



Cultural Contexts of Health and Well-being, No.1

First meeting of
the expert group

Copenhagen, Denmark,
15–16 January 2015

Beyond bias: exploring the cultural contexts of health and well-being measurement



**World Health
Organization**

REGIONAL OFFICE FOR
Europe



The World Health Organization was established in 1948 as the specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health. It fulfils this responsibility in part through its publications programmes, seeking to help countries make policies that benefit public health and address their most pressing public health concerns.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region embraces nearly 900 million people living in an area stretching from the Arctic Ocean in the north and the Mediterranean Sea in the south and from the Atlantic Ocean in the west to the Pacific Ocean in the east. The European programme of WHO supports all countries in the Region in developing and sustaining their own health policies, systems and programmes; preventing and overcoming threats to health; preparing for future health challenges; and advocating and implementing public health activities.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease, WHO's books contribute to achieving the Organization's principal objective – the attainment by all people of the highest possible level of health.

Cultural Contexts of Health and Well-being, No.1

First meeting of
the expert group

Copenhagen, Denmark,
15–16 January 2015

Beyond bias:
exploring the cultural
contexts of health
and well-being
measurement

ABSTRACT

This first expert group meeting on the cultural contexts of health and well-being was convened by the WHO Regional Office for Europe on 15–16 January 2015. As part of the adoption of Health 2020, the European policy for health and well-being, WHO Member States agreed to a measurement framework, which would measure and report on objective and subjective well-being. However, practical challenges remain, particularly with respect to the influence of cultural factors on well-being and well-being measurement. The aim of this meeting was to provide advice on how to consider the impact of culture on health and well-being, and how to communicate findings from well-being data across such a culturally diverse region as Europe. This report outlines the detailed recommendations made by the expert group in relation to each of these objectives.

KEYWORDS

CULTURAL COMPETENCY

CULTURE

HEALTH

MEETING REPORTS

PUBLIC HEALTH

WELL-BEING

Address requests about publications of the WHO Regional Office for Europe to:

Publications, WHO Regional Office for Europe, UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (<http://www.euro.who.int/pubrequest>).

ISBN 978 92 890 5100 2

© World Health Organization 2015

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization

in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

Cultural Contexts of Health and Well-being, No.1

First meeting of
the expert group

Copenhagen, Denmark,
15–16 January 2015

Beyond bias: exploring the cultural contexts of health and well-being measurement

Contents

Executive summary	iv
Introduction	1
Update on progress with well-being work	1
Outline and main objectives of the meeting	3
Agreeing on a working definition of culture	3
Recommendations	4
Rethinking data and evidence needs for well-being	5
Recommendations	8
Reporting effectively on well-being	9
Recommendations	12
Identifying research gaps in relation to culture and well-being	12
Recommendations	14
Conclusions	15
References	16
Annex 1. Programme	19
Annex 2. List of participants	23

Executive summary

This first meeting of experts on the cultural contexts of health and well-being was convened by the WHO Regional Office for Europe on 15–16 January 2015. As part of the adoption of Health 2020, the European policy for health and well-being, WHO Member States agreed to a measurement framework, which would measure and report on objective and subjective well-being. However, practical challenges remain, particularly with respect to the influence of cultural factors on well-being and well-being measurement. The aim of this meeting was to provide advice on how to consider the impact of culture on health and well-being, and how to communicate findings from well-being data across such a culturally diverse region as Europe.

The topic provided a unique opportunity to bring together researchers working across disciplines, including medicine, psychiatry, public health, communication, philosophy, psychology, medical anthropology and history of medicine.

The expert group hopes that such innovative cross-disciplinary work will make health policies more effective, by identifying cultural enhancers and cultural obstacles for health and well-being.

This focus on the cultural contexts of health is corroborated by the 2014 Lancet Commission on Culture and Health, which argued that “the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide.”¹

The expert group also hopes that its work can broaden WHO’s focus from disease and disease prevention to include a more positive focus on health, subjective well-being and people’s lived experience.

Exploring the social and cultural contexts of health and well-being requires a whole-of-government, as well as whole-of-society, approach in line with the vision of Health 2020. It means empowering people to find their own meanings of disease and health. It means creating more people-centred, culturally-grounded health systems, which treat people as normative agents rather than passive bio-

¹ Napier AD, Ancarno C, Butler B, Calabrese J, Chater A, Chatterjee H et al. Culture and health. *Lancet*. 2014; 384:1607–39.

The humanities and social sciences are well placed to help explore the meanings people create around experiences of disease, health and well-being.

mechanisms. The humanities and social sciences are well placed to help explore the meanings people create around experiences of disease, health and well-being.

Finally, in line with the fourth priority of Health 2020, a culture-centred approach means focusing on the role of culture in making communities resilient to health challenges, engaging with the role of culture as a positive resource for well-being, and exploring the extent to which case studies of cultural resilience can be translated to other cultures.

