lasting history and that it was possible that not only recent events would be relevant to shed light on the issue, but older events as well. Therefore, the time limit for what might be relevant was set to be quite long. With the starting point for the featured WHO-policy having its origins in WHO's guidelines from the 1980s, it was natural to limit the research project's time perspective from then until now. However, in the data acquired through reliable sources selected through a systematic literature review presented below, little evidence of much relevance to the research question was found dating all the way back to the 1980's.

1.3 WHO Policy

In 2008, the WHO formally linked HiAP with social inequalities in health with the assumption that upwards movement on the socio-economic latter is associated with increased quality in health (Kvåle et al., 2020, p. 150; WHO, 2008). This follows the concept often referred to as the social gradient in health, meaning the more poor people are the worse their health is likely to be (Backwith & Mantle, 2009, p. 502) due to worse social determinants of health. The gradient is a wicked problem (Kvåle et al., 2020, p. 160) that furthers the complexity of the public health challenge. Additionally, the problem of public health more generally is described by researchers as a wicked problem that requires intersectoral action because (arguably) the determinants of population health lay mostly outside of the health sector (Synnevåg et al., 2018, p. 983). (Wicked problems are public challenges that are complex and interwoven, and where no solution is obvious, true or false (Head & Alford, 2015)).

The core directives given by the health promotion conference and presented in the Ottawa Charter were to increase intersectoral action for health (IAH), to ensure that decision-makers are aware of the health consequences that result from political decision-making, to ensure that health-promoting environments are maintained and to increase access to and strength of community action for better health outcomes (WHO, 1987, p. 6). A challenge countries face while working with the charter's directives is managing to set health as a goal for other sectors and organizations than those who are traditionally concerned with health and to coordinate them to work together without eroding the quality and effectiveness of those sectors and organizations in the process (Kvåle et al., 2020, p. 50). J. M. Spiegel et al. (2011, p. 22) criticized the international response following the Ottawa Charter. They argued that the decades following its launch the dominant priorities of the international community were related to financial matters that were addressed in the form of New Public Management. There were supposedly less of an emphasis on health promotion and the language of the Ottawa Charter seemed to be used to initiate intersectoral cooperation to make up for the lack of commitment to in public sectors. Nevertheless, the Ottawa Charter marks an important step in globally initiated health promotion and its effects on national policies and practice are widespread and global (Potvin & Jones, 2011).

Here I describe what specific transnational policy I chose to investigate as representative of the larger phenomenon of transnational policy. This is necessary as an operationalization is needed to be able to measure transnational policy, as this is a theoretical phenomenon and therefore impossible to measure directly (Bukve, 2021, p. 103). This thesis discusses the phenomenon of transnational policy traveling from the transnational level to national level. The specific assembly of elements that the transnational policy in question consists of is based around the Ottawa Charter and its associated and emergent principles and trends. The core ideas in the Charter are IAH, community action, healthy environments, and health-conscious decision-making. These form the main body of the policy I was interested in observing. In addition to this I wanted to shed light in the preventative aspects of WHO-policy such as HiAP principle and addressing the social gradient and social determinants of health. As Karlsen et al. puts it, HiAP encourages examination of the determinants of health and implies that they are "mainly controlled by other sectors than health" (Karlsen, Kiland, Kvåle, & Torjesen, 2022, p. 1). My logic for including these in the same category and as representative of, or indeed as the same WHO-policy, is due to the fact that the Ottawa Charter mentions social factors of health. This is clearly a precursor to the idea of social determinants of health that later showed up in national policies and transnationally in a WHO report from 2008 ("Closing the gap in a generation:

health equity through action on the social determinants of health…" (WHO, 2008)). Also, the charter has a clear emphasis on intersectoral work for health and a completely wholistic view of health promotion (WHO, 1987). This combined with the interconnectedness between these ideas made me decide to focus on these elements specifically. Later in this document the phrase "WHO-policy" will refer to these specific elements as described here. Notably, community action and intersectoral action/work for health, healthy environments, health-conscious decision-making, the HiAP principle, the social gradient and addressing social determinants or factors of health.

A natural question that follows then is, why or how is WHO-policy representative of the greater phenomenon of transnational policy? The WHO fits Abbott's classifications of a transnational- and governance organization as it sets public health goals and policies and is a globally spanning organization with 149 offices (subnational units) in different countries around the world and has 194 member states in total (WHO, 2021b). It is thus undisputable that the WHO is a transnational governance organization. The Bitannica Dictionary (2022) defines the word policy as referring to "an official accepted set of rules and ideas about what should be done". Additionally, regarding health-related policy and specifically mentioning the Ottawa Charter, de Leeuw, Clavier, and Breton (2014) emphasize that policy is a driver for development and implementation, as opposed to an intervention in itself. It is thus clear that the WHO-policy in this thesis can firmly be placed in representation of the general phenomena of transnational policy as the WHO undoubtedly is a transnational (governance) organization and the Ottawa Charter with its principles and emergent trends (as summarized in the term WHO-policy in this thesis) can be interpreted as a policy. This is in line with the Britannica dictionary definition since it is containing officially accepted rules and ideas presented as goals that are established on a transnational level.

1.4 The cases

Here I argue for why these cases are chosen, based on their diversity in governance and economy and the idea of these countries being "puzzles" of public health. Then I address the two cases that are chosen in this thesis and give a quick overview of their respective approaches to public health work.

1.4.1 Two puzzles

Cuba and Norway are interesting to use as cases for several reasons: Cuba has a reputation for being a leader in the health sector, which seems contradictory from a western political perspective as Cuba is a socialist republic with a totalitarian regime as a governance structure (Britannica, 2021) and a low gross domestic product (GDP) of 9,100 US dollars (USD) per capita (measured in 2019) (The World Bank, 2021a). As Backwith and Mantle (2009, p. 500) puts it; "the Cuban situation is unusual and perhaps unique". Norway, on the other hand, is a parliamentary and constitutional democracy (Thorsen, 2021) with a high GDP of 75 826 USD per capita (measured in 2019) (The World Bank, 2021b). However, both countries have high scores for life expectancy at birth: 83 years in Norway (The World Bank, 2021d) and 79 in Cuba (The World Bank, 2021c), as well as low infant mortality rates with Norway at 2 (The World Bank, 2021f) and Cuba at 4 (per 1000 live births) (The World Bank, 2021e). The good results in population health despite the variation between Cuba and Norway are central to the theme of this study as it provides variation in public health solutions due to the different challenges they have and seemingly have overcome to achieve such scores in public health. Additionally one researcher describes Norway as a "public health puzzle" and argues that the high quality of health it is experiencing is amplifying the comparatively low quality of health still experienced in the country (Bambra, 2011). The Cuban health paradox and the ambiguous Norwegian public health policy (Kvåle et al., 2020, p. 159), as well as their similar good population health outcomes despite the differences in governance and economy are the basis for my choice of these two countries as empirically studied contexts. In the method section of this thesis, I will further discuss the case choice and elaborate on why variation in cases is desirable in qualitative research.

1.4.2 Norwegian public health

Norway's journey with the WHO-policy begins with HiAP entering Norwegian politics through the Norwegian Public Health Act (PHA) from 2012 (Regjeringen, 2021). As a result of a collectivist perspective on public health the PHA formed the basis for, among other things, an encouragement from the government of municipalities' procurement of public health coordinators (PHCs) (Kvåle et al., 2020, p. 157). In an article from Kvåle et al. (2020, pp. 159-161) it is argued that Norway's approach to public health work, which is characterized as a hybrid between individualistic and collectivist logic, is hampered by too little accountability of

the state, which may lead to insufficient reduction of social inequalities. A study they refer to establishes that Norwegian municipalities' work towards fair distribution to counter social health inequalities corresponded negatively with municipalities procurement of PHCs (S. Hagen, Overgard, Helgesen, Fosse, & Torp, 2018). However, a later study found that the employment of PHCs in conjunction with organizational measures to improve their effectiveness can be an important tool for HiAP in local public health policies (Karlsen et al., 2022).

Another study presents the academic consensus of Norway having relatively high social inequality in health, but that this is in fact due to the positive achievements of the country and that researchers need new methods for properly investigating that phenomenon (Bambra, 2011). However, it remains that health inequalities in Norway is larger than in many other European countries and is growing (Folkehelseinstituttet, 2018, p. 8). This forms my opinion of the Norwegian case as being quite ambiguous and complex in nature. On the one side Norway is a country that has worked towards health equity through various measures, but on the other side it has a problem of growing health inequality. A paradox in Norwegian public health arises as the inequalities are growing despite the country's' wealth and welfare offers.

1.4.3 Cuban public health

Cuba has supposedly had a perspective on public health that emphasizes a connection between health and, among other things, social factors since 1974, something the national plan "Medicina de la Comunidad" (Community Medicine) the same year expresses, which was a plan that market the starting point for Cuba's intersectoral approach to public health work (Pagliccia & Pérez, 2012, p. 83). Cuba is a country that, over the past 50 years, has had quite unique and formative challenges, primarily the Cuban Revolution in 1959 and second the impact of the dissolution of the Soviet Union in 1991. These events seem to have left their marks on country's public health approach, as it was left with little choice but to investigate alternatives that contributed as little as possible to further the financial predicament it found itself in. Despite the circumstances, Cuba is known to have exceptional public health policy compared to similar countries in Latin America and is hailed as a success story and a role model for countries with similar challenges by both researchers of- and well-known actors in transnational governance (James Wolfensohn (World Bank) and Margaret Chan (WHO) (Pagliccia & Pérez, 2012, p. 79).

An article from the International Journal of Epidemiology from 2003 provides a comprehensive list of Cuba's health-related achievements over time. One of these is Cuba's infant mortality rate, which was on a par with Canada and the United States in 2003. Countries such as Bolivia, Brazil and Argentina lagged far behind (Cooper, Kennelly, & Ordunez-Garcia, 2006, p. 818). Cuba's public health policy is interesting as it could show that economic development is not necessarily the strongest predictor of public health development (the Cuban health paradox) and that well-developed public policy, independent of external forces is paramount (Pagliccia & Pérez, 2012, p. 79; J. Spiegel & A. Yassi, 2004). As the locals say "[Cubans] live like the poor and die like the rich" (J. M. Spiegel et al., 2011, p. 16), summing up the puzzle of Cuban public health quite nicely.

1.5 Thesis structure and composition

This thesis is structured into seven chapters. Chapter 1 consists of an introduction of the topics, themes, and purpose of this thesis as well as a section about transnational policy, a presentation of the research question of the thesis, some background information on WHO-policy and a presentation and discussion of the two cases studied and the reasons for choosing them. Chapter 2 presents the theoretical background and framework I utilize; these are mainly transnational governance and translation theory. It also elaborates on WHO-policy as a translation object or as the group of ideas that are translated from the transnational- to the national level. Chapter 3 discusses the main design and method used for acquiring, systematizing and synthesizing data and how they are applied in this thesis with regards to validity, reliability, and transparency. Chapter 4 presents the data sources and the analysis of the cases, first the Norwegian case and then the Cuban case. It also contains summaries of each content analysis. Chapter 5 discusses the main findings of the thesis and their implications for the research question of this thesis. Chapter 6 consists of a conclusion and suggestions for further research. Lastly, Chapter 7 contains closing remarks and reflections about the thesis.

2 Theory

In relation to the project's theoretical and analytical limitations, the research problem focuses on translation of transnational policy and is based on two distinct cases. The theory to be used to illuminate the phenomena has already been determined and it will therefore be natural to say that the project has what Bukve (2021) calls a fixed framework. The investigated phenomenon in this thesis is the movement of transnational policy from the transnational to the national and local level. With the help of translation theory I investigate the phenomenon for the purpose of expanding insight about it (Bukve, 2021, p. 212). I do this based on insight gained from a multi-case study of public health policy. The cases are both based on the same policies from the same transnational policy arena but are colored by very different countries, both in terms of governance and economy.

2.1 Theoretical departure

An article with the title "From the Rule of Law to the Law of Rules" (Djelic, 2011) illustrates how the literature on globalization has moved from having a strong focus on the Westphalian, state-centric conceptualization of governance towards a greater focus on the transnational level. Central to the understanding of governance is the concept of "transnational governance", it describes policymaking as happening decentralized and often multicentered and fragmented as opposed to unified (Djelic, 2011). Governance can thus be seen as something that emerges out of many different actors and not necessarily out of traditional governance institutions such as states. An example of how transnational governance can take place is through states translations of "soft laws" to "hard laws" (Djelic, 2011).

Especially relevant to this thesis, is the notion of states not acting in a vacuum but being influenced by each other as well as nongovernmental actors (Djelic, 2011). It would be worthwhile to contribute to the understanding how governance is affected by international organizations such as the WHO.

One field of research aiming to understand how ideas, practices and knowledge move from one setting to another, and undergo changes in the process, is the field of translation theory (Wæraas & Nielsen, 2016). Translation theory has its origin in translation of language, but instead of languages translation theory in organizational research centers on ideas, practices and knowledge that moves from context to context (Røvik, 2016). In this theoretical approach what is being translated is called translation objects. From a Scandinavian institutionalist

perspective, the translation object undergoes a transformation because of the translation process and the variation between the context it emerged in and the one it settles into (Wæraas & Nielsen, 2016).

Translation theory is relevant to this thesis as it provides a framework for interpreting the directives from the WHO, and how they have been implemented in the two cases, as these can be identified as translation objects.

Research based on translation theory has traditionally dealt with management ideas being transferred between contexts. Wæraas and Nielsen (2016) lists largely conceptual ideas that I find comparable to the WHO-policy in this thesis that have been studied using translation theory. These are lean, reputation management, Total Quality Management, MBA Models and hospital management innovation (Wæraas & Nielsen, 2016, p. 247). However, my goal is to use the growing knowledge about translation processes to investigate two cases of translation of transnational policy to national conceptualizations and practices. I am not the first to use translation theory to analyze policy implementations (see: Creed, Scully, and Austin (2002), categorized as having "policies" as translation objects by Wæraas and Nielsen (2016)) and some researchers in the field of policy implementation studies have already referred to the process of policy implementation as a process of translation (Sausman, Oborn, & Barrett, 2016, p. 564). Additionally, Djelic (2011) in an article on transnational governance, often mentions translation specifically when discussing national implications of transnational soft law and political pressure.

2.1.1 Transnational Governance

Here I discuss transnational governance and its importance related to policy translations and the underlying motives behind them. The purpose of this section is to acknowledge the greater picture and achieve a bird's eye view of the relevant theoretical contributions in transnational governance that are crucial to a nuanced view of the most fundamental mechanisms involved in the topic of this thesis.

The theory of transnational governance, as mentioned above, explains how the world of governance is decentralized, fragmented and multicentered, and therein that policymaking is impacted by soft laws. Furthermore, international organizations (IOs) have a critical role in these processes, especially those who are transnational rule-making arenas. These are often much less structured and formal compared to national institutional settings (Djelic, 2011, p.