The expert group was tasked with addressing the following four objectives of the meeting:

- agreeing on a working definition of culture
- rethinking data and evidence needs for well-being
- suggesting ways to report more effectively on well-being
- identifying research gaps in relation to culture and well-being.

This report outlines the detailed recommendations made by the expert group in relation to each of these objectives. In summary, the key recommendations were that WHO:

- establishes an expert group to explore the cultural contexts of health and well-being from an interdisciplinary perspective, including insights from the humanities and social sciences;
- adopts the United Nations Educational, Scientific and Cultural Organization (UNESCO) 2001 definition of culture (see Box 1) and produces a position paper suggesting ways in which this definition can be studied systematically and integrated into the Health 2020 priority areas;
- identifies existing quantitative and qualitative research and narrative case studies that illustrate the impact of culture on health and well-being, and identifies useful policy interventions;

Box 1. Definition of culture

In its 2001 Universal Declaration on Cultural Diversity, UNESCO defined culture as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs”.

- encourages more research into the cross-cultural measurement and comparability of subjective well-being data;
- enhances current well-being and health reporting through the use of new types of evidence, particularly qualitative and narrative research from a larger variety of academic disciplines and from a wide array of cultural contexts; and
- explores culture-centred, participatory approaches that engage local communities in sensitive and measured ways to explore what it means to be well and healthy, and foster avenues of communication for sharing cultural resources of well-being and health.

Introduction

The first expert group meeting on the cultural contexts of health and well-being was convened by the WHO Regional Office for Europe on 15–16 January 2015 (see Annex 1 for the programme). Participants included researchers working across disciplines, including medicine, psychiatry, public health, communication, philosophy, psychology, medical anthropology and history of medicine (see Annex 2).

Participants were welcomed to the meeting by Dr Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe; and Professor Mark Jackson, Professor of the History of Medicine, Exeter University, United Kingdom, who was elected as Chair for the meeting. Both the WHO Secretariat and the Chair thanked the Wellcome Trust for its generous contribution towards the financing of the meeting. Dr Simon Chaplin, Director of Culture and Society at the Wellcome Trust, also welcomed participants and expressed the Wellcome Trust's enthusiasm for this work as part of its wider partnership with WHO. During his opening presentation, Dr Chaplin made a strong case for the importance of interdisciplinary research, both to strengthen and to challenge the systems of value in which people operate.

Mr Jules Evans was elected as rapporteur for the meeting. Participants were invited to declare any conflicts of interest; none were noted. The programme was adopted.

Update on progress with well-being work

The WHO Secretariat set out the overall purpose of the meeting in supporting the European Health 2020 policy, which has a focus on improving health and well-being across Europe by 2020 (1).

In 2014, as part of the monitoring framework for Health 2020 (2), Member States of the WHO European Region adopted a set of indicators for both objective and subjective well-being, including measuring life satisfaction. Questions remained, however, about the degree to which it was possible to accurately measure well-being at the regional level and to make meaningful international comparisons,

This expert group was convened to consider the impact of cultural contexts on well-being measurements, and more broadly to explore how a better understanding of the cultural contexts of health can help Member States meet their health and well-being targets.

including cross-cultural aspects that could guide policy. This expert group was convened to consider the impact of cultural contexts on well-being measurements, and more broadly to explore how a better understanding of the cultural contexts of health can help Member States meet their health and well-being targets.

Health 2020 has initiated a recalibration that is bringing well-being back into WHO's focus, enabling the Organization to go beyond its traditional disease-centred approach and to embrace instead a more holistic conception of its role. This is, in fact, aligning WHO with its original 1948 definition of health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (3).

The meeting falls within the scope of the European Health Information Initiative (EHII), which seeks to improve the health of the people of the European Region by strengthening the information that underpins policy. The work is being taken forward in collaboration with a number of European partners, including several Member States and national institutions, the European Commission, the Organisation for Economic Cooperation and Development (OECD), and the Wellcome Trust.²

EHII has six key areas:

- development of information for health and well-being with a focus on indicators
- enhanced access to and dissemination of health information.
- capacity-building
- the strengthening of health information networks
- support for health information strategies
- communication and advocacy.

All information, data and evidence that impacts on health is considered by WHO in its reporting of health information. Consequently, the work of the expert group was vital, given that it has the capacity to enrich what information is gathered and how it is analysed. A key component of EHII is also to streamline the ways in which this information is brought to the attention of policy-makers. The expert group was, therefore, tasked specifically with making clear, actionable recommendations that WHO could implement or develop.

² Other EHII members include: the Federal Ministry of Health (Austria); the Ministry of Social Affairs and Health, and the National Institute for Health and Welfare (Finland); the Ministry of Health, Welfare and Sport, and the National Institute for Public Health and the Environment (RIVM) (Netherlands); the Ministry of Health (Poland); the Federal Research Institute for Health Organization and Informatics of the Ministry of Health, and the WHO Collaborating Centre on Health Statistics and Analysis (Russian Federation); the National Board of Health and Welfare, and the Public Health Agency of Sweden (Sweden); the Ministry of Health (Turkey); and the Manchester Urban Collaboration on Health.

Outline and main objectives of the meeting

The four main objectives of the meeting were:

- agreeing on a working definition of culture
- rethinking data and evidence needs for well-being
- suggesting ways to report more effectively on well-being
- identifying research gaps in relation to culture and well-being.

The meeting also sought to address three technical questions.

- Can cultural bias be accounted for while measuring well-being?
- Can well-being data provide insight into cultural resilience?
- How can the WHO Secretariat communicate information about the complex interactions between well-being, culture and health meaningfully across the culturally diverse WHO European Region?

Agreeing on a working definition of culture

The expert group considered the work of the 2014 Lancet Commission on Culture and Health, which argued that “the systematic neglect of culture in health and health care is the single biggest barrier to advancement of the highest attainable standard of health worldwide” (4).

The treatment of diabetes illustrates this point: according to “the rule of halves”, the percentage of people successfully treated is a fraction of the total diabetic population, mainly because of sociocultural factors. This is a critical issue for health ministries and for governments as a whole; the United Kingdom’s National Health Service, for instance, spent £23.7 billion in 2012, 10% of its entire budget, on diabetes and diabetes-related complications, yet hardly any of this money is invested in understanding the sociocultural factors preventing people from getting successful treatments (5).

There is, consequently, a strong economic argument for focusing more on the cultural contexts of health. In addition, there is also a strong ethical argument for doing so: recognizing the impact of culture on health helps policy-makers to pay attention to people’s agency, their

Anthropologists have recently become interested in culture as a shared social construction, a dynamic process, a striving for something new, as well as a preservation of tradition.

beliefs and values, and the meanings they construct from their experiences of health and illness.

An important question that first needed to be addressed, however, was how “culture” should be defined in the context of health. The meeting heard from several experts, including representatives from the Italian National Institute for Statistics (ISTAT), which includes “Landscape and cultural heritage” as one of its 12 domains of well-being that comprise the *Benessere equo sostenibile* (BES) framework to measure equitable and sustainable well-being (6).

Anthropologists in the expert group explained that culture had for the last three decades been seen as too blunt, static and monolithic a concept to be much use to anthropologists. However, more recently, anthropologists have become interested in culture as a shared social construction, a dynamic process, a striving for something new, as well as a preservation of tradition. Arjun Appadurai defines culture as “a dialogue between aspirations and sedimented traditions” (7). This idea of culture as something forward-looking, even visionary, chimes well with the forward-looking spirit of the Health 2020 report.

The expert group agreed to embrace the United Nations Educational, Scientific and Cultural Organization’s (UNESCO) definition of culture as described in the 2001 Universal Declaration on Cultural Diversity (8). This definition conceives of culture as a way of life rather than simply as religious, social or ethnic characteristics delimited by geopolitical boundaries, thus acknowledging the presence (and importance) of dynamic microcultures that exist everywhere, and that even the process of focusing on well-being is developing its own cultural artefacts.

Recommendations

The expert group recommended using UNESCO’s definition of culture, published in the 2001 Universal Declaration on Cultural Diversity, which defines culture as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (8).

The expert group also recommended producing a position paper, which would seek to achieve several objectives.

1. Clarify UNESCO's definition to spell out its assumptions and implications for the study of culture and well-being and what the definition means for empirical study across disciplines.
 - Values do not exist in a social vacuum and change over time, perpetuated in practice.
 - To study values, one has to study agency and practice.
 - Boundaries of cultural groups are fluid.
 - All forms of knowledge are cultural, including scientific and medical practice.
2. Identify in which ways culture, as defined, relates to health and well-being.
 - How does cultural competence help to promote health and well-being?
 - How does the concept of well-being affect our cultures of care?
 - How does culture affect and/or enable well-being measurement?
 - How does culture affect and/or enable reporting and communication on health and well-being?
 - How does culture affect health behaviour and the perceptions of health, disease, care and prevention?
3. Elaborate how each of these ways can be studied systematically, and what the implications are for policy-relevant qualitative and quantitative research.

Rethinking data and evidence needs for well-being

Representatives from Gallup, ISTAT, OECD, UNESCO and the United Kingdom's What Works Centre for Wellbeing all presented their research, experiences and thoughts on the ways in which culture is relevant with regard to work on social indicators. The issue of cultural bias was explored, that is, whether cultural factors might introduce measurement error in any form of self-reported survey data. More broadly, the discussions explored what subjective well-being data can tell us about the impact of culture on health and well-being.

According to experts at the meeting, several factors may affect cross-cultural comparability of subjective well-being data. One is language and translation issues in which semantic and conceptual equivalence challenges should be considered. Semantic equivalence refers to the choice of terms and semantic structures to ensure the equivalence of the translation. Conceptual equivalence refers to the degree to which a concept exists in the target language, irrespective of the words used. Additionally, there may be operational difficulties when using emphasis in non-Latin based scripts (e.g. capital letters).