53). Soft law is a way for "Trickle-down trajectories" to take place (Djelic, 2011, pp. 52-54). The concept of trickle-down trajectories describes transnational organization's impact on national systems of government. The transformation of soft laws into hard laws is one of the mechanisms of manifestation of trickle-down trajectories, other kinds of mechanisms are *conditionality* based and marketing based in nature (Djelic, 2011, p. 54). A good example of a conditionality-based soft law is the Europeans Union's criteria for membership: The EU requires new member states to transform their hard law systems and local rule to be accepted to join the organization (Djelic, 2011, p. 54). This puts pressure on potential member states and has a great impact on European countries' internal governance. Then there is the marketing-based, trickle-down trajectories that are characterized by seduction, socialization, and network strategies (Djelic, 2011, p. 54). The method of the mechanisms that fall into this category is to associate the soft laws of a transnational rule-making arena or other type of IO with legitimate notions such as science and expertise. They can also show up as forms of peer pressure between states and organizations that deliberately elicit a sense of a "risk of exclusion" from markets and political arenas (Djelic, 2011, p. 54). Assuming that states are competitive in terms of foreign affairs and international relations, it seems that aligning themselves with soft laws to increase the likelihood of being perceived by peers as legitimate, largely incentivizes states to go along with them, giving further power to the transnational arenas that create them. Haack, Pfarrer, and Scherer (2014) discuss how organizations have been criticized for associating themselves with agencies in the United Nations system (which WHO in a part of), accusing them of "blue washing," a term referring to the color of the UN flag. This is an example showing how organizations are believed to be invested in a battle for legitimacy and that they can be conceived of as having an incentive to associate themselves with transnational policy arenas such as the WHO. I believe that due to the incentives and pressures presented here, states all over the world seek recognition from and alignment with organizations like the WHO, at least to a degree. This demonstrates the motivation for the implementation of soft laws but does not give an instrumental framework for how to analyze independent cases of soft law adoption and alignment. The following is an overview of- and a discussion about the framework I use to analyze the cases and acquire nuanced information and knowledge about the greater phenomenon of movement of transnational policy.

2.1.2 Translation vs. diffusion

Scholars agree that ideas and practices move between organizations, from one setting to another. What has been a point of disagreement is where the power to move the ideas come from and what conclusions we can pull from the movement of ideas and practices to study them better (Wæraas & Nielsen, 2016). Organizational theory discussing the spread of ideas from organizations to other organizations started by highlighting what researchers call diffusion processes. The diffusion perspective is a neo-institutional or American institutionalist approach that conceptualizes ideas that spread as emanating from a central point and losing its concentration and/or composition as it travels further away from its original context (Andersen & Røvik, 2015, p. 5; Røvik, 2016, p. 2; Wæraas & Nielsen, 2016, p. 245). This conception has since been criticized by advocates of the translation approach (mainly Scandinavian institutionalists), as being suboptimal as it prescribes the energy of the transfer of ideas to one certain point and subsequently missing out on the complexity that is characteristic of the phenomenon, given the perspective of the movement of ideas and practices being potentially a multicentered process (Czarniawska-Joerges & Sevón, 1996, p. 23; Røvik, 2016, p. 2) . Instead, the proponents of the translation approach and perspective suggest that the energy provided for the ideas and practices to move emanate from the responses that the ideas trigger in those who translate the them (Czarniawska-Joerges & Sevón, 1996, p. 23; Røvik, 2016, p. 2). In addition to diffusion, Neo-institutionalists also believe that idea-spreading leads to homogenization of the organizations that are receiver contexts (Røvik, 2016, pp. 2-3). Meaning the involved organizations become more similar in terms of their strategies, forms, and practices. This is what researchers call the isomorphism phenomenon and it is understood as organizations that are inhabiting the same environments naturally becoming more similar (Røvik, 2016, p. 3). Translation theory contrasts this notion as research shows that organizations implement ideas and practices very differently and that they are transformed by those who translate them into new versions with significant variations from the original ideas (Røvik, 2016, p. 3).

2.1.3 Translation theory

Wæraas and Nielsen (2016) outline three distinct perspectives on how to approach translation theory. These are the actor-network theory (ANT) perspective, the knowledge transfer perspective, and the Scandinavian institutionalism perspective. The ANT conceptualization of translation theory closely resembles the Scandinavian institutionalist perspective (Wæraas &

Nielsen, 2016, p. 244). In the ANT perspective the emphasis is on the actors as they pursue the spread of their ”point of view” as well as the notion that translation objects are changed by those possessing the ”power” to translate resulting in variations in translation (Wæraas & Nielsen, 2016, pp. 242-244). Some researchers using the ANT perspective focus on management ideas as translation objects, similar to the Scandinavian institutionalist perspective, although some concentrate more on value based objects (claims, convictions, interests and meanings) (Wæraas & Nielsen, 2016, p. 243). The knowledge transfer perspective on translation theory emphasizes the conscious transfer and translation of organizational knowledge between organizations (Wæraas & Nielsen, 2016). This perspective also designates significantly more importance to the practical level of translation, often referring to the necessity of expert knowledge, routine changes and translation as a tool to improve effectiveness (Wæraas & Nielsen, 2016, p. 245).

2.1.3.1 Geometric, Semiotic, Political

Wæraas and Nielsen (2016) identify three elements as to clarify the differences and similarities of the three perspectives on translation theory. The elements are the geometric, the semiotic and the political (Wæraas & Nielsen, 2016, p. 248). *Geometric* meaning the translation objects travel from the source context to the recipient context, *semiotic* meaning the changes and new versions (Røvik, 2016, p. 3) that arise as a result of the translation and the *political* referring to the means of which the translation object is promoted or actors are being pressured into absorbing the translation object (Wæraas & Nielsen, 2016). The similarities between ANT and the Scandinavian institutional perspectives are in how they view the semiotic element. The perspectives recognize the process of translating as actively changing the translation object when decontextualizing (Wæraas & Nielsen, 2016), whereas the knowledge transfer perspective is more concerned with how the recipient context is responsible for the variation seen as the result of the contextualization part of the translation processes (Røvik, 2016). The geometric element can be reduced to the idea of translation happening through a source, brokering and the recipient context (Wæraas & Nielsen, 2016). Brokering is here referring to the space between the contexts and how the idea is delivered from one to the other. All three perspectives emphasis the geometric perspective as an important element of the translation process (Wæraas & Nielsen, 2016)

2.1.3.2 Combination of translation perspectives

Although all three approaches are quite similar, the main differences can be reduced to the ANT perspective being more politically minded, the knowledge transfer perspective focusing more on the geometric elements and the Scandinavian institutionalist perspective focusing mostly on the semiotic and the geometric dimensions (Wæraas & Nielsen, 2016). Since these three approaches to translation theory are so similar as well as complementary to each other Wæraas and Nielsen (2016) encourages researchers to combine them when doing translation research. For example the Scandinavian institutional approach could contribute with its added complexity of decontextualization and disembedding to aid with the understanding of how the object of translation is consciously transferred (as per the knowledge transfer perspective) influenced by how the object has developed in the source context (Wæraas & Nielsen, 2016). Another example is how the ANT perspective can be enhanced by paying attention to how networks are constructed in order to facilitate the spread of certain objects of translation with regards to the objects' development due to the decontextualization process (Czarniawska-Joerges & Sevón, 1996; Wæraas & Nielsen, 2016). The knowledge transfer perspective puts an emphasis on the effectiveness of translation processes and asserts a normative notion that effective translations, often because of superior translation competence, are better translations. This aspect of the knowledge transfer perspective is said to be complementary to both the ANT perspective and the Scandinavian institutional perspective (Wæraas & Nielsen, 2016), however I do not see how translation effectiveness has any relevance to my research question as I seek to understand *how* the translation object has been translated, not *how effectively* nor how one translation is better than the other based on conclusions of normativity.

In summary, Wæraas and Nielsen's (2016) geometric, semiotic, and political elements of translations as well as the three perspectives on translations in combination with each other serve as part of my theoretical framework and guide the focus in the discussion of the data in the analysis section of this thesis.

2.1.3.3 Decontextualization and contextualization

Røvik (2016) has developed an instrumental theory of translation to help improve translation competence and thus translation performance. In his work he discusses important concepts in translation theory. These are the geometric and semiotic concepts of decontextualization and contextualization, complexity, embeddedness, explicitness, and modes and their respective

rules. *Decontextualization* or disembedding is understood to be the process of extracting the translation object from its context and describing it independently of it. The potential misstep in decontextualization is to fail to extract the core idea/practice/knowledge and potentially leading to missing out on the benefits experienced by (or, in my case, intended by) the source context. Here the source-context affects the translatability of the object, and the translators are, through their translation, adding variety to the translation. Complexity, Embeddedness, and explicitness speak to the difficulty of the decontextualization process. A translation object is more complex the more it resigns in people and less complex the more it relies on technology. This is because technological objects are physical and more tangible and therefore easier to translate without alteration. Ideas and practices based in people are more susceptible to variation as they must move through more subjective layers as to be decontextualized, or as Røvik (2016) puts it they are based more in "context-specific human skills". Embeddedness refers to the translation object's location. If the object is multicentered (high in embeddedness), then it is harder to decontextualize, if it is in one specific actor/location (low in embeddedness), then the process is less challenging. Explicitness implies to what degree the translation object is written down or otherwise tangible within the source context, if the objects is silent/tacit then there is increased difficulty inherent in extracting out the object from the source context. *Contextualization* refers to the translation of the decontextualized object into the recipient context, from abstraction to reality. The success of the contextualization depends how well the translation object fits into the new context. Sentral questions here are whether the object contains unnecessary elements that do not fit well in the new context or if the object is missing the crucial elements that are required to reach the intended goals of translation.

2.1.3.4 Modes of translation

Røvik (2016) also presents modes of translation. The modes are namely the reproducing mode, the modifying mode, and the radical mode, listed in order from the outcome of the translation process being least different from original translation object to most different. The choice of mode by the translators can be made both consciously and unconsciously. If the choice is made unconsciously then it can be expected to be a result of subjective factors such as culture, habits, administration, economy and traditions in the recipient context.

First, the reproducing mode, is close to simply replicating other organizations ideas and practices. There are obvious economic incentives for using this mode as not much effort needs

to be invested into decontextualizing and contextualizing, this method would also theoretically produce the same levels of positive outcome in the recipient context as in the original context if replication is possible. The mode would also satisfy actors attempting to achieve legitimacy because of following fashions, following the political element of translation (Wæraas & Nielsen, 2016). The rule given to this mode is copying.

Second, the modifying mode, seeks to walk the line between alteration and replication. The idea is to make the translation object fit the recipient's context, but not at the expense of the core, wanted elements. One rule in the modifying mode is addition. The purpose of addition is to clarify the original idea by adding to it so it can make more sense in the recipient context. The other rule in the mode is omission. This is when translators leave out or tone down certain aspects of the translation object to make it more palatable for the new context.

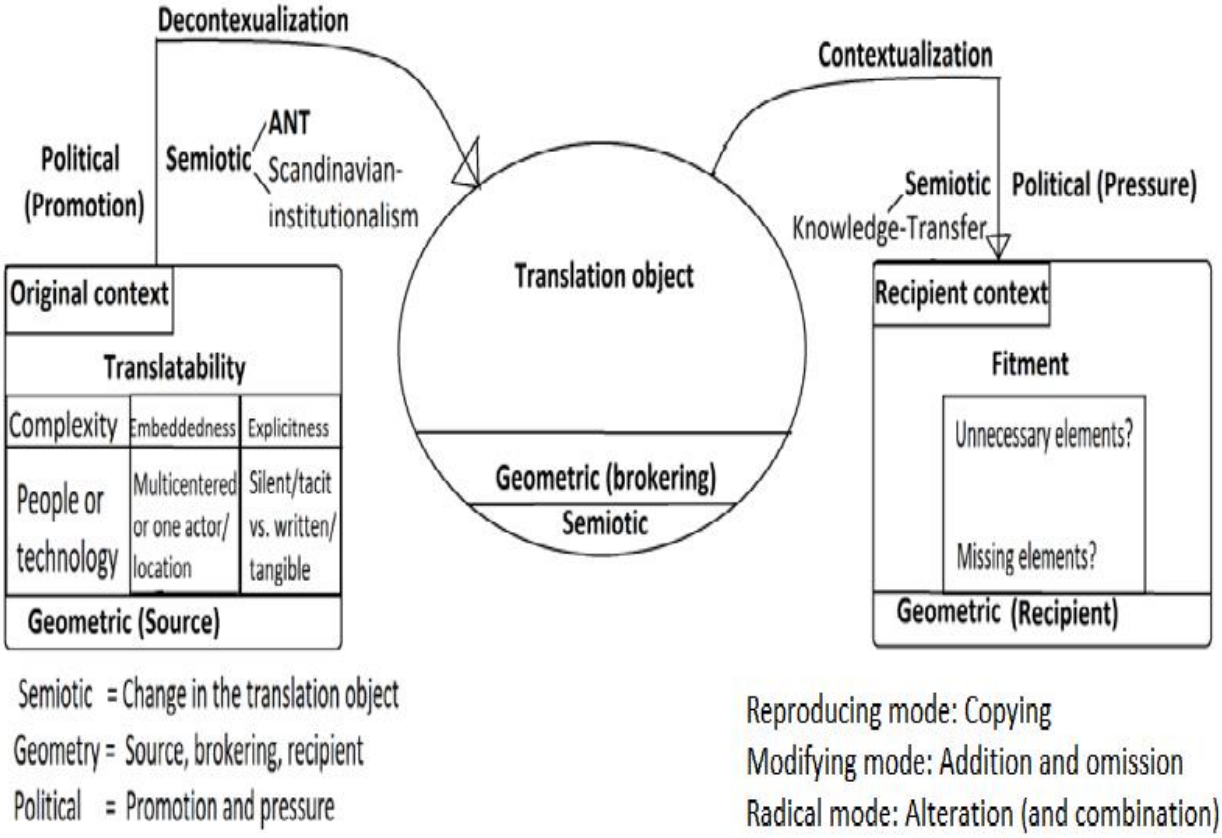
Lastly, the radical mode, takes on the translation object as more of a suggestion than something to imitate. Here the actors who are translating feel very independent from the source context and would perhaps like to avoid being associated with the source actors. The rule in this mode is alteration, meaning transforming the source material or combining it with other objects to create something new.

This theoretical contribution by Røvik (2016), as discussed here, was made with the purpose of guiding deliberate translation processes in mind. Nevertheless, I will use his contributions as a part of my theoretical framework to aid in analyzing the data from my two cases.

Based on transnational governance and translation theory my I expected to find national policies and public health measures that resemble the directives of the WHO-policy in the source contexts. The translation object, transnational policy, WHO-policy would have been translated, thus transformed, and materialized in the Cuban and Norwegian public health systems with a high degree of variety due to the differences between the countries as discussed in the introduction. The ways in which the finished translations would differ from the original translation object and the relevant surrounding data highlighted by the secondary sources (as discussed underneath) would indicate what modes were used in the translations and the rules of the modes (Røvik, 2016) and the elements and perspectives of translation (Wæraas & Nielsen, 2016) were expected to be useful for interpreting and shedding light on how the translations of WHO-policy in both countries had occurred.

2.1.3.5 Applying translation theory

Figure 1 shows the different concepts discussed in the theoretical section of this thesis and their places of relevance in the translation process. Here the WHO is the source context, the WHO-policy is the translation object, and, in each case, the respective country is the recipient context. Decontextualization is the process of extracting the translation object from the sources context and contextualization is the process of implementing it in the recipient contexts. Decontextualization and contextualization is performed by translators who, in the two cases, are policy and governance actors of the respective source contexts. Out of the different concepts described in the theory section the ones that proved most useful to the content analysis in this thesis were the modes and rules of translation, since these can be used to estimate the fitment of the translation object. Because this thesis uses data from the source contexts, the analytical findings are based on the theoretical interpretations of how the translation object appears and differs from its original state when it is described in the source contexts. Subsequently, the resulting knowledge is used to describe how it was translated. Was it copied, was elements added, was something omitted or was the translation object completely altered? Determining what rules were followed and thus what modes were used can aid in understanding the translation processes, discover nuance between the cases and enlighten the phenomenon of translation of transnational policy.