Another factor is cognitive challenges. The Cantril Ladder of Life Scale has proven to be cognitively challenging in different cultural contexts, in part because the wording that introduces the concept is relatively involved. Also, the use of metaphorical constructs may not be equally useful in all cultures.

Response bias is another factor. Some cultures may have numeric preferences on a 0–10 scale, but it is hard to tell whether this represents a genuine difference in subjective well-being levels or a culturally ingrained approach towards scales.

Good survey methodology, such as questionnaire design and validation, adequate translation practices, cognitive testing, etc., is essential in order to minimize measurement error. Caution should in any case be exercised when drawing international comparisons, as further research is still needed to establish the cross-cultural comparability of subjective well-being measures.

There may be deeper cultural differences underlying emotional reporting styles. The expert group discussed the “positivity bias” in North American responses to well-being questionnaires, versus a “modesty bias” in responses from Confucian cultures. Cultural analysis of artefacts such as advertisements and greeting cards suggest that these different response styles might reflect different cultural conceptions of well-being, including the types of mental states that are most highly valued (e.g. excitement versus calmness).

Questions have been raised about whether well-being questionnaires, as they are currently constituted, have an in-built cultural bias. They define subjective well-being in terms of human flourishing in this world, a particularly modern, secular, European definition of well-being. Many individuals and cultures throughout human history

Important health information can be gathered about the well-being of groups, communities and even nations, by (for example) systematically analysing historical records, anthropological observations or other forms of cultural outputs.

would see well-being not in terms of human flourishing but in terms of alignment with a spiritual dimension.

On the issue of a conceptual framework for well-being, two main schools of thought were outlined: universalism, which holds that human needs are universal and, therefore, a single framework for understanding well-being can be pursued; and relativism, which insists that different cultures have different models of well-being, different emotional styles and different languages, all of which render cross-cultural well-being comparisons difficult or even invalid.

On the second broader question regarding what subjective well-being data can tell about the impact of culture on health and well-being, several speakers explored some of the interesting and (as yet) not-fully-explained outliers in well-being data.

For example, why are some Central and Latin American countries outliers in life satisfaction relative to their income levels? Several speakers pointed to the possible role of religion as a factor of cultural resilience in countries like Brazil, Costa Rica and El Salvador, which typically score high on life satisfaction measures. However, religious adherence is also high in low-scoring countries such as Chad and Uganda; hence, this would require further investigation.

Negative outliers in well-being measurements suggest the impact of cultural and sociopolitical factors. For example, in some eastern European countries, well-being scores are consistently lower than their per capita income levels might predict. Coherent narratives explaining these kinds of findings are still missing; however, the expert group remarked that it was time for subjective well-being research to shift towards analysis and synthesis of data and results, in order to understand and make sense of the often conflicting results that are being presented.

It was suggested that one way to achieve this would be to promote a more interdisciplinary approach to well-being research and analysis. Important health information can be gathered about the well-being of groups, communities and even nations, by (for example) systematically analysing historical records, anthropological observations or other forms of cultural outputs. Taking advantage of a more multidisciplinary approach to the way WHO conceptualizes and reports on well-being might have several advantages.

First, such an approach could allow for more compelling and more localized well-being narratives, which could provide an important complement to findings from existing, international data sources, especially where developing and implementing resource-intensive, country-specific well-being surveys is not an option. This is crucially important to the Regional Office because European Member States have already expressed a concern about the current burden of reporting. International agencies should not unnecessarily increase this burden.

Second, the use of more culturally specific sources of evidence (gathered from, for instance, traditions and rituals) can help give a voice to those people whose views are systematically left out of national and global well-being surveys because they belong to groups that are hard to reach for survey purposes.

Finally, an integrated, multidisciplinary approach – open to insights from the human and wider social sciences – can help to encourage a more balanced discussion about well-being. Working between disciplines exposes the systems of values in which academics operate and encourages the kind of reflexivity that facilitates a better understanding, for instance, of how all the attention on well-being is producing its own cultural dynamics that might themselves have negative side-effects.

Recommendations

The expert group made three recommendations.

1. Investigate the benefit of combining the analysis of existing well-being data from national authorities or international organizations with the analysis of new forms of evidence from a wider array of disciplinary perspectives from the humanities and social sciences. This approach should tackle particular case studies, such as counterintuitive subjective/objective well-being data contradictions (e.g. Denmark's higher premature mortality including from suicides compared to its high levels of life-satisfaction and happiness scores) and attempt to create a meaningful narrative from an interdisciplinary perspective.
2. Take on a more vocal advocacy role in demonstrating and

promoting the importance of cultural contexts in well-being and health more broadly, particularly in relation to the four priority areas articulated in Health 2020 (see Box 2).

3. Commission evidence reviews from different disciplinary perspectives, which describe their potential contribution to each priority area, and then describe the gains of a multidisciplinary approach.

Reporting effectively on well-being

Although the study of well-being has been around for several decades, national and international reporting on well-being measurements is still in its infancy. The OECD launched its Better Life Index (9) and has published a *How's Life?* report in 2011 (11) and 2013 (10). The United Kingdom's Office for National Statistics (ONS) launched its subjective well-being measurements in 2012 (12); ISTAT launched BES in 2013 (6), and the United Nations Sustainable Development Solutions Network launched its *World happiness report* in the same year (13). In line with these initiatives, the idea of national well-being measurements has become more broadly-accepted in the public consciousness.

None the less, well-being reports still face two main challenges. Firstly; some scepticism about the precise meaning of the concept still exists. Secondly, the policy response to well-being evidence is also still in its

Box 2. Health 2020 priority areas

The Health 2020 policy framework proposes four priority areas for policy action based on the global priorities set for WHO by its Member States, and aligned to address the special requirements and experiences of the European Region. These areas also build on relevant WHO strategies and action plans at the regional and global levels.

The four priority areas are to:

- *invest in health through a life-course approach and empower citizens;*
 - *tackle Europe's major disease burdens of noncommunicable and communicable diseases;*
 - *strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and*
 - *create supportive environments and resilient communities (1).*
-

infancy. Statistical reports help to build the evidence base for policy, but must be supplemented with other forms of evidence in order to make concrete recommendations for policy. A focus on well-being has created interest in the potential effectiveness of mental health promotion activities, for example, but statistical reports do not provide direct policy advice about which activities will be most effective and under what circumstances.

The second challenge is considered in the next section of the report. The first challenge may have emerged partly from the communicative style in which data is presented by organizations and reported in the media.

Communications about well-being have sometimes employed a visual look, which uses symbols or pictures of people outwardly expressing their happiness. This reporting style risks alienating parts of the population, particularly during a period of austerity and global uncertainty. It presents one particular model of well-being (extrovert, high arousal, individualist), which will not resonate for people who understand well-being in different terms. Immigrant communities and communities that are usually disenfranchised are also likely to be missing from these depictions of well-being.

Conventional well-being reporting also often suggests a so-called formula for well-being, which those countries that rank highly in global well-being surveys have discovered and implemented. Such claims can strike sceptics as unhelpful and reductionist, seemingly championing a particular normative philosophy that may be inappropriate in other cultural contexts. They also leave no room for people to decide their own definitions of well-being. Moreover, such top-down frameworks of reporting on culture and well-being are likely to miss out on the rich diversity of cultural contexts within which health and well-being are situated. To think of communication as a one-way information process misses out on the value of communication as a resource for building dialogues and bridges.

The expert group, therefore, suggested that policy initiatives should be participatory and interactive, allowing room for personal choice and creativity. In line with Health 2020's first priority, they should be empowering, giving people data at the local level, which informs their interactions with local services. Communication pathways need to be fostered to create opportunities for communities to share their stories

In order to better engage with the public on well-being, it is important to explore ways to include individuals' and groups' personal stories of well-being and resilience.

of well-being. Useful precedents for two-way communication include the ONS' national conversation on well-being, made up of public consultations and debates. Another useful case study is Heart Health Indiana, which explored the issue of heart disease among African-Americans in a culturally sophisticated, community-grounded way, connecting with local communities and local community media to share community-driven stories of health and well-being (14).

Useful examples for well-being data websites that are interactive and empowering include the section on measuring national wellbeing from the ONS website, with interactive maps enabling users to explore well-being data at local level (12). The OECD's Better Life website allows users to construct their own weighted index based on the values that matter to them, rather than imposing a particular normative model onto users (9). Public Health England's website now provides data on levels of anxiety and depression within particular boroughs in the United Kingdom, which can be used by local communities to urge local governments to spend more on mental health services (15).

In order to better engage with the public on this topic, it is important to explore ways to include individuals' and groups' personal stories of well-being and resilience, drawing on narrative or qualitative accounts, and encouraging people to share what well-being means to them, via social media like YouTube. Connecting available well-being data with community-grounded narratives creates a space where two-way conversations can take place, thus highlighting diverse accounts of the relationship between culture and well-being.

More broadly, the expert group suggested that it was important to communicate the case for culture's relevance to health and well-being to the general public, as well as fostering independent communication channels for members of the public to participate in. To create spaces for acknowledging the positive role of culture in health and well-being, communication needs to examine the structural limitations that disenfranchise cultural articulations of health. Moreover, rooted in this close examination of structures, a commitment needs to be placed on creating cultural networks of communication at the grassroots that foster opportunities for diverse understandings of culture, health and well-being to be voiced.

From a policy perspective, it may be useful to focus on case studies of cultural resilience. The important question, from a policy

perspective, is whether these case studies discover factors, skills, values or policy interventions that might be transferable to other cultures and communities.

Recommendations

The expert group made five recommendations for WHO to consider.