(Figure 1 – Map of the translation process with terms from Røvik (2016) and (Wæraas & Nielsen, 2016))

2.2 WHO-policy as a translation object

The WHO is the original/source context in this thesis. The ideas and proposed practices of the WHO-policy (translation object) originates from it. WHO-policy's translatability is contingent on its complexity, embeddedness, and explicitness. It was developed through conferences and events arranged through and together with the WHO. The background for the development of WHO-policy in general originates in the contexts of the multitudes of countries that work together with the WHO. However, the policy, as described above, is written down in the Ottawa Charter and in reports from the WHO. It has a high level of explicitness since it resides in plainly written documents originally, as opposed to being a living practice in need of extraction from a social context such as an office or other kinds of workspaces. Additionally, it is low in embeddedness. The physical sources of the translation object are relatively limited in number, and I find it hard to imagine the WHO-policy as challenging to "dis-embed" from its source

materials. Although it is easily accessible, this does not mean that it is free from the subjective influence of the translators. This leads to variety in the source context (semiotic). Lastly, the complexity of the translation object is high. The policy is not confined to a specific technology and is not something that can easily be transferred from one context to another. Implementing, integrating, and orchestrating the principles of the WHO-policy into policy and practice on a national and especially local scale is an enormous task and, as will be discussed considering the findings in the empirical part of this thesis, not without its challenges. Also noteworthy about the WHO-policy as a translation object is the political element that follows the transnational reality of the WHO. The organization has legitimacy and soft power and as reviewed in the transnational governance section; there are reasons for states to align themself with its goals and soft laws. There is the risk of exclusion from international arenas and the battle for legitimacy that drive states into alignment and pressures them into accepting the WHO-policy.

A challenge in using translation theory to investigate transnational policy is to be able to separate what is representative of the translation object in the data and what is not. The description of the WHO-policy becomes useful here. The elements that are central to the policy and thus representative of the translational object in this thesis are: Public health work with an emphasis on community, healthy environments, intersectoral work, health-conscious policy decisions, HiAP and social determinants of health. When these topics are found in the data, they are considered as evidence of how WHO-policy has been translated. This evidence in conjunction with translation theory form the basis for analysis in this thesis.

Synnevåg et al. (2018, p. 984) discusses the scope of the HiAP approach regarding how to research it. They consider HiAP as having a whole-of-government and a whole-of society aspect. The whole-of-government term refers to health work across sectors at the national level, while whole-of-society addresses intersectoral work between civil society, the voluntary sector, academia, the private sector, intergovernmental organizations, and other local actors. In this thesis I discuss both of these aspects of the WHO-policy.

3 Method

In this section I discuss what research method was used in this thesis and how I have designed my research strategy. First, I present the qualitative method and argue for why it is appropriate for this thesis. Second, I discuss the "strategic choice" route to theoretical generalizability, the choice of using a multi-case design and the value of nuance in research. Third, I discuss the important elements that form the criteria for high quality research and my attempt to integrate them in my study. And lastly, I give my interpretation of a systematic review; how to collect, select and analyze secondary sources of data. As well as an overview of how I this was done for this thesis.

3.1 Qualitative Method

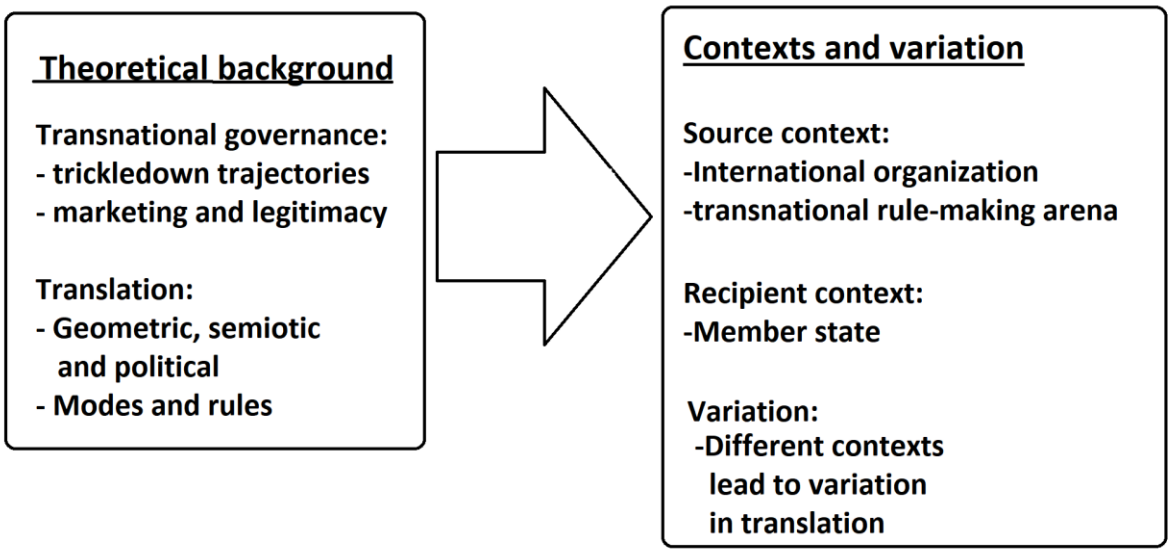
I have chosen a qualitative method because this type of research design is best suited for studies based on *how*-questions and that try to investigate and describe processes (Pratt, 2009, p. 856). The process in this case is the translation of transnational policy. To clarify and justify my choice of research method in this study I see it necessary to discuss what constitutes a qualitative method and how is differs from a quantitative method. Jacobsen (2015, p. 141) explains the difference as such: The qualitative method is associated with a low number of investigated units and the purpose of studies using this method is to maintain the variation and diversity of experiences and interpretations. The quantitative method, on the other hand, is characterized by investigating many units to increase the generalizability through discovering *covariation* between and *extent* of phenomena. In this study I am investigating the phenomenon of translation of transnational policy and my research question is formed in such a way that it is asking *how* it manifests. To answer the question, I need to showcase the variation and diversity of experience of the phenomenon to interpret it as it manifests. If the research question was based on finding out to what *extent* the phenomenon is occurring (say, how widespread HiAP is; how many countries implement is) or aiming at discovering a correlation (manifesting as *covariation*) between WHO-policy and population health, then a quantitative method would be more appropriate. This is because I could use quantitative data (many units) to research such questions. As summarized by Jacobsen (2015, pp. 133-137), the quantitative method is best suited for studies aiming to test hypotheses and theories, that seek to investigate phenomenon

more or less independently from its context and that draw conclusions that are inherently quantitative (how often, how many), whereas the qualitative method is best suited for when studies where the purpose is to develop theories and hypotheses, that seek to discover and create a large amount of information about few units and that seeks a deeper explanation of the studied phenomenon. The purpose of my thesis is to generate a large amount of information about translation of transnational policy with the aim of explaining it more deeply. The cases and their contexts are central to that purpose and as they provide nuance, which I elaborate bellow (in the section called; Multiple case study).

3.2 Case study

The aim of my thesis is to examine *how* different countries work with WHO policy in the hope of contributing to the understanding of how translation of transnational policy happens. To achieve this aim, I have used a case-oriented approach as opposed to a variable-oriented one. Case-oriented studies are often more holistic and variable-oriented studies are often more reductionistic (Bukve, 2021, p. 98). A holistic design is chosen to give a detailed view of the phenomenon that is studied and to give rich and in-depth knowledge of it, whereas studies with a reductionistic design is more usually specific with narrow conclusions that are often more generalizable (Bukve, 2021, pp. 98-100).

When choosing specific methods of acquiring data for the investigation of social phenomena it is important to select data that is relevant for the phenomenon that is being investigated and in case-oriented studies, whether single-case or multiple-case, it is not sufficient to find data that is statistically generalizable as to be representative to the larger population (as it is in quantitative studies), but rather the importance lies in collecting data from cases that have been strategically selected for being representative of the phenomenon that is being investigated in the study (Bukve, 2021, p. 217). The approach taken to achieve theoretical representativeness depends on the type of study that is being conducted (Bukve, 2021, p. 218). Since this study is case-oriented the approach used to achieve theoretical representativeness is what Bukve (2021, p. 218) calls “strategic choice”, this involves strategically choosing cases that coincides with a theoretical departure in the form of a theoretical model that describes contexts and variation connected to the phenomenon the study is investigating. Figure 1 shows the theoretical model that forms the basis for the choice of cases in this study.



(Figure 2 – Theoretical model describing contexts and variation connected to translation of transnational policy)

3.2.1 Multiple case study

The two cases I have chosen are the countries; Cuba and Norway and in terms of an international organization and transnational rule-making arena (see figure 1) I have chosen the WHO of which both countries are members. In this study I investigate them both regarding their respective translations of WHO-policy (in the form of the Ottawa Charter from 1986). Since there is more than one case in this study, it is using a *multiple-case* strategy. Both are cases that differently express the same phenomenon as is consistent with descriptions of multiple-case strategies. Bukve (2021, p. 99) states that in single-case studies the case itself is the phenomenon of interest, whereas multiple-case studies see the cases as multiple expressions or manifestations of the same phenomenon. The variation between them can be useful in that it contributes to the research by adding nuance. Because of the holistic nature of data that is collected using the qualitative method the results of such research is often very nuanced (Jacobsen, 2015, p. 130). Jacobsen (2015, p. 130) explains how the high level of nuance is helpful in discovering what is specific and unique about the contexts that are selected for research. This is relevant to this thesis as the two cases investigated in this study were chosen specifically for their specific and unique contexts, as presented in the introduction. However, the "primary level of analysis" (as Bukve (2021, pp. 99-100) calls it) in is not the cases, but instead the phenomena being expressed in them. My reasoning for conduction a multiple-case

study then is rooted in my interest in the phenomena of translation of transnational policy as opposed to any member-state's case of such a translation. The obvious differences between the two countries, as pointed out in the introduction, serve as sources of variation to allow for a broader view of the phenomenon.

3.3 Research design

The purpose of this thesis is theoretically interpretive. Theoretically interpretive research is well suited to analyzing and clarifying individual phenomena based on established research literature that are expressed through theories and academic concepts (Bukve, 2021, s. 91). What characterizes a study as being theoretically interpretive is that its purpose is to use established theories from existing research literature to shed light on a study's research problem, as opposed to the purpose being to develop new theory (Bukve, 2021, s. 91). The reason why I have chosen a theoretically interpretive research design has its origins in the research problem and the complex nature of the topic, as well as the fact that there already exists theory containing knowledge that can aid in interpretation of the phenomenon that is concerned here. The research question concerns the translation processes that takes place between an intergovernmental organization and transnational rule-making arena, and two countries of differing governance systems and economic situations. Through analysis of the cases, with the help of theory on translation and transnational governance, I aim to shed further light on the translation processes of transnational policy to state-level implementation. Furthermore, since the cases were chosen based on a theoretic model (see figure 1) and strategic selection of cases as described above, this thesis can be said to have a theory-informed strategy where the theoretical starting point is decided early in the research project and used to establish what cases are representative of the phenomenon in question as well as being the theoretical framework on which to build the analysis. In contrast to a strategy based on interpretive reconstruction (another strategy in theoretically interpretive studies), where one proceeds with the data collection in the beginning of the research project, followed by an attempt to determine which theories and concepts provide the best interpretation and understanding of what is being researched (Bukve, 2021, s. 92).

3.3.1 Quality of analysis

To conduct proper research there are criteria that must be met. A requirement for good research is that it is conducted in a way that produces data that can be used to draw conclusions about the phenomenon it is investigating, in a justifiable way (Bukve, 2021, p. 103). Good research seeks to contribute to the literature in such a way by adhering to criteria for researching social phenomenon in qualitative analysis. Tjora (2018, p. 79) discusses three such criteria used to ensure quality in qualitative research, namely generalizability, reliability, and validity.

Generalizability in qualitative analysis refers to whether the conclusions of the research is limited to only be relevant to the empirical sample of the research (low generalizability) or if it consists of inductive concepts that increases the understanding of a greater, and therefore more common phenomenon (high generalizability) (Tjora, 2018, p. 71). Applied to this thesis this would mean that the conclusions drawn here, out of analysis of the cases as they are evidenced by the data, contributes to understanding of the phenomenon of translation of transnational policy itself and not simply an understanding of how this takes place in the cases.

Reliability refers to the whether or not the research is following an internal logic and to what degree it is coherent throughout the research project and therefore how reliable it is (Tjora, 2018, p. 79). A concern when doing research is that the human aspect of the research project, manifested in the biases of the researcher, is having an effect on the quality of the research. Tjora (2018, p. 83) draws a connection between the ideal of the "objective observer" in positivistic research and an idea of perfect reliability. He explains how there is no entirely objective researcher and that the more time a researcher spends invested in a certain topic, the more likely he/she is to develop biases that may hinder or even increase the ultimate reliability of their research (Tjora, 2018, p. 83).

Jacobsen (2015, p. 72) calls the biases that a researcher brings into research projects "Før-dommer", it translates to "pre-judgements". These are the unconscious delimitations researchers implicitly set for their studies and are shaped by the researchers' subjective worldview. When conducting research that aims to be reliable it is therefore important for researchers to be explicit about their delimitations (Jacobsen, 2015, p. 72) and to acknowledge their personal interest in the research topic and how it relates to their work (Tjora, 2018, p. 83).

Bukve (2021, p. 104) describes a scientific study's reliability as dependent on whether others who conduct the same project can arrive at the same results of the original study. If they do, it means the research was sufficiently carried out to meet the standards of reliability. One way to

increase the reliability of a research project is by providing transparency. Transparency refers to openness in presentation of data and the process of acquiring data. A high level of transparency is achieved by clearly accounting for the choices that have been made throughout the research project and how data was acquired (Tjora, 2018, p. 84).

3.3.2 Operationalization and validity

Validity is about whether or not the answers discovered in the research are answers to the questions initially asked in the study or not (Tjora, 2018, p. 80). Bukve (2021, p. 103), on the topic of validity, points out the fact that phenomena described theoretically can never be measured directly but must be operationalized through indicators that can be measured through analysis of empirical data. The validity of research is thus dependent on the researcher's ability to determine what measurable indicators to operationalize the theoretical research question with. The phenomenon described theoretically in this thesis is translation of transnational policy. To be able measure the phenomenon it has been operationalized. The transnational policy that is being translated has been operationalized as WHO-policy (elaborated on in the introduction of this thesis) and its manifestations in the contexts of the cases. The aspects of WHO-policy are something that can be measured through data to form an empirical foundation on which to analyze the phenomenon. Below I discuss what method was used to collect the data that form the empirical foundation and how it was analyzed.

3.4 Literature review

The method used to collect data in this study is a literature review that is falsifiable and transparent. Denyer and Tranfield (2011, p. 671) describes the systematic review approach to data collection as "…a specific methodology that locates existing studies, selects, and evaluates contributions, analyses, and synthesizes data, and reports the evidence in such a way that allows reasonably clear conclusions to be reached about what is and is not known". Hence, when performing a systematic review the researcher does not generate primary data but makes use of secondary data sources, sources that have already collected primary data (Jacobsen, 2015, p. 145). Because of logistical challenges such as the large physical distance between Norway and Cuba, the researcher's poor knowledge of the Spanish language and the limited time-span and resources of the research project (as well as a global pandemic due to Covid-19), utilizing other qualitative methods such as interviews or observation (Jacobsen, 2015, p. 145) were ruled out and a method based on documents or secondary sources were chosen instead as such a method of data collection is suitable for research projects where collecting primary data is

impossible (Jacobsen, 2015, p. 170). Throughout the data collection process, it is important to be transparent and structured in relation to how sources are selected and why they are chosen and not excluded from the study. This is to increase the reliability or credibility of the research and to ensure that the results found are replicable similarly to the data that is being collected and used in systematic reviews (Denyer & Tranfield, 2011, s. 674-675). Below I attempt to provide transparency by being explicit about my decisions on data collection.

3.4.1 Data collection

As presented above the data collection method used in this study is a systematic review. Only relevant research literature on Cuba and Norway and reports from the WHO, were chosen to be acquired to form the empirical basis of analysis. The reason why I chose specifically these types of data to be collected has its origin in discovering, through reviewing the literature, that there are official documents and research literature in the field of public health in both Cuba and Norway that is rich enough to work with the research question.

In addition, I had concerns about the reliability of data concerning Cuba. The fact that Cuba is a socialist republic and a totalitarian regime (Britannica, 2021) and that "…a number of scholars have questioned the validity of Cuba's health outcomes" and that scholars have suggested that the Cuban government has may have misrepresented statistics to make the country's socialist project appear more successful (Kath, 2007, p. 47) are reasons for anyone investigating anything related to Cuba to be cautious and critical of sources in their research. Jacobsen (2015, pp. 187-188) identifies the main concern regarding acquisition of secondary sources as whether the sources are to be trusted and that, regarding general quality of secondary sources as it relates to reliability, he states that sources that come from institutions that have a personal interest in the relevant field are less reliable (Jacobsen, 2015, pp. 190-191). Therefore, to mitigate the risk of building the empirical foundation of this thesis on unreliable data I chose use research literature from international, quality assured and peer-reviewed journals relevant to Cuba and Norway and relevant official reports from WHO, as opposed national reports and other less reliable documents. Some master theses and a chapter in a research book were also analyzed.

According to Denyer and Tranfield (2011, p. 684) systematic reviewers are expected to explore several methods in their location of data sources, not limited to electronic databases. As such I searched in libraries, electronic databases and sought out recommendations from experts (my supervisor) and explored the reference lists of relevant studies and reports that was discovered

in my study. More specifically the methods used to locate research literature on Norway and Cuba and relevant official reports from WHO for this study was:

- Reliable electronic databases, namely Oria.no (database used in the University of Agder and by its library) and Google Scholar, as well as WHO's *iris* (Institutional Repository of Information Sharing).
- The Kristiansand Public Library
- Recommendations from my supervisor
- Reference lists of discovered data sources

When performing database and library searches for a systematic review it is important that the specific search words are tightly aligned with the research question (Denyer & Tranfield, 2011, p. 684). Therefore, the search words used to locate relevant studies and reports were in close alignment to the research question and the operationalization of the studied phenomenon (see section 3.3.2 on operationalization and validity). The initial search words where: Public health, WHO, health in all policies, Ottawa Charter, United nations, national health, Cuba, Norway. These were tested though performing a multitude of literature searches in the above-mentioned data bases and altered or omitted if they proved to not provide data sources that were relevant to the thesis. The final search strings were decided though a process of testing search words (in English and Norwegian), their possible variations (synonyms, antonyms, superordinate and subordinate terms) (Zins, 2000) and combinations and through using different search conventions such as; simple operators and Boolean logic (Denyer & Tranfield, 2011, p. 684) to optimize the search results.

The final search strings and their number of search results, pre-exclusion:

"Helse I alt vi gjør" (translates to: "Health in all policies") - (**19 results)**

HiAP AND Norway - **(107 results)**

Cuba AND HiAP - (**203 results)**

Cuba AND intersectoral action - **(12 216 results)**

Cuba AND public health AND 'Ottawa charter' - **(837 results)**

Cuba AND national health AND Community - **(142 816 results)**

(156 198 search results in total)

3.4.2 Data selection

3.4.2.1 Criteria for inclusion

To decide what data sources were relevant to the study, and which are not, pilot searches (Denyer & Tranfield, 2011, pp. 684-685) were performed to find data sources that seemed to contribute to knowledge on Cuba's and Norway's translations of WHO-policy and to describe what were the characteristic about those who did and did not. This helped in realising what data sourcesshould be selected and which to discard.

> The criteria for inclusion of the data sources was as follows: Selected must be either research literature on Norway and Cuba or reports from WHO; they must also show evidence of WHO-policy translations in either Cuba or Norway to contribute to the understanding of how WHO-policy has been translated into the national, regional, or local levels of public health and finally the selection of data sources is also limited to publications from January 2004 until May 2022.

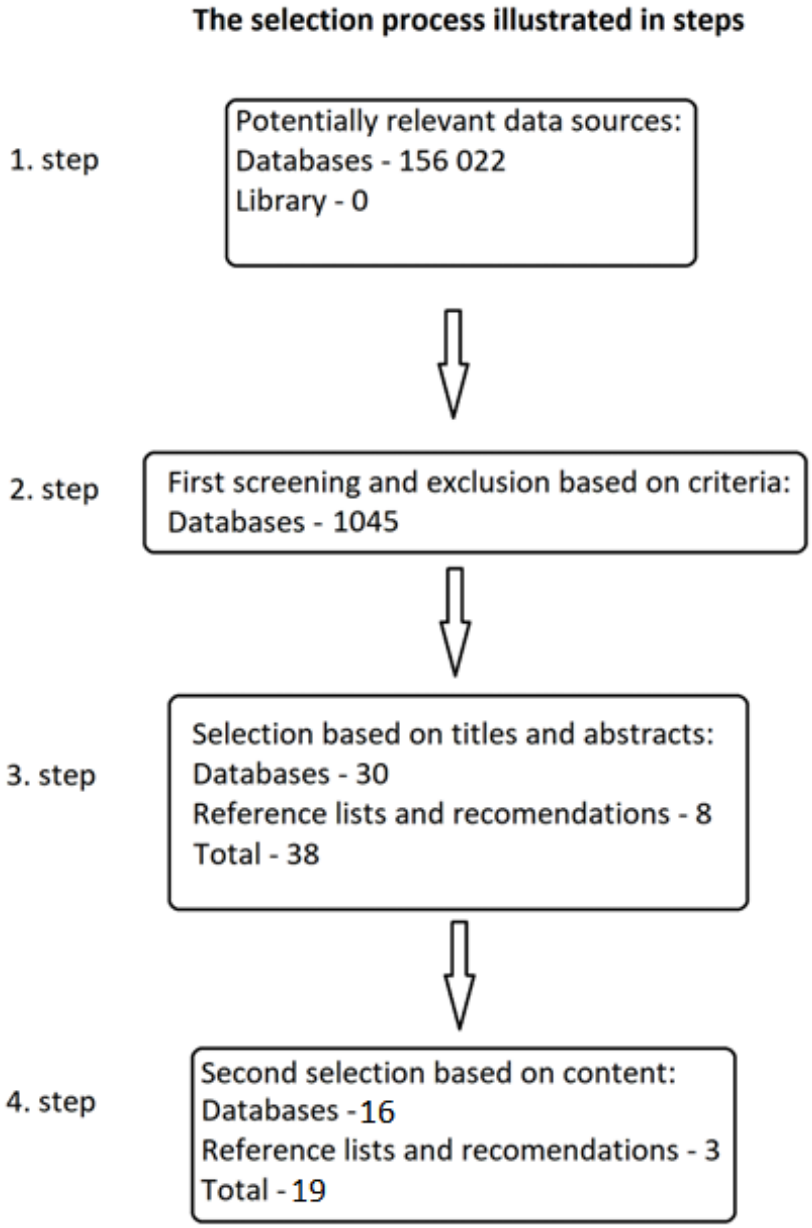
The reason for the time limitation is in part to limit the scope of the study. But also, undertaking the pilot searches to clarify the reasons for why some data sources were more relevant than others (Denyer & Tranfield, 2011, pp. 684-685), made it clear that the more recent publications were often more relevant and comprehensive, and that research and reports published pre 2004 were less so.

3.4.2.2 Data sources

Selection of data sources

After applying the final search strings to the databases, 156 198 search results were retrieved in total and as mentioned above some of the collected data sources were referred to in other documents obtained from data bases and some were recommended by my supervisor. Searches in the Kristiansand Public Library gave 0 results. As shown in the section on data collection, some searches gave more results that other. In instances of more than about 100 search results and especially in those with thousands of results the likelihood of discovering relevant data sources is seemingly decreasing exponentially the further down the list of search results they are located. This led to the decision to make massive exclusions in those cases where the amount of search results was extreme. This step of the selection process brought the number of potentially relevant search results down to 1045. The remaining search results where then investigated to determine which to include based on their titles and abstracts. In this stage of the selection 6 relevant data sources were found in reference lists of potentially relevant data

sources and added. There were also 2 data sources that were recommended by my supervisor and added to the list of potentially relevant data sources. This step brought the number of potential data sources to 38. Next, using the criteria of inclusion, I reduced the number of potential data sources to 20 by reviewing their content. The final selection then, consists of 9 with evidence of WHO-policy translations in the Cuban context and 11 with evidence of WHO-policy translations for the Norwegian context.



(Figure 3 – Modell of the selection process)

Content analysis

After the data collection process and the selection was completed, the documents underwent a content analysis or coding process. The first step of this process was to extract the relevant data from the documents was categorized, to get an overview and limit the scope. The second step was to create categories and subcategories based on what translation of WHO-policy (mostly public health measures) data was describing. The third step was where knowledge was synthesized out of the web of categories and subcategories. The knowledge that was synthesized was not visible through the documents individually, but became apparent when the data was placed into context (Denyer & Tranfield, 2011, p. 685). This new knowledge was then presented in an understandable and appropriate manner (Jacobsen, 2015, pp. 207-217) and discussed in conjunction with the theoretical framework.

4 Results and Content Analysis

In this section I present the selections of data sources for each case, present the data in categories, and discuss the topic of translation of WHO-policy in light of the data. Data from the selected secondary sources were categorized into sections discussing the same elements of public health or that contributed to certain conceptual elements surrounding the Norwegian- and the Cuban public health situations and arguably present evidence of how the WHO-policy have been translated by the recipient contexts. When analyzing the data, the main objective from a theoretical standpoint was to interpret how the WHO-policy had been translated by looking at whether it had been entirely copied (reproducing mode), added to or if omission of certain aspects had taken place (modifying mode) or if it had been entirely altered (radical mode). Attention was also given to the characteristics of each case more holistically as this provides nuance and because deeper understanding of translation of transnational policy could be discovered by discussing the findings of each case in a more thematic way. First a content analysis of the Norwegian case is presented and then one of the Cuban case. The analysis in both cases is structured starting with the older, most widespread, and central datapoints describing the translation of the WHO-policy and further down the less widespread manifestations of the translation object and possible conceptual themes are discussed. At the end of the content analysis of each case is a summary of the most important findings of each case. I hope that in presenting the analysis in this way the reader of this thesis will be presented with context for the more local elements of public health or the more conceptual ones by first having been presented with the major and overarching public health measures of each country. This should make for a clear and comprehensive display of the case findings.

4.1 The Norwegian Case

Overall, ten secondary data sources were carefully selected and analyzed out of 126 search hits related to the Norwegian case in this thesis. Two of the data sources were master theses, one from the University of Agder and one from the Norwegian University of Science and Technology (NTNU), both established Norwegian universities. Seven where from peer-reviewed research journals: *Scandinavian Journal of Public Health, International Journal of Health Policy and management* (two articles), *Health Policy, Societies* (two articles) and *Plan.* And one book chapter from *Transitions and Boundaries in the Coordination and Reform of Health Services*. Two journal articles (Susanne Hagen, Øvergård, Helgesen, Fosse, & Torp,

2018) (Karlsen et al., 2022) were based on quantitative analysis using survey data. Another journal article (Susanne Hagen, Helgesen, Torp, & Fosse, 2015) used Norwegian register data as well as survey data. Qualitative studies were also used, three based on interviews; two master theses (Hlawn, 2018; Håbesland, 2015), one journal article (Synnevåg et al., 2018). As well as three based on document analysis, two journal articles (Higdem, 2015; Hofstad, 2016) and one book chapter (Kvåle et al., 2020). Furthermore, one journal article (Fosse & Helgesen, 2017) was based on both qualitative and quantitative analysis using surveys, documents and interviews. Out of these ten data sources eight categories of findings were synthetized and analyzed using the theoretical perspective translation. Relevant public health measures found in the selected articles were found to be the Public Health Act, Municipal Planning, health overviews and Public Health Coordinators. Other public health measures and relevant conceptual findings are also presented below.

Data sources for the Norwegian case:

Author:	**Title:**	**Type and source:**	**Data location:**	**Contribution:**
(Susanne Hagen et al., 2015)	Health in All Policies: A cross-sectional study of the public health coordinators' role in Norwegian municipalities	Article *Scandinavian Journal of Public Health*	**Oria- database searches:** HIAP AND Norway	Discusses HiAP, PHCs and Health promotion in Norway *Quantitative analysis, Norwegian register data and surveys*
(Higdem, 2015)	Møtet mellom helse og plan	Article from the journal: *Plan*	"Helse I alt vi gjør" (translates to: "Health in all policies")	Discusses work to increase equality in public health and HiAP in Norway *Qualitative document analysis*
(Håbesland, 2015)	Folkehelsekoordinatoren - styrking av det tverrsektorielle folkehelsearbeidet	Master thesis *NTNU (Norwegian University of Science and Technology)*	"Helse I alt vi gjør"	Discusses Norwegian intersectoral action *Qualitative analysis, multiple case, interviews*
(Hofstad, 2016)	The ambition of Health in All Policies in Norway: The role of political leadership and bureaucratic change	Academic article from the journal: *Health Policy*	HIAP AND Norway	Describes Norway's implementation of HiAP *Qualitative document analysis*
(Fosse & Helgesen, 2017)	Advocating for health promotion policy in norway: The role of the county municipalities	Research article from the journal:	"Helse i alt vi gjør"	Describes the PHA and its significance for Norwegian municipalities

		Societies		*Quantitative and qualitative analysis, surveys, documents, and interviews*
(Hlawn, 2018)	Folkehelse og kommuneplanlegging: Koblingen mellom folkehelse og kommuneplanlegging igjennom systematisk folkehelsearbeid	Master thesis *University of Agder*	"Helse I alt vi gjør"	Details the Norwegian public health and municipal planning *Qualitative analysis, multiple case, interviews*
(Synnevåg et al., 2018)	Intersectoral planning for public health: Dilemmas and challenges	Research article *International Journal of Health Policy and Management*	HIAP AND Norway	Describes municipalities' implementation of HiAP in Norway *Qualitative analysis, multiple case, interviews*
(Susanne Hagen et al., 2018)	Health Promotion at Local Level in Norway: The Use of Public Health Coordinators and Health Overviews to Promote Fair Distribution Among Social Groups	Research article *International Journal of Health Policy and Management*	HIAP AND Norway	Discusses PHCs and Health overviews *Quantitative analysis, surveys*
(Kvåle et al., 2020)	Public Health Policy to Tackle Social Health Inequalities: A Balancing Act Between Competing Institutional Logics	Chapter from the book: *Transitions and Boundaries in the Coordination and Reform of Health Services* Cham: Springer International Publishing	**Recommended by supervisor**	Discusses HiAP in Norway and Collectivist and individualist perspectives on public health. After implementing PHCs inequality increases *Qualitative document analysis; policy documents and white papers*
(Karlsen et al., 2022)	'Health in All Policies' and the Urge for Coordination: The Work of Public Health Coordinators and Their Impact and Influence in Local Public Health Policies: A Cross-Sectional Study	Research article from the journal: *Societies*	**Recommended by supervisor**	Discusses HiAP in Norway, PHCs and factors that affect their influence. PHCs can increase public health equality *Quantitative analysis, surveys*