1. Explore culture-centred, participatory approaches that engage local communities in sensitive and measured ways to explore what it means to be well and healthy, and foster avenues of communication for sharing cultural resources of health and well-being.
2. Avoid visual clichés and simplistic normative pronouncements that impose one model of health and well-being onto a diverse population. Instead, WHO should consistently make it clear that there are diverse paths to diverse definitions of well-being.
3. Focus on interesting and counterintuitive case studies that might contain insights into how resilience might be culturally influenced or even produced.
4. Make communication on well-being initiatives two-way and not merely the report of well-being expert advice to governments and populations. Effective communication about well-being will require listening to countries, groups and people about their own definitions and explorations of well-being, encouraging them to answer what living well and being healthy means in their own cultural context.
5. Present research through websites, such as WHO's health information and evidence portal for Europe (16), in a way that is accessible, interactive and granular for the public to use.

Identifying research gaps in relation to culture and well-being

The expert group identified several areas where further research is needed.

- How are culture, health and well-being **interconnected**?
- How and to what extent are survey measurements influenced by **cultural bias**?

- As to **interventions**, how can health and well-being be improved by taking a cross-cultural perspective? What are useful and economically viable recommendations for policy-makers?
- To what extent are interventions which promote well-being **sustainable**?
- How can **narrative forms of evidence** be integrated into evidence-based health policy?

Case studies should be identified that explore the dynamic, two-way relationships between culture and health, between culture and subjective well-being, and between subjective well-being and health. Investigations into the interconnections between these elements would use an interdisciplinary approach, ideally with a longitudinal perspective.

Further work needs to be done to consider how **cultural bias** might affect international subjective well-being comparisons. While it is important to continue focusing on established measurements of subjective well-being that are not yet incorporated into the Health 2020 measurement framework (such as hedonic and eudaimonic well-being), it may be useful to also ask: what are the cultural constructions inherent in these measurements? What are the most important aspects of subjective well-being that these measurements currently leave out?

More work is needed to make the political and economic case for focusing on culture, health and well-being. More studies that show what works are needed: what policy **interventions** have been shown to lead to a sustainable rise in well-being at the national, local and individual levels? Are these interventions replicable? It was noted that the move in some countries (such as the United Kingdom) away from a single focus on lifestyle advice (e.g. on alcohol and tobacco use) to a more holistic wellness service might be a useful example to investigate. These wellness services use a community assets based approach, involving the community in the design process, thereby reflecting different cultural perspectives on health and well-being. In particular, the expert group suggested diabetes, as well as mental health as two areas where more qualitative or interdisciplinary approaches to public health are already proving useful.

For the WHO Regional Office for Europe and Member States, it is important to focus research on the Health 2020 priorities, and to find

It is important to recognize and value the unique contributions that both qualitative and quantitative data can make, depending on the questions to be addressed.

ways in which subjective well-being and cultural context approaches can help Member States formulate policies within these priority areas (see Box 2).

More research is needed on the **sustainability** of interventions to promote well-being. To what extent does hedonic adaptation make it difficult, if not futile, to try and permanently raise the subjective well-being level of a nation? How can the positive impact of cultural interventions for health be made to last, particularly within groups that fall below average national subjective well-being levels? Are there examples where hedonic adaptation does not occur, and what can be learned from this? The expert group agreed that more long-term longitudinal studies in this area are needed.

Research that looks at the suitability of **narrative forms of evidence** derived from the humanities and social sciences is needed. The conventional hierarchy of evidence drawn upon to inform evidence-based policy privileges randomized control trials, case control trials and other statistically valid forms of quantitative data. However, such a hierarchy has been recognized to shut down access to the subjective meanings of experiences, the contextual nature of knowledge production and the dominant discourses that inform both policy and research orientations. It is important, therefore, to recognize and value the unique contributions that both qualitative and quantitative data can make, depending on the questions to be addressed. There are, of course, examples of conventional research which uses qualitative and narrative forms of data with respect to shaping research questions and testing research instruments. However, evidence-informed policy has rarely explicitly taken up the richly textured accounts of daily life that can be captured through narrative research.

Recommendations

The expert group made five recommendations.

1. Identify and systematically collect and analyse existing data and case studies that illustrate the impact of culture on health and well-being, and that identify useful policy interventions.
2. Encourage more research into the cross-cultural measurement and comparability of subjective well-being data in a number of areas to be prioritized later.

3. Focus on a varied set of case studies to explore the cultural contexts of health from an interdisciplinary perspective, bringing in the humanities and social sciences. Diabetes and mental health are two areas where more qualitative or interdisciplinary approaches to public health are already proving useful.
 4. Seek out case studies where national or local governments and their policies have successfully improved the subjective well-being of their populations. Are such interventions replicable in other countries and cultures?
 5. Investigate and, where appropriate, promote the use of narrative forms of evidence derived from the humanities and social sciences in order to enhance health and well-being reporting.
-

Conclusions

It was agreed that, in order to continue to build on the useful momentum gathered during the expert group meeting, a small working group should be established to provide WHO with guidance and advice on how to take forward the recommendations elaborated during the meeting.

The work of this expert group will be broken down into several work packages along the lines of the sections outlined in this report. Thus, one work package will focus on producing a concise conceptual framework to explain how the UNESCO definition of culture can be understood and operationalized in the context of health.

This framework will then permit the identification of case studies that illustrate the impact of cultural contexts on health and well-being, allowing for potential policy recommendations to be identified. The framework should also make the case for how research from the humanities and social sciences can provide important added value by providing a way of integrating the subjective accounts of personal experiences into the narratives of well-being and health.

In relation to WHO's work on well-being in particular, the longer term objective will be to create a richer set of tools and methodologies for reporting on well-being. Thus, in addition to the data already being collected via WHO's subjective and objective well-being indicators, future well-being reports should be augmented by well-being

cases studies examined from multidisciplinary perspectives and communicated using a culture-centred approach. If successful, this form of well-being reporting may eventually be encapsulated in the form of guidance documentation, which can be used by Member States to help them understand, report on and improve the well-being of their populations.

Based on the recommendations above, the WHO Secretariat will formulate a detailed action plan for 2015/2016 for discussion with the expert group.

References

1. Health 2020: a European policy framework supporting action across government and society for health and well-being. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.euro.who.int/en/publications/abstracts/health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being>, accessed 13 March 2015).
2. Targets and indicators for Health 2020. Version 2. Copenhagen: WHO Regional Office for Europe; 2014 (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2014/targets-and-indicators-for-health-2020.-version-2>, accessed 13 March 2015).
3. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948 (<http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1&ua=1>, accessed 3 April 2015).
4. Napier AD, Ancarno C, Butler B, Calabrese J, Chater A, Chatterjee H et al. Culture and health. *Lancet*. 2014; 384:1607–39.
5. Hex N, Bartlett C, Wright D, Taylor M, Varley D. Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. *Diabetic Med*. 2012; 29:855–62.

6. BES: Benessere Equo e Sostenibile [BES: project to measure equitable and sustainable well-being] [website]. Rome: Italian National Institute of Statistics; 2015 (<http://www.misuredelbenessere.it/>, accessed 13 March 2015).
7. Appadurai A. The capacity to aspire: culture and the terms of recognition. In: Rao V, Walton M, editors. Culture and public action. Palo Alto (CA): Stanford University Press; 2004:59–84.
8. UNESCO Universal Declaration on Cultural Diversity. Paris: United Nations Educational, Scientific and Cultural Organization; 2001 (http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html, accessed 13 March 2015).
9. OECD Better Life Index [website]. Paris: Organisation for Economic Co-operation and Development; 2015 (<http://www.oecdbetterlifeindex.org/>, accessed 13 March 2015).
10. How's life? measuring well-being. Paris: OECD Publishing; 2011 (http://www.oecdilibrary.org/economics/how-s-life_9789264121164-en, accessed 13 March 2015).
11. How's life? 2013: measuring well-being. Paris: OECD Publishing; 2013 (<http://www.oecd.org/statistics/howslife.htm>, accessed 13 March 2015).
12. Well-being interactive content. In: Office for National Statistics [website]. Newport: Office for National Statistics; 2015 (<http://www.ons.gov.uk/ons/guide-method/user-guidance/well-being/interactive-content/index.html>, accessed 13 March 2015).
13. World happiness report 2015 [website]. Paris: United Nations Sustainable Development Solutions Network; 2015 (<http://unsdsn.org/happiness/>, accessed 3 April 2015).
14. Heart Health Indiana [website]. Purdue: Purdue University and the Indiana Minority Health Coalition; 2015 (www.hearthealthindiana.com, accessed 3 April 2015).
15. Mental health dementia and neurology. In: Public Health England [website]. London: Public Health England; 2015 (<http://fingertips.phe.org.uk/profile-group/mental-health>, accessed 13 March 2015).

16. Health information and evidence portal. In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2015 (<http://portal.euro.who.int/en/portal/>, accessed 3 April 2015).

Annex 1. Programme

Thursday, 15 January 2015

Opening

Welcome by WHO Secretariat

Election of Chair and Rapporteur

Adoption of agenda and programme

Claudia Stein: Summary of progress on well-being measurement, as well as purpose, objectives and expected outcomes of the meeting

Simon Chaplin: The importance of interdisciplinary and multiskill approaches to research in health and well-being

Session 1. Why culture matters in relation to well-being

David Napier: culture and health

Göran Tomson: culture, well-being and policy

Adolfo Morrone: culture as a dimension of well-being

Discussion

- *What are the key arguments for the need to consider cultural factors in relation to well-being measurement?*
- *Is there research that demonstrates the instrumental value of culture in relation to well-being? E.g., does cultural participation have health and well-being benefits?*
- *Why is culture a relevant dimension in relation to well-being?*