4.1.1 Public Health Act

An article describes Norway's strategy for preventative health measures and local development for health as follows: First, implement a common vision of public health through the PHA (to aid municipalities, CMs and state-level health actors in coordinating their public health efforts), then demand health overviews that present the population health situation and factors that affects it (social determinants of health) (Higdem, 2015, pp. 4-5). Scholars have pointed out that the PHA reflects health promotion in Norwegian public health policy more than anything else (Fosse & Helgesen, 2017, p. 2). Norway was the first country to pass a public health act, in 2011 (Kvåle et al., 2020, p. 154). It was implemented in 2012 and coordinates with the Planning and Building Act's goals of reducing social inequalities in health. One result of the PHA is that sixty-two percent of municipalities have established intersectoral groups working to better population health (Hofstad, 2016, p. 572). Also, researchers found that there is a correlation between municipalities scoring badly on socio-economically inequalities and their likelihood of implementing HiAP measures (Susanne Hagen et al., 2015, p. 604).
The PHA gives municipalities the responsibility for monitoring the social determinants of health (Kvåle et al., 2020, p. 157) and introduces the HiAP principle to Norwegian public health policy (Karlsen et al., 2022, p. 2), although some scholars argue there has been highly prioritized policies to implement HiAP in Norway since 2003 (Susanne Hagen et al., 2015, p. 597). The PHA uses soft forms of regulation to give municipalities room for planning, and thus contributing to more local participation (Synnevåg et al., 2018, p. 983). Noteworthy, is the fact that the PHA gives the municipalities the main responsibility for health promotion (Susanne Hagen et al., 2015, p. 597; Hofstad, 2016, p. 569). Additionally, the PHA demands greater influence from the health sector in the ordinary planning on the regional and municipal levels, and that the planning should have a greater focus on preventative health measures (Higdem, 2015, p. 4). Another element of the PHA is the establishment of intersectoral working groups as well as employment of Public Health Coordinators (PHCs) on the regional and municipal levels (Fosse & Helgesen, 2017, p. 3).

The PHA is the most notable artifact of translation of WHO-policy in Norway. It sets the goals of reducing social inequalities in health, integrates social determinants of health into Norwegian policy, establishes intersectoral working groups (for community participation) and bases the solution to the wicked problem of public health on initiating HiAP. The WHO-policy covers intersectoral and community action, as well as the idea of social determinants of health.

HiAP is also central to it. All of these are in acknowledged in the PHA. In terms of translation then, the PHA seems to a large degree to copy traits from the WHO-policy, meaning the reproducing mode has been utilized to a large extent (Røvik, 2016). This means the translation object did not need to be changed much to fit into the recipient context (contextualization), and that the decontextualization was done with little subjective influence**.** The political reasons for Norway to implement WHO-policy is likely to follow the logic of "risk of exclusion" and seeking legitimacy as discussed in the theoretical section, however, my data does not elaborate much on that.

4.1.2 Municipal Planning

In 2004 the County municipalities (CMs) were instructed by the Norwegian Directorate of Health to facilitate municipal public health policies. Some of the CM partnership mechanisms that emerged as a result of that were the encouragement of municipalities to employ PHCs (in addition some CMs employed PHCs) and requesting municipalities to develop local planning systems (Fosse & Helgesen, 2017, pp. 2-3). In 2009, the revised Planning and Building Act (PBA) put HiAP topics on the agenda for municipal plan work. These topics were social sustainability in health, cross-sectoral community perspective for preventative public health and overall social factor for public health (Kvåle et al., 2020, p. 156). The PBA put health, expressed as population health and health equity, on the planning agenda in Norway and with the PBA and the PHA attention has increasingly been given to public health in municipal planning (Hofstad, 2016, p. 571). There are two perspectives on planning in the municipalities. One view planning as an instrumental tool and as a rational activity that happens in a top-down system with planners as experts on the top. The other perspective sees planning as a collaborative effort dependent on communication. This is a more bottom-up perspective where planners are seen as facilitators promoting reflection (Synnevåg et al., 2018, p. 983).One study found that:

1. 49% of municipalities involved their PHC in the making of the municipal master plans.
2. Municipalities with a health overview were three and a half times more likely to involve their PHC.
3. And, municipalities with a health promotion partnership with the county councils were more than four times more likely to involve their PHC (Susanne Hagen et al., 2015, p. 603).

Another study found that many of the county municipalities that had developed public health plans had addressed social inequality issues but few addressed them using intersectoral policies (Fosse & Helgesen, 2017, p. 9). In addition, when developing plans for municipalities to achieve HiAP goals municipal actors found it difficult to balance the use of qualitative and quantitative data (Synnevåg et al., 2018, p. 985).

The topics of social sustainability in health, a cross-sectoral community perspective for preventative public health and overall, social factors for public health are all very similar to some of those found in the WHO-policy, as discussed in the first chapter of this thesis, some are community action for health, intersectoral (cross-sectoral) action for health and addressing the social factors of health.

Social sustainability in health, as seen here in Norwegian municipal planning, is not something that is mentioned specifically in the relevant WHO-policy. However preventative public health ideas like HiAP, focus on the social gradient and social factors or determinants of health are central. These are very similar ideas to social sustainability in health since they have long term perspectives on the social dimension of public health. Arguably preventative public health and social sustainability in health are both two sides of the same coin. I argue therefore that copying has occurred, and that the reproducing mode was used when making the PBA.

Like the translation of into the translation object into the PHA, the creation of the PBA, in terms of public health, did not need to be changed much be contextualized, and the decontextualization was done with little subjective influence. The different perspectives on how to conduct municipal planning however could be a sign of conflicting values and norms int the municipalities. As Røvik (2016, p. 6) describes, discussing compatibility between new old and new practices, resistance can be triggered when contextualizing and can lead to extended trial-and-error translation processes. Perhaps the reproduced WHO-policy with its emphasis on community participation meets some resistance on the practical level, despite being accepted into policy on the more conceptual level. This raises the question of whether the fitment of the translation object is as good as policymakers estimated when performing the translation. This theme is further substantiated by the assertion that few CMs addressed social inequalities through intersectoral policies.

4.1.3 Health Overviews

Karlsen et al. (2022, p. 1) state that examination of the determinants of health is foundational to the HiAP approach and implies that the determinants are "mainly controlled by other sectors than health". With this understanding of public health, health overviews are conducted in Norwegian municipalities, as prescribed by the PHA to map out the determinants of health. One study declares that municipalities that have developed health overviews are more likely to prioritize fair distribution of the social determinants of health, compared to those that did not develop health overviews (S. Hagen et al., 2018, p. 815). Another study found that one fourth of Norwegian municipalities had created a health overview in 2015 (Hlawn, 2018, p. 53). Hagen et al. argues that there is a circle of effects that can be seen in municipal public health regarding HiAP implementation. Municipalities implementing HiAP through planning are more likely to employ PHCs, municipalities with PHCs are more likely to implement health overviews and municipalities having developed health overviews may want to involve PHCs more in the planning processes (Susanne Hagen et al., 2015, p. 604). This circle of events can lead to a perpetual increase in HiAP implementation in Norwegian municipalities. Hofstad claims that the mandatory development of Health overviews is one of the most important tools of the PHA (Hofstad, 2016, p. 568). However, when developing health overviews, actors attempting to use national Norwegian statistical data find it challenging to do so. This leads them to instead try and gather local data, which comes with its own set of challenges. They often end up using data they find to be limited in scope and number. Another challenge is to measure the cost-effectiveness of measurements performed to better public health on a local level. This leads to municipalities relying on recommendations from national authorities as well as the employees own personal experiences when producing health overviews (Hofstad, 2016, p. 570).

The health overviews seem to be a successful HiAP tool that not only highlights where to focus when addressing public health inequality, but also because it drives municipalities in the direction of increasing levels of HiAP work. However, for some there appears to be challenges connected to acquiring enough good data for production of accurate health overviews. The nationally mandated production of health overviews to examine the social determinants of health on the local and regional levels is something that mirrors the WHO-policy's focus on health inequality and the factors that cause it. The core elements of the WHO-policy have been copied here and therefore the reproducing mode has been used, at least in requesting the health overviews. The WHO-policy elements do not specifically mention health overviews, but as

Karlsen et al. (2022, p. 1) state, it advocates for the examination of the determinants of health. In the Norwegian case this is done through the municipal health overviews. Therefore, one could argue that explication (Røvik, 2016, p. 8) has taken place. This is something Røvik (2016) discusses as a version of addition in the modifying mode of translation. Explication refers to implicit information that resides in the translation object that is made implicit trough translation for the practice to function in the recipient context. It seems as if the concept of health overviews have been explicated from the idea of working with the social determinants of health as describes in the first chapter in this thesis as being a part of the WHO-policy. However, I would not characterize this as a modification of the translation object since actors in the recipient context simply has explicated or unpacked an important element from the WHO-policy in this translation. This means the translation object needed few changes to fit into the Norwegian context. Although, similar to the translation of WHO-policy in Norwegian municipal planning there seems to be a trial-and-error process at work.

4.1.4 Public Health Coordinators

Researchers found that positioning PHCs higher in the municipality's organization correlates with better intersectoral public health work. However, most of the PHCs studied were placed outside of the chief executive officer's staff (Susanne Hagen et al., 2015, p. 604). Another study stated that PHCs perceive their influence over the policymaking decisions of their municipality as being determined to a large degree by organizational factors such as position size, and their placement in the organizational structure of the municipality. Similarly PHCs perceive a higher position in the organization as well as a job description as corresponding positively with their intersectoral agency (Karlsen et al., 2022, p. 1). Researchers claim the PHC's administrative position in the municipality should be prioritized to realize the goals of HiAP (Håbesland, 2015, p. 35), this likely as some PHCs find it challenging to get their points across when dealing with interdisciplinary public health work (Håbesland, 2015, p. 50). Other researchers emphasize that a PHC in the right place and with the right conditions can be a policy entrepreneur with the combination of possibilities such as problem solving, brokering, mustering political will, framing political issues and lobbying decision-makers (Karlsen et al., 2022, p. 5) and also that municipalities that structure the organization to incorporate intersectoral agency are more likely to effectively address the issue of social inequality in health (Karlsen et al., 2022, p. 14).

A PHC is an instrumental tool to ensure that HiAP principles are prioritized regardless of political trends and leadership, this is needed since political trends and focus is subject to constant change. Their purpose is to encourage cross-sectoral integration of public health work. However, PHCs are found to have a limited ability to integrate cross sectoral work for public health unless they are either in a high position, attain legitimacy from the top of the organization or have excessive organizational knowledge coupled with solid experience and competence (Hofstad, 2016, p. 572). One study, with survey data from 2011 and 2014, found that PHC's have limited influence over cross-sectoral coordination as they do not have enough administrative and political leverage (Kvåle et al., 2020, pp. 160-161) and Hagen et al. (2018) found that municipalities that employed PHC's were less successful in terms of bettering social inequalities than those who did not. Another, more recent study though, using survey data from 2019, found the opposite and in fact stated that employing PHCs have a positive effect on fair distribution and that PHCs can be important HiAP tools for public health on the local level as they reportedly can impact annual municipal budget- and finance plans which enhances social justice in local politics (Karlsen et al., 2022).

PHCs are actors whose responsibility is to follow up and encourage intersectoral action for public health. From the data it is clear that their major determinant of success is their position in the organization and whether they have a description for their job or if they have solid experience and competence or attain legitimacy in the organization through other means. Consequently, with the right conditions PHCs can be great HiAP tools for public health work. The procurement of PHCs is not something the WHO-policy specifically encourages, however, the PHC checks many of the boxes given by the policy: PHCs coordinate intersectoral work for public health, they can play an integral part in the production of health overviews of social determinants, and they can put health on the agenda for all sectors on the municipal level.

In terms of translation this is a case of the modifying mode being used since addition clearly has occurred in the form of the PHC. For some reason, in the contextualization process Norwegian policymakers found it necessary to advocate for a municipal position solely dedicated to coordinating the intersectoral public health work. Røvik (2016, p. 8) discusses how, when the modifying mode is used, a dilemma of replication sometimes occurs between the need to exactly copy the translation object and the need for the recipient context to innovate. The case of PHCs in Norway is an example of innovation in translation. If anything, this is an amplification of the intensions of the WHO-policy manifested in the recipient context. The specific WHO-policy element that is represented by the PHCs is intersectoral action.

4.1.5 Other Public health measures

Some important Norwegian HiAP measures are health overviews, public health plans, municipal master plans, action plans, reporting systems and health impact assessments (HIAs) (Synnevåg et al., 2018, p. 984). These all contribute to inform politicians of the consequences of their decisions on public health. Another one is the promotion of Healthy Lifestyle Centers (HLC) in every municipality, a result of the PHA (Kvåle et al., 2020, p. 157), the HLCs are centers for people who are interested in how they can better their personal health situation. Yet another Norwegian public health measure, that some Norwegian municipalities initiated, is a program called *New Patterns – Safe Upbringing* which is meant to help in preventing poverty and its associated challenges from passing on from one generation to the next, (Hlawn, 2018).

There are many national, regional, and local public health measures that are, more or less inspired by the WHO-policy. First, the HIAs in particular are in line with the Ottawa Charter's (WHO, 1987) encouragement of awareness of the local public health consequences of political decision making. Second, the HLCs provide an open channel for individuals to better their health, which corresponds to the Ottawa Charter's call to reorient health services (WHO, 1987). And lastly, the *New Patterns – Safe Upbringing* program is a tool that addresses poverty, an important social determinant of health, in the spirit of preventative public health promotion, with a very long-term perspective. These last two measures are not mandatory for Norwegian municipalities, but they are implemented by some.

In terms of translation and looking at these Norwegian public health measures all together, similar to the manifestation of PHCs, these measures seem to be direct translations of the WHO-policy with an amplified or innovative element. The translation mode used is the modifying mode. The core ideas and principles of the translation object have been maintained with the addition of certain elements that make them fit better as a result of the contextualization process and that facilitates their development in the recipient context through being adapted into the Norwegian context.

4.1.6 Decision making – public health outcomes

Researchers found that HiAP initiatives taken by the Norwegian Directorate of Health were perceived not to be coordinated well, thus making it difficult for CMs to implement them

(Fosse & Helgesen, 2017). Some found that "fair distribution of the social determinants of health among social groups" was a high priority among health promotion initiatives, but lesser emphasis was given to the focus on public health outcomes when making policy decisions (S. Hagen et al., 2018, p. 815). Moreover, 86% of Norwegian municipalities were found to employ PHCs, although surveys from 2011 and 2014 show "that only about one-third" of the municipalities said they had fair distribution among social groups as a priority in their political decision-making (Karlsen et al., 2022, p. 2). There seems then to be a conflict between the newer public health ideas and the traditional practice of the municipalities, making it difficult to fully integrate the consequences on public health into decision-making in municipalities and CMs.

An important aspect of the WHO-policy is the encouragement of decision makers' awareness of public health outcomes and consequences of their decisions and policies. This is something that is acknowledged in aspects of Norwegian public health work. However, as evidenced by some of the selected data sources of this study, this is easier to accomplish in policy at the national level than practice at the regional and local ones. The deficit in emphasis on the public health outcomes of policy decisions furthers the theme that reproducing WHO-policy fits in with the Norwegian context on the national level, but not at the regional and local. Or that there is at least some trial-and-error (Røvik, 2016, p. 6) at play. Seemingly, the closer the translation is to the ground floor, the more changes the translation object needs to ensure proper fitment in the recipient context. When new functions are implemented in new units of organizations, the contextualization process can be relatively uncomplicated (Røvik, 2016, p. 6), however, in this case there is an attempts to somewhat alter the functions of existing units of the municipalities and CMs. This likely causes conflict between the new and old practices and leads to a extended translation process (Røvik, 2016, p. 6).

4.1.7 Low hanging fruit

The social gradient, describing the correlation in society between poverty and poor health, can be addressed by working towards health equity (Hofstad, 2016). However, local actors find it challenging to work with the social gradient and instead focus on vulnerable groups because that is a less challenging, more narrow focus. This means somewhat deviating from the aim of the national policy agenda (Hofstad, 2016, p. 571). The municipalities have been observed as paying more attention to what some researchers call "low hanging fruit" in public health instead

of focusing on the real social determinants of public health. The low hanging fruit here is arranging for physical activity in municipal urban planning (Hofstad, 2016, p. 571). This theme is further evidenced by the county municipalities being found to have experienced difficulties changing sectors' perspectives on public health from limited, classical lifestyle ideas to the more recent ideas of social determinants of health. They find it difficult to integrate the PHA's principles due, in part, to the government having an organizational structure based on separated sectors (Fosse & Helgesen, 2017, p. 1). The county municipalities mostly focus on socially disadvantaged groups in their planning towards better public health, however the HiAP principles point more towards the social gradient and addressing health equity. The CMs focus more on the classical health issues such as lifestyle, physical activity and diet, rather than the social determinants of health (Fosse & Helgesen, 2017, p. 5).

The PHA and the PBA is largely inspired by HiAP and aims to create health equity by addressing the social determinants in health. However, this seems to be a challenging concept to work with and is perhaps misunderstood by many Norwegian public actors. The result seems to be a shift of focus from the determinants of health and the gradient towards what Hofstad (2016, p. 571) terms "low hanging fruits". Although she uses the term to specifically address the focus on physical activity, I think the term can be extended to also include focus on vulnerable or socially disadvantaged groups, active lifestyles, and diet instead of addressing the social gradient itself and the social determinants of health. The Ottawa Charter outlines a definition of health that focuses on holistic well-being and specifically states that health promotion goes "…goes beyond healthy lifestyles…" (WHO, 1987). Successfully focusing on vulnerable groups whose health situation is more at risk than the rest of the population, increasing the general populations engagement in physical activity and promoting healthier diets does mean the total population health increases. However, that does not change the correlation in society between poverty and poor health. The gradient remains present; better socioeconomical status still leads to better health. Thus, focusing mostly on the "low hanging fruits" seem to miss out on the benefits of more holistic approaches towards greater well-being as the WHO-policy provides.

Regarding translation theory, the theme of "low hanging fruits" suggests a case of omission of- and addition to the translation object in the translation process. Omission of work directly affecting the gradient and addition of physical activity, diet and focus on vulnerable groups. This suggests the modifying mode of translation was used, one could also argue the radical mode has been used since the policy has been altered by the recipient context. Røvik (2016)

suggests the changes in translation objects occur to make it fit better in the recipient context because of contextualization. The change that has occurred here seems to have happened because the Norwegian public actors found it easier to work with less complicated concepts than those found in the original context and that the added aspects are easier to manage and perhaps easier to measure and report.

4.1.8 HiAP as a threat to "status quo"

A concern shared by some Norwegian municipal actors is the risk of HiAP being used as a forceful tool that threatens the power balance. Some fear that HiAP's instrumental nature is at odds with Norwegian ideals of dialogue, understanding and respect. And others say the methods like HIAs feel as if they are imposed and are unnatural to work with. In the same vein putting health above every other discipline in municipalities is seen by some as disrespectful to the other sectors knowledge and identity (Synnevåg et al., 2018, p. 987).
Again, this adds to the theme of challenges accumulating in the lower levels of public administration as there is a resistance to the implementation of policies and practices resembling the WHO-policy. One possible reason for this, in addition to the extended trial-and-error translation process discussed by Røvik (2016, p. 6), is that the political element as explored by Wæraas and Nielsen (2016), in the form of HiAP policies and methods like HIAs, is pressuring the municipalities to align with the WHO-policy and that contextual factors stand in the way of seamless contextualization as the fit is not perfect as transnational political forces class with those on the municipal level.

4.1.9 Summary and further discussion

Norwegian public health policy is to a large degree inspired by the WHO-policy as most of the evidence from the data points to the reproducing mode of translation having been used in relation to how translation of the WHO-policy on the national level. The case shows a strong coherence of public health policy with the PHA as a clear overarching policy from which the health overviews, PHCs and other Norwegian public health measures emerge and the PBA that seemingly embraces central elements of the WHO-policy as foundation for municipal plan work. Public health in Norway is often explicitly tied to HiAP in the research literature and it seems clear that many policy decisions in the country is made on the basis of elements found in the WHO-policy. However, a theme that is recurrent in this content analysis related to the

Norwegian case is the apparent discrepancy in translation between the national level and the regional and local levels. On the one hand, the national policies such as the PHA, the PBA, the description of what PHCs and health reviews are supposed to be, that all fits in near perfect alignment with the WHO-policy. On the other hand, there are the challenges PHCs face, such as organizational variables, whether or not they have a job description and the size of their position. All of those variables effect the level of agency the PHCs. There are also the difficulties related to the analytical work required to produce health overviews, a fear of HiAP being used as a tool to impose policy on municipal workers and to hinder the Norwegian ways of dialogue in problem solving. As well as a lack of emphasis on the public health consequences in decision-making. And lastly, there are the competing perspectives on municipal planning and the simplistic view of addressing the social gradient trough promotion of physical activity and a healthy lifestyle. Thus, the data sources in this thesis paint a picture that makes a discrepancy in translation between policy and practice in the country apparent. The question is to what extent the explicitness of the challenges in the Norwegian case is due to a large number of challenges or simply a high degree of scrutiny by researchers in the field?

4.2 The Cuban Case

Nine secondary data sources were selected and analyzed out of 156 072 search results related to the Cuban case in this thesis. Eight of them were research articles from peer-reviewed research journals. The journals were *Journal of Public Health Policy International Social Work, Social Science and Medicine, International Journal of public health, International Journal of Health Services, Policy & Politics, Health Promotion International* and *International Journal of Health Planning and Management.* Three of the journal articles were based on literature reviews (Backwith & Mantle, 2009; Baggott & Lambie, 2018; Kath, 2007), one used both a literature review and a document analysis (J. M. Spiegel & A. Yassi, 2004), one was based on a qualitative network analysis using interviews (Pagliccia et al., 2010), one based on a qualitative document analysis (Pagliccia & Pérez, 2012), one used qualitative analysis based on interviews (J. M. Spiegel et al., 2008), another was based on a quantitative analysis using surveys (J. M. Spiegel et al., 2011). Additionally, one selected data source was a report from PAHO (the Pan American Health Organization), a regional office of the WHO (Rice, 2011). Out of these nine secondary data sources five categories of findings relating to Cuban translations on the WHO-policy were synthesized and analyzed with the theoretical perspective of translation.

Data sources for the Cuban case:

Author:	Title:	Type and source:	Data location:	Contribution:
(J. M. Spiegel & Yassi, 2004)	Lessons from the Margins of Globalization: Appreciating the Cuban Health Paradox	Research article *Journal of Public Health Policy*	**Oria database searches:** 'Ottawa Charter' AND Cuba AND 'Public Health'	Discusses the Cuban Health paradox and Cuban health policy *Qualitative literature review and document analysis*
(Backwith & Mantle, 2009)	Inequalities in health and community-oriented social work: Lessons from Cuba?	Research article from the journal of: *International social work*	Cuba AND intersectoral action	Describes intersectoral work in Cuba related to health *Qualitative literature review*
(Pagliccia et al., 2010)	Network analysis as a tool to assess the intersectoral management of health determinants at the local level: A report from an exploratory study of two Cuban municipalities	Research article from the journal: *Social Science and Medicine*	Cuba AND intersectoral action	Discusses intersectoral action in Cuban municipalities and discusses Cuban public policy mirroring Ottawa charter topics *Qualitative network analysis, interviews, multiple case*
(J. Spiegel et al., 2011)	Intersectoral action for health at a municipal level in Cuba	Research article *International Journal of Public Health*	'Ottawa Charter' AND Cuba AND 'Public Health'	Discusses intersectoral action for health at a municipal level in Cuba *Quantitative analysis, surveys, multiple case*
(Pagliccia & Pérez, 2012)	The Cuban experience in Public health: Does Political Will have a role?	Research article *International Journal of Health Services*	Cuba AND intersectoral action	Discusses intersectoral action and political will in Cuban public health *Qualitative document analysis*
(Kath, 2007)	Inter-sectoral cooperation, political will and health outcomes: a study of Cuba's Maternal–Infant Health Programme	Research article from the journal: *Policy & Politics*	**Google scholar database searches:** Cuba AND intersectoral action	Describes Cuba's intersectoral approach to public health *Qualitative literature review*
(J. Spiegel et al., 2008)	Promoting health in response to global tourism expansion in Cuba	Research article from the journal: *Health Promotion International*	Cuba AND national health AND Community	Discusses Cuban health promotion work *Qualitative analysis, interviews, multiple case*

(Rice, 2011)	Trends and Achievements in Promoting Health in the Americas: Developments from 2003-2011	Report from the *Pan American Health Organization, regional office of the WHO*	Cuba AND public health AND 'Ottawa charter'	Discusses university and community efforts for health promotion in Cuba *WHO report*
(Baggott & Lambie, 2018)	"Enticing case study" or "celebrated anomaly"? Policy learning from the Cuban health system	Research article *International Journal of Health Planning and Management*	**Referred to** in: (Cairney, St Denny, & Mitchell, 2021)	Discusses intersectoral action for health in Cuba *Qualitative literature review*

4.2.1 Public health planning

The Healthy Municipalities Strategy was launched in Cuba in 1989, its purpose was to address non-medical determinants of health. The strategy involved the economic, the education and the social sector as well as community actors (J. M. Spiegel & A. Yassi, 2004, p. 99). And in the 1990's Cuba reformed its approach to health promotion:

1. They introduced the Popular Councils to decentralize decision-making to the local level (beneath the municipal level).
2. New-found Community participation linked to "Healthy Cities" (a WHO movement) promoted public involvement in decisions regarding local health measures.
3. And, intersectoral participation started taking place through the national-, provincial-, municipal-, and popular councils (J. M. Spiegel & A. Yassi, 2004, p. 100).

Additionally, in 1991 the Cuban Ministry of Public Health launched a plan focusing on intersectoral collaboration called "Objectives, Aims, and Guidelines for Improving the Health of the Cuban Population 1992-2000" (J. M. Spiegel et al., 2011, p. 16). The plan specifically encouraged community participation in decision making on the local level and the creation of health commissions locally, regionally, and nationally ((Municipal level) Health Councils and the Committee of Quality of Life and Health) (J. M. Spiegel et al., 2011, p. 16).

These examples of Cuban public health policies reflect the WHO-policy's recommendations of addressing the public health factors that are outside the health sector. Strengthening community action for health in the form of Cuban Health Councils and increasing awareness of outcomes of policy decisions as it relates to public health is also in alignment with the WHO-

policy advocacy for community action and health-conscious decision-making as discussed in the first chapter of this thesis.

The specific Cuban health policies mentioned here were launched not long after the launch of the Ottawa Charter (WHO, 1987), giving the impression of Cuba being early adopters of its principles on health promotion. I proceed with the assumption that these policies are indeed translations of the translation object and conclude that the reproducing mode has been used. The elements of health-conscious decision making, and community action are some of the most central to the WHO-policy seem to have been translated more or less through copying. Therefore, the translation has happened trough reproducing, and the translation object fit the national level of the recipient context well, similar to the PHA and PBA in the Norwegian case.

4.2.2 Health Councils and Health Directors

Cuba's implementation of Consejos de Salud (Health Councils) is seen as evidence of their intersectoral action in pursuit of good health outcomes. The Health Councils act through coordinating intersectoral work on the local, provincial, and national level by operating with representatives from different sectors in both government and civil society (Pagliccia et al., 2010, p. 395). The Health Councils were established in the 1990's and research shows that they indeed have implemented supportive structures and policies towards intersectoral action, and provided regular and systematic engagement in different sectors to address determinants of health (Baggott & Lambie, 2018, p. 215). On the Health Councils there are Health Directors from the municipal and the provincial levels whose role is to coordinate their health-related work. They are usually given the status of vice directors of the municipal and the provincial governance structures, giving them an enabling position for influencing other sectors as well as the health sector (Baggott & Lambie, 2018, p. 215). Research also shows that health directors are seen as important figures in Cuba, able to influence wide, intersectoral policies that affect population health (Baggott & Lambie, 2018, p. 215).

Cuban Health Directors are similar to Norwegian PHCs in that they are regional and local public actors with an intersectoral responsibility of coordinating sectors to achieve health goals. However, in the Cuban case it seems as if they have more authority in their position since they are often also local and regional vice directors. The Health Councils are intersectoral working groups similar to those in the Norwegian case encouraged by the PHA, but they also seem to have more authority and a handfast position in their context as they are councils instead of working-groups.

The procurement of Health Councils and Health Directors specifically is not mentioned in the WHO-policy; however, they do serve many of the functions promoted in the translation object: They coordinate intersectoral work for public health, they reportedly play an important role in addressing social determinants of health, they influence intersectoral policies and promote community action for health. In terms of translation this would be a case of the modifying mode since addition of the councils and directors have taken place. Evidently, actors of the Cuban context advocate for municipal positions specifically devoted to coordinating the intersectoral public health work. This is another instance of amplification of the intensions of the WHO-policy manifested in a recipient context through innovation (Røvik, 2016, p. 8).

4.2.3 Cuban community-oriented social work

In contrast to countries such as England, which mainly implements health-care oriented measures to reduce health inequalities in the population, Cuba uses a community-oriented health measure in its place, described as the Cuban community-oriented social work (COSW) (Backwith & Mantle, 2009, p. 499). COSW in Cuba is argued to have emerged as a response to problems regarding socio-economic inequality that emerged as a result of the collapse of the Soviet Union and the subsequent Cuban special period in the 1990's. The work is said to focus mostly on vulnerable groups being addressed by social workers called "emergentes" who work in communities to address emergent social problems such as child malnutrition, pupils who are absent from schools and elderlies in need of economic and social assistance. In addition, there are "health technicians" who assist doctors and nurses in combating public health issues, as well as "university-based" social workers who train unemployed youth to become "emergentes" (Backwith & Mantle, 2009, p. 507). In all of the fourteen Cuban provinces Project Management Offices were launched in the 2000's as a matter of national policy. One of the tasks of these regional offices is to develop community capacity and health improvement through working with community organizations, particularly towards youth as they are seen as a vulnerable group that is more at risk of substance addiction and sexually transmittable diseases (J. M. Spiegel et al., 2008, pp. 63-64).

Another example of local community action towards public health in Cuba is the "Reunion del Sistema" (System meeting) in the municipality of Caibarién. It is described as a meeting between the healthcare sector and community leaders from various sectors and government levels. These meetings are intersectoral and lead to decisions regarding health measures and community well-being (health) (J. M. Spiegel et al., 2008, p. 65).

Community-oriented action seems to be a theme that is consistently present throughout Cuban public health work. The purposes of the "emergentes", the "health technicians" and the "university-based" social workers do all align with the WHO-policy. They either contribute to IAH or further community-work addressing social inequalities and thus work with the social determinants of health. All of which are central elements of the WHO-policy as discussed in the first chapter of this thesis. However, the approach taken towards these purposes can be characterized as being very much oriented to designated local community actors. I argue that the modifying mode has been used to translate here, since there appears to be an addition of an aspect of community agents in the Cuban case. This modification of the WHO-policy might have occurred in the contextualization process because of local factors, be they cultural, political, or otherwise. Røvik (2016, p. 8) describes translation processes that use the modifying mode as having to balance foreignizing with domestication. This seems to be a case where domestication of the translation object takes place to a large degree. This likely has to do with Cuba's political emphasis on social capital (Kath, 2007) and the large number of medical physicians present in the Cuban population (The World Bank, 2022), more on this in the summary and further discussion of the Cuban case at the end of this chapter as well as in chapter 5 of this thesis.

4.2.4 Intersectoral action for health (IAH)

A study concluded that joint action from the civil society and the Cuban government takes place in Cuban municipalities (Pagliccia et al., 2010, p. 398). Another study concluded that Cuba's "formal collaborative relationships between sectors and institutions" has served an instrumental role in its positive health outcomes (Kath, 2007, p. 60). One of the cross-sectoral programs of the Cuban public health system is the Maternal-Infant Health Program (PAMI) (Kath, 2007, p. 50). It functions in conjunction with the Federation of Cuban Women (FMC) and the Committee for the Defense of the Revolution (CDR) (Kath, 2007, p. 54) and is the most successful public health program in Cuba in terms of reducing infant- and maternal mortality in the population (Kath, 2007, p. 50).

Another example is the intersectoral work that takes place in Cuba in case of disease outbreaks. In cases of outbreaks of Dengue fever (a common occurrence in Cuba since the late 1970's) intersectoral mechanisms are triggered to prevent the disease from spreading. These involve meetings in the Cuban Health Council of the Popular Assembly between a community delegate,

the Federation of Cuban Women FMC, the Committee for the Defense of the Revolution (CDR), the Association of Combatants of the Revolution, the Communist Party, Water and Sanitation personnel and representatives of adjacent workplaces. This intersectoral team develops action plans for all sectors in these cases (Jerry Spiegel et al., 2011, p. 20).

A third example of Cuban intersectoral health work is their work in cases of detected dysfunctional families. In these cases, intersectoral action is taken by the Prevention Group of the related health area consisting of a community delegate, a social worker, a health and education representative, a representative from the Ministry of Labor and Social Security and the Ministry of the Interior. In conjunction with the family this intersectoral group determines solutions and assigns them to the family (J. M. Spiegel et al., 2011, p. 20). Common to the IAH procedures in Cuba is the presence of the municipal Health Councils and/or local intersectoral prevention units (J. M. Spiegel et al., 2011, p. 21) consisting of different combinations of actors as demonstrated above.

One data source states that the Cuban government has implemented cross-governmental programs in health, and, for example, the Ministry of Education in Cuba has implemented health related programs in the education sector. The article also mentions the sport sector promoting physical exercise and intersectoral action in the field of nutrition, housing, and the general sanitation in Cuba (Baggott & Lambie, 2018, p. 215).

The data in this literature review suggests that Cuban IAH is diverse and largely contingent on specific situations and health challenges, rather than being the result of any overarching public health policy in particular. However, there is evidence of widespread intersectoral work for health in Cuba, which reflects one of the core elements of the WHO-policy, namely IAH. In addition, many community actors are involved in certain public health measures which is also an aspect the of public health work that is emphasized in the translation object, namely community action for health. Similar to the presence of PHCs, HIAs and HLCs in the Norwegian case, these situationally contingent cases of IAH in Cuba seem to have been results of modifying the WHO-policy to make it fit in the recipient context. This has happened with the addition of the specificities of the programs, and arguably with some omission due to the lack of emphasis on the preventative health aspect concerning the social determinants of health. However, the inclusion of IAH in the education and sport sectors could represent a nod in the direction of addressing those WHO-policy elements. This is yet another case of domestication of the translation object as described by Røvik (2016, p. 8) since the WHO-policy so clearly has been wrapped up in the characteristics of the Cuban context.

4.2.5 University for Health Initiative

Launched in 1996, the University for Health Initiative of the Santiago de Cuba Medical Science University was initially a part of the "Healthy Municipalities" movement. The purpose of the initiative was to promote healthy lifestyles in universities for faculty and students and also featured actions that impact the local community. Some of them are the "race for health" (celebrated early on 18th November and promotes physical activity among students, staff and local community), establishment of "Tobacco smoke-free spaces" (prohibits sale of alcohol and tobacco on university campuses), promotion of recreational and cultural activities without tobacco or alcohol, organization of educational activities that bring awareness and knowledge to environmental issues and how they affect local communities, sex education for health science majors and the development of the "say NO to drugs" event (a collaboration between departments) (Rice, 2011, p. 25).

This local public health measure is yet another example of the strong emphasis on the community aspect of the WHO-policy in the Cuban context. However, this one might be so far removed from the translation object that if it was somehow inspired by the WHO-policy it was certainly altered. That would put this particular translation in the radical mode since the outcome is hardly similar to translation object from the original context. This is evidenced by the focus on healthy lifestyles as opposed to the more wholistic "well-being" definition of health from the Ottawa Charter (WHO, 1987). Also, the emphasis on forbidding alcohol, tobacco and drugs plausibly has an effect on students, staff, and local community health, but it does little to address the social gradient and the social determinants of health. However, the highlighting of environmental issues and their effect on local communities aligns quite nicely with the WHO-policy's advocacy for healthy environments (WHO, 1987).

4.2.6 Summary and further discussion

Cuban public health policy, as it relates to the WHO-policy, builds largely on intersectoral action and community-based solutions to address the social determinants of health. These approaches, though in alignment with WHO-policy, have developed in part due to the harsh economic situation the country found itself in as a result of the special period. Most of the national policies enabling the many public health measures taken in Cuba come from the early 1990's, coinciding with the collapse of the Soviet Union and the Cuban special period. The public health measures of the Cuban case were found to have mostly been translated through

modification. This is perhaps because they have emerged more out of necessity than from external political pressure. One study from the selected data sources summarizes the philosophy behind the Cuban approach well; it argues that the success of Cuban public health (despite their poverty in financial capital) can be partly explained by their emphasis on social capital; reciprocity, social networking, cooperation between sectors, institutions, individuals and other collective achievements (Kath, 2007). As opposed to financial capital since this was, and still is, lacking. The Cuban public health story is one characterized by national policies that attempt to use as much of the country's social capital as possible to make up for the lack of economic prosperity in the country. And from the data gathered in this thesis, it seems like they have succeeded to a large degree by focusing on the social capital latent in the communities. Arguably they have, in an effective way, used core principles of the WHO-policy such as community participation, intersectoral action and health-conscious decision-making as tools to avoid the consequences on health that usually correlate with poor economy, due to the social gradient in health. In addition to the concept of social capital researchers propose that political will has been integral to Cuba's public health success (Pagliccia & Pérez, 2012; J. M. Spiegel et al., 2011, p. 22). The idea of political will is defined by Pagliccia and Pérez (2012) as having to do with renewals of commitments, reformation of the system, development of resources, reviewing performance and responsible management. They also emphasize that the political will to achieve good public health is not the same as the political will to achieve cost reduction and that the way to build political will is through societies developing their own way.

5 Discussion

In this section I discuss the findings from the cases combined to form the foundation required to answer the research question relating to translation of transnational policy in countries differing greatly in governance structure and economy. Regarding the fitment of the WHO-policy, as investigated in the content analysis, the Cuban case showed most of the translation object had been modified and the Norwegian case showed how most had been translated by reproducing. The very different contexts of the Cuban and Norwegian cases likely play a role in why this is. The data from both of the two cases emphasize administrative planning for public health, both have overarching public health policies that guide their public health work and both of these puzzling public health cases emphasize intersectoral health work on the local, municipal level both in practice and described in their overarching public health policies. The data from the Norwegian case presents HiAP as being central to Norwegian public health work, whereas the data on the Cuban case shows that Cuban public health work to a large extend places community and IAH as the most prioritized WHO-policy principles. As discussed in the summary of the Cuban case, social capital and historical, financial necessity likely plays a large role in Cuba's translation of WHO-policy elements into public health. Cuban public health measures are also shown to be loosely linked to the overarching national policies and in some cases seemingly independent from them. Knowing exactly how this happens and why is difficult as researchers point out how instances of intersectoral action in Cuba is hard to describe with models and processes, (although they can be witnessed through case studies of specific intersectoral work (J. M. Spiegel et al., 2011, p. 20)) and that very little peer-reviewed research has been conducted to describe, precisely, how intersectoral action is taking place in Cuba, despite the presence of widespread recognition of Cuban national policies promoting IAH (J. M. Spiegel et al., 2011, p. 16). Additionally researchers express a lack of research on Cuban social-work (Backwith & Mantle, 2009, p. 506). However, from the content analysis, my impression is that Cuban public health measures are largely contingent on situations and perhaps individual community characteristics. The focus on community efforts could be seen as a result of the high number of physicians in Cuba (ca. 8 per 1000 people, whereas the global average is a ca. 2 (Norway on about 5)) (The World Bank, 2022), as they could be seen as "carriers of ideas" as theorized by Sahlin and Wedlin (2008) to facilitate the travel of ideas (another theory contesting diffusion theory). In this case I find that the high number of medical experts in the population likely facilitate bottom-up approaches to public health like those discussed in the content analysis.

The case of Norwegian public health work differs from this as there are clearer ties between the WHO-policy and Norwegian public health policy, as well as greater continuity between the national public health policies and the local public health measures. Although there is seemingly a level of conflict between the overarching policies of the national level and the municipal actors who work with implementing them. In a book chapter on public policy implementation in Norway Kiland, Kvåle, and Torjesen (2015, p. 22) encounters a similar conflict. They conclude that it is caused by the presence of collective and individualistic public health ideas that are experienced by municipal actors as being ambiguous and challenging to reconcile. The conflict between national public health policy and municipal practice echoes some of the core topics of public leadership in Nordic countries, where traditional aspects of public organizations are challenged by new trends. Goldsmith and Larsen (2004), in an article discussing public leadership, argue that leaders of local government in Nordic countries are being pressured into changing because of the increasing amount of reforms and changes in responsibilities of municipalities and CMs. This is very similar to the concerns raised by municipal actors in the Norwegian case, regarding the threat of HiAP turning health into a topic to rule all other concerns of local government. The emphasis, in both the Cuban and Norwegian cases, on low hanging fruits (vulnerable groups, physical health and healthy lifestyles) can be seen as evidence of traditional remnants from pre-WHO-policy public health that leads to extended, trial-and-error translation processes (Røvik, 2016, p. 6). The national policy levels manifest a sort of *de jour* translation of the transnational policy where core elements are reproduced, this is especially true in the Norwegian case. However, at the *de facto* level of analysis, the regional and local practices that results from the translation, there is more modification arguably to account for the increasing levels complexity inherent in local cultures as well as governance and administrative systems.

6 Conclusion

This thesis aimed to shed light on the translation of transnational policy and has done so through a multiple case study of the Cuban and Norwegian public health work as it relates to the WHO-policy. My findings add to the notion of the complexity of the wicked problem of public health work by presenting challenges and interpretation that arise when translating transnational policies in attempts to solve it. The main research question of this thesis was: How have countries with different governance systems and economies translated transnational policy in the form of WHO-policy into public health measures and policies? What I found out was that the two public health puzzles chosen in this study have translated the WHO-policy into their respective contexts in different ways in order to make them fit and sometimes because the countries public health systems had different requirements. In the Cuban case there is the Cuban Paradox that still stands as a mystery, although some attribute it to Cuban political will. Cuban public health is characterized by its down-to-earth, community-based, and situationally contingent intersectoral action, likely due to the large numbers of physicians in the country, but likely also due to other factors that could need further investigation. In the Norwegian case, the country's "deeply embedded value of universalism and equality" (Karlsen et al., 2022, p. 3) could simply be a good fit for implementing HiAP and the other principles of WHO-policy. What this means in broader terms, first and foremost, is that the national significance of transnational policy is to a large degree contingent on the characteristics of the relevant recipient contexts. In addition, speaking to the phenomenon of transnational policy and transnational governance as well, is that national adaptations are more similar to the transnational policy than on the regional and local level. Evidence that this is trues was found in both cases, their stark differences notwithstanding.

Also, the discovery of WHO-policy being largely reproduced in the Norwegian case and largely modified in the Cuban case could suggest that countries that are similar to Norway in terms of culture, governance systems and economy and other factors are more likely to adopt transnational policy more similarly to the original policy. And that countries that are more similar to Cuba are more likely to modify the transnational policy in their adaptations.

Moreover, a case could be made that the two countries' success in population health is attributable to the fact that they both have translated the WHO-policy into their policies and public health measures. To know this for certain more studies would have to be conducted investigating translation of the WHO-policy in countries with poor population health outcomes as well.

7 Closing remarks

There were some inherent challenges in undertaking this multiple case study. Seemingly, finding relevant research connected to the Norwegian case was much easier than for the Cuban case. The result of this became fewer categories in the content analysis for the Cuban case. This is because the lower number of relevant studies meant fewer researchers discussing the same topics, thus fewer categories were created for it. This means that the Norwegian case has effectively more relevant content to analyze in this study than the Cuban case. This could be the case because there simply is less research on Cuban public health work as it relates to the WHO-policy. However, it could also mean that my lacking knowledge of Cuban public health served as a barrier to between me and the relevant data sources. Nevertheless, a good number of relevant secondary data sources were selected, and the Cuban case did yield findings relevant to the research question of this thesis. Additionally, the choice of a systematic review as the method for data collection gave great freedom in that working with secondary sources provides the researcher with the opportunity of readjusting the aim of inquiry when acquiring and systematizing data. The method also provides security regarding reliability of data, at least in this thesis in that the sources were from reputable, established, and trustworthy sources.

The theoretical departure of this thesis, consisting of some transnational theory and mainly translation theory, has its own inherent weaknesses and strengths. A strength here is the rich theoretical framework that deeply describes how ideas and practices are translated and the transnational governance theory that depicts political pressures that drives transnational policy across institutions. However, when it comes to using translation theory as a tool to investigate how translation has happened few conclusions can be drawn in certainty. Also, translation theory has mostly been used for studying the diffusion of management ideas and practices. However, I find that the ideas and principles of the WHO-policy are quite managerial in nature, since they are overarching principles such as HiAP that do effectively instruct countries on how they should manage the public sector towards health promotion, manage being a key word here.

Additionally, there is a high probability that not all relevant studies and reports were identified since the author only understands the English and Norwegian languages and there are likely relevant studies relating to the Cuban case written in Spanish that ultimately should have been a part of the selected data sources. Also, I am a native Norwegian and therefore it is unfeasible that I have an unbiased perspective on the Norwegian case and might have the tendency to

believe that the Norwegian ways are the normal ways, and that anything else is out of the ordinary. Additionally, all policies and public health measures in the cases cannot be said with complete certainty to entirely be translations of the WHO-policy as there could likely be other factors that lead to their manifestation despite the presence of resemblance between WHO-policy elements and national policies and public health measures. However, the strength of the theoretical framework, based heavily on translation theory, is that it allows for evaluation of how transnational policy has been interpreted in the recipient contexts. Translation theory gives the researcher the ability to retroactively investigate how the translation object has been affected, which can serve to guide attention to the central elements that give deep understanding of each case of translation, giving the clarity and depth that was required to answer the *how*-question of this thesis. To further asses the transfer/diffusion/translation of transnational policy on the national level alternative concepts and theories from other literature fields than specifically translation theory could be utilized such as: Implementation theory, research related to bounded rationality and wicked problems, network governance theories and theories and concepts from the fields of multilateral governance and multilevel administration to name a few.

8 Bibliography

Abbott, K. W. (2012). The transnational regime complex for climate change. *Environment and Planning C: Government and Policy, 30*(4), 571-590.

Andersen, H., & Røvik, K. A. (2015). Lost in translation: A case-study of the travel of lean thinking in a hospital. *BMC Health Serv Res, 15*(1), 401-401. doi:10.1186/s12913-015-1081-z

Backwith, D., & Mantle, G. (2009). Inequalities in health and community-oriented social work: Lessons from Cuba? *International social work, 52*(4), 499-511. doi:10.1177/0020872809104253

Baggott, R., & Lambie, G. (2018). "Enticing case study" or "celebrated anomaly"? Policy learning from the Cuban health system. *Int J Health Plann Manage, 33*(1), 212-224. doi:10.1002/hpm.2451

Bambra, C. (2011). Health inequalities and welfare state regimes: theoretical insights on a public health 'puzzle'. *J Epidemiol Community Health, 65*(9), 740-729. doi:10.1136/jech.2011.136333

Britannica. (2021, November 11, 2021). Cuba. Retrieved from https://www.britannica.com/place/Cuba/Trade#ref233422

Bukve, O. (2021). *Forstå, forklare, forandre : om design av samfunnsvitskaplege forskingsprosjekt* (2. utgåve. ed.). Oslo: Universitetsforlaget.

Cairney, P., St Denny, E., & Mitchell, H. (2021). The future of public health policymaking after COVID-19: A qualitative systematic review of lessons from Health in All Policies. *Open Research Europe, 1*, 23.

Cooper, R. S., Kennelly, J. F., & Ordunez-Garcia, P. (2006). Health in Cuba. *International Journal of Epidemiology(35),* 817–824.

Creed, W. D., Scully, M. A., & Austin, J. R. (2002). Clothes make the person? The tailoring of legitimating accounts and the social construction of identity. *Organization science, 13*(5), 475-496.

Czarniawska-Joerges, B., & Sevón, G. (1996). *Translating organizational change*(Vol. 56).

de Leeuw, E., Clavier, C., & Breton, E. (2014). Health policy – why research it and how: health political science. *Health Research Policy and Systems, 12*(1), 55. doi:10.1186/1478-4505-12-55

Denyer, D., & Tranfield, D. (2011). Producing a Systematic Review. In *The SAGE Handbook of Organizational Research Methods* (pp. 671-689). London: SAGE Publications Ltd.

Djelic, M.-L. (2011). From the Rule of Law to the Law of Rules. *International Studies of Management and Organization, 41*, 35-61. doi:10.2753/IMO0020-8825410102

Folkehelseinstituttet. (2018). *Helsetilstanden i Norge 2018: Folkehelserapporten - kortversjon*. Retrieved from Folkehelseinstituttet: https://www.fhi.no/globalassets/dokumenterfiler/rapporter/2018/helsetilstanden-i-norge-20182.pdf

Fosse, E., & Helgesen, M. (2017). Advocating for health promotion policy in norway: The role of the county municipalities. *Societies (Basel, Switzerland), 7*(2), 5. doi:10.3390/soc7020005

Goldsmith, M., & Larsen, H. (2004). Local Political Leadership: Nordic Style. *International journal of urban and regional research, 28*(1), 121-133. doi:10.1111/j.0309-1317.2004.00506.x

Gostin, L. O. (2020). COVID-19 Reveals Urgent Need to Strengthen the World Health Organization. *JAMA Health Forum, 1*(4), e200559-e200559. doi:10.1001/jamahealthforum.2020.0559

Hagen, S., Helgesen, M., Torp, S., & Fosse, E. (2015). Health in All Policies: A cross-sectional study of the public health coordinators' role in Norwegian municipalities. *Scand J Public Health, 43*(6), 597-605. doi:10.1177/1403494815585614

Hagen, S., Overgard, K. I., Helgesen, M., Fosse, E., & Torp, S. (2018). Health Promotion at Local Level in Norway: The Use of Public Health Coordinators and Health Overviews to Promote Fair Distribution Among Social Groups. *International Journal of Health Policy Management, 7*(9), 807-817. doi:10.15171/ijhpm.2018.22

Hagen, S., Øvergård, K. I., Helgesen, M. K., Fosse, E., & Torp, S. (2018). Health promotion at local level in Norway: The use of public health coordinators and health overviews to promote fair distribution among social groups.

Head, B. W., & Alford, J. (2015). Wicked Problems: Implications for Public Policy and Management. *Administration & society, 47*(6), 711-739. doi:10.1177/0095399713481601

Higdem, U. (2015). Møtet mellom helse og plan. *Plan*(3-04), 4-10.

Hlawn, T. (2018). Folkehelse og kommuneplanlegging : Koblingen mellom folkehelse og kommuneplanlegging igjennom systematisk folkehelsearbeid. In: Universitetet i Agder ; University of Agder.

Hofstad, H. (2016). The ambition of Health in All Policies in Norway: The role of political leadership and bureaucratic change. *Health Policy, 120*(5), 567-575. doi:10.1016/j.healthpol.2016.03.001

Håbesland, G. (2015). *Folkehelsekoordinatoren - styrking av det tverrsektorielle folkehelsearbeidet.* NTNU,

Haack, P., Pfarrer, M. D., & Scherer, A. G. (2014). Legitimacy-as-Feeling: How Affect Leads to Vertical Legitimacy Spillovers in Transnational Governance. *Journal of Management Studies, 51*(4), 634-666. doi:10.1111/joms.12071

Jacobsen, D. I. (2015). *Hvordan gjennomføre undersøkelser? : innføring i samfunnsvitenskapelig metode* (3. utg. ed.). Oslo: Cappelen Damm akademisk.

Karlsen, T.-I., Kiland, C., Kvåle, G., & Torjesen, D. O. (2022). ‘Health in All Policies’ and the Urge for Coordination: The Work of Public Health Coordinators and Their Impact and Influence in Local Public Health Policies: A Cross-Sectional Study. *Societies, 12*(1), 11. Retrieved from https://www.mdpi.com/2075-4698/12/1/11

Kath, E. (2007). Inter-sectoral cooperation, political will and health outcomes: a study of Cuba's Maternal–Infant Health Programme. *Policy & Politics, 35*(1), 45-64.

Kiland, C., Kvåle, G., & Torjesen, D. O. (2015). The ideas and implementation of public health policies: The Norwegian case. In *Managing Change* (pp. 9-25): Springer.

Kvåle, G., Kiland, C., & Torjesen, D. O. (2020). Public Health Policy to Tackle Social Health Inequalities: A Balancing Act Between Competing Institutional Logics. In *Transitions and Boundaries in the Coordination and Reform of Health Services*. London: Palgrave Macmillan, Cham.

Pagliccia, N., & Pérez, A. Á. (2012, Januar). The Cuban Experience in Public Health: Does Political Will Have a Role? *International Journal of Health Services(1),* 77–94.

Pagliccia, N., Spiegel, J., Alegret, M., Bonet, M., Martinez, B., & Yassi, A. (2010). Network analysis as a tool to assess the intersectoral management of health determinants at the local level: A report from an exploratory study of two Cuban municipalities. *Soc Sci Med, 71*(2), 394-399. doi:10.1016/j.socscimed.2010.03.041

Potvin, L., & Jones, C. M. (2011). Twenty-five Years After the Ottawa Charter: The Critical Role of Health Promotion for Public Health. *Canadian Journal of Public Health, 102*(4), 244-248. doi:10.1007/BF03404041

Pratt, M. G. (2009, Oktober). From the Editors: For the Lack of a Boilerplate: Tips on Writing up (And Reviewing) Qualitative Research. *The Academy of Management Journal(52-5),* 856-862.

Regjeringen (Producer). (2021, Juni 1). Regjeringen.no. *https://www.regjeringen.no/no/tema/helse-og-omsorg/folkehelse/innsikt/folkehelsearbeid/id673728/*. Retrieved from https://www.regjeringen.no/no/tema/helse-og-omsorg/folkehelse/innsikt/folkehelsearbeid/id673728/

Rice, M. (2011). Trends and Achievements in Promoting Health in the Americas: Developments from 2003-2011.

Røvik, K. A. (2016, March 16). Knowledge Transfer as Translation: Review and Elements of an Instrumental Theory. *International Journal of Management Reviews*, 290-310.

Sahlin, K., & Wedlin, L. (2008). Circulating ideas: Imitation, translation and editing. *The Sage handbook of organizational institutionalism*, *218*, 242.

Sausman, C., Oborn, E., & Barrett, M. (2016). Policy translation through localisation: implementing national policy in the UK. *Policy and politics, 44*(4), 563-589. doi:10.1332/030557315X14298807527143

Spiegel, J., & Yassi, A. (2004). Lessons from the margins of globalization: Appreciating the Cuban health paradox. *Journal of Public Health Policy(25),* 85–110.

Spiegel, J. M., Alegret, M., Clair, V., Pagliccia, N., Martinez, B., Bonet, M., & Yassi, A. (2011). Intersectoral action for health at a municipal level in Cuba. *Int J Public Health*, *57*(1), 15-23. doi:10.1007/s00038-011-0279-z

Spiegel, J. M., Gonzalez, M., Cabrera, G. J., Catasus, S., Vidal, C., & Yassi, A. (2008). Promoting health in response to global tourism expansion in Cuba. *Health Promotion International*, *23*(1), 60-69. Retrieved from https://watermark.silverchair.com/dam040.pdf?token=AQECAHi208BE49Ooan9kkhW_Ercy7Dm3ZL_9Cf3qfKAc485ysgAAAsYwggLCBgkqhkiG9w0BBwagggKzMIICrwIBADCCAqgGCSqGSIb3DQEHATAeBglghkgBZQMEAS4wEQQMdOk0ayYatOf1KX3IAgEQgIICeWCSM0tEVKQkcizMiOPpmHF3tb3Oof9scZbNKCMZlb-P4dJeZmsOQt2blVbKvRE_b6Aqx7i9DWrgLMM3iVvHHoDj1iQ1G5TNEuXo9jL_zmnP2sb6Nc8XTxzhqluWFdVJrAQTp3LqbLX-U_2I1M9wVIGQ5rJzI7Q-nyTKxjRW6C9K_OgkuabZYIxQunqKuZ21CzFc7SqEk0UdK6RPC6Mav0wAKlz6_Rq2gfU-l5t9pzzw5C_X3RXz1Gk9RHTcK5ChOXlOIbWnZg2Hdxs0MfcmEUF_588z5GOWf7783Q3aY4Wab10yQhPRGlxTvOfyrc2ryO60DX58k8YiIoLgJ8mcsxgkbr0FZxINsR7Cgm-hAzzbLRy1fiXCuqA3LNPTJv22bksd31GpIt5Xu6uwCsegTPxeJTYC-Oq8KweYzYS80uQDy3hevUketXHaR0kgXHt8T_ybIOpbRbAbFRFZWDfo4Fh3VwzWo1GCKc43IagRBj7q-Rlspg0HSAPm9G9wj-x3dv72MSFcUzNeT2VCL9Nq-cl0dDF0PuEE_Jb1hEDcyEcI65r14FUBycvmHPEKb1lDHahFjgpL0rJh-c3WcUfogTu-2ZTSyyxiQdTqe0hIZ8pBbLwiE7eHDIgX0HZarMEsO6rFp5Ojm8zACP-l7xEU88LYEctWezzncFJ-_tTtjYddT39PM4EDTwo0F3L1LqZ218Y9yAdG8otR7-oqEZTYfLv5zeSfuA3pXfodezfwV6xWFlOVgB2p1ipkrPat0lPljKyLQjB0ToatEvqxskKcrG2BdRRDOzxAHtctek1tKQBvWVUi9lSO_K1gNt5OXEhrliD5zsZObDxZTQ

Stone, D., Porto de Oliveira, O., & Pal, L. A. (2020). Transnational policy transfer: the circulation of ideas, power and development models. *Policy and Society*, *39*(1), 1-18.

Synnevåg, E. S., Amdam, R., & Fosse, E. (2018). Intersectoral planning for public health: Dilemmas and challenges. *International Journal of Health Policy Management, 7*(11), 982-992. doi:10.15171/ijhpm.2018.59
The Bitannica Dictionary. (2022). Policy. Retrieved from https://www.britannica.com/dictionary/policy
The World Bank. (2021a). GDP per capita (current US dollar) - Cuba. Retrieved from https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?end=2019&locations=CU&start=1970&view=chart
The World Bank. (2021b). GDP per capita (current US dollars) - Norway. Retrieved from https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?end=2019&locations=NO&start=1970&view=chart
The World Bank. (2021c). Life expectancy at birth, total (years) - Cuba. Retrieved from https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=CU
The World Bank. (2021d). Life expectancy at birth, total (years) - Norway. Retrieved from https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=NO
The World Bank. (2021e). Mortality rate, infant (per 1,000 live births) - Cuba. Retrieved from https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=CU
The World Bank. (2021f). Mortality rate, infant (per 1,000 live births) - Norway. Retrieved from https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=NO
The World Bank. (2022). Physicians (per 1,000 people) - Cuba, Norway, World. Retrieved from https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=CU-NO-1W
Thorsen, D. E. (Producer). (2021, november 11). Norges politiske system i Store norske leksikon. *snl.no*. Retrieved from https://snl.no/Norges_politiske_system
Tjora, A. H. (2018). *Viten skapt : kvalitativ analyse og teoriutvikling*. Oslo: Cappelen Damm akademisk.
WHO. (1987, May 16-17). Health Promotion Ottawa Charter. *World health*, 2-8.
WHO. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report*: World Health Organization.
WHO. (2021a). WHO Director-General's opening remarks at the 10th Global Conference on Health Promotion. Retrieved from https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-10th-global-conference-on-health-promotion
WHO. (2021b). WHO presence in countries, territories and areas: 2021 report.
Wæraas, A., & Nielsen, J. A. (2016, February 11). Translation Theory 'Translated': Three Perspectives on Translation in Organizational Research. *International Journal of Management Reviews*, 236-270.
Zins, C. (2000). Success, a structured search strategy: Rationale, principles, and implications. *Journal of the American Society for Information Science, 51*(13), 1232-1247.