Session 2. Defining culture

Edward F. Fischer: Anthropological considerations

Molly Steinlage: Operationalizing a definition of culture

Discussion

- *What are the main problems encountered with defining culture?*
- *Do we need a particular definition of culture in relation to health?*
- *Is it possible to account for macro (e.g. national) cultures as well as micro (e.g. local or interpersonal) cultures?*

Session 3. Locating the “subjective” in subjective well-being

Erik Angner: An historical perspective of subjective well-being

Roger Smith: The philosophy of subjective well-being

Discussion:

- *How can insights from the humanities contribute to our understanding of the cultural dynamics of subjective well-being?*
- *Are alternative sources of data, such as the historical or cultural record, valid in constructing narratives of national and regional subjective well-being?*

Session 4. Measuring subjective well-being across a culturally diverse region

Pablo Diego Rosell: Perspective on survey design and translatability

Carrie Exton: Cultural transmission in migrant communities

Dawn Snape: Creating an evidence platform for culture and well-being

Discussion

- *What are the main arguments for and against cultural validity in relation to international subjective well-being comparisons?*
- *What are the challenges in relation to survey design?*
- *What are some of the key cultural variables (e.g. language, religion, gender equality, etc.), and what role might they play in relation to subjective well-being measurement?*

Session 5. Signal versus noise in subjective well-being data

Eduard Ponarin: Subjective well-being across the European Region

Batja Mesquita: Cultural variation in positive and negative affect

Discussion

- What are the dominant models of cultural variation? How do these apply to the European Region?
- Are there universal cultural preconditions for well-being?
- Can culture, well-being and health be connected via unifying concepts (such as resilience, for instance)?

Conclusions day 1 (Chair)

Friday, 16 January 2015

Summary of day 1 (Rapporteur)

Session 6. A roadmap for integrating culture into subjective well-being measurement

Ivo Quaranta: Defining culture (recap)

Ilona Kickbusch: Rethinking our data and evidence needs

Mohan Jyoti Dutta: Communicating effectively about well-being

Sarah Atkinson: What are the research gaps?

Session 7. Generating an additional topic for the break-out sessions

Participants will be invited to come up with a further group topic to be discussed in Group 5 during the break-out sessions.

Break-out session 1. Assigned topics

Participants will be assigned to specific groups.

Group 1: definition(s) of culture

Group 2: data and evidence

Group 3: reporting

Group 4: research gaps

Group 5: TBD

Break-out session 2. Free choice topics

Participants will re-convene in the same groups. At this point, groups should identify clear next steps for WHO to take.

Session 8. Feedback

Group chairs will report back from their respective groups (5 minutes). Each report will be followed by a brief discussion with all participants (10 minutes).

Session 9. Conclusions and next steps

Summary and key points from day 2

WHO Secretariat to outline next steps

Annex 2. List of participants

Temporary advisers

Dr Peter Achterberg

Senior Adviser

National Institute for Public Health and the Environment

PO Box 1, Bilthoven 3533 SE, The Netherlands

Email: peter.achterberg@rivm.nl

Dr Erik Angner

Associate Professor

George Mason University

Fairfax, VA 22030, United States of America

Email: eangner@gmu.edu

Professor Sarah Atkinson

Professor of Geography and Medical Humanities

Department of Geography, Durham University, South Road, DH1 3LE

Durham, United Kingdom

Email: s.j.atkinson@durham.ac.uk

Dr Simon Chaplin

Director of Culture and Society

Wellcome Trust

Gibbs Building, 215 Euston Road, NW1 2BE London, United Kingdom

Email: s.chaplin@wellcome.ac.uk

Dr Pablo Diego Rosell

Senior Consultant

Gallup

The Adelphi, 1-11 John Adam Street, WC2N 6HS London,

United Kingdom

Email: pablo_diego-rosell@gallup.com

Professor Mohan Jyoti Dutta

Provost's Chair Professor

Head, Communications and New Media

Director, Center for Culture-Centered Approach to Research and Evaluation (CARE)

Faculty of Arts and Social Sciences, National University of Singapore

Block AS6, Level 3, 11 Computing Drive, Singapore 117416, Singapore

Email: cnmmohan@nus.edu.sg

Mr Julian Evans (Rapporteur)

Policy Director

Centre for History of Emotions

Queen Mary, University of London, United Kingdom

Email: jules.evans@mac.com

Professor Edward F. Fischer

Director, Center for Latin American Studies

Professor of Anthropology, Vanderbilt University

1016 Caruther Ave, Nashville, TN 37204, United States of America

Email: edward.f.fischer@vanderbilt.edu

Ms Lidia Gargiulo

Senior Researcher

Italian National Institute of Statistics (ISTAT)

Viale Liegi, 13, Rome 00198, Italy

Email: gargiulo@istat.it

Dr Flora Haderer

Project Coordination for the Director General of Public Health

Department for Child and Youth Health, Gender Health and Nutrition

Federal Ministry for Health

Radetzkystr. 2, 1030 Vienna, Austria

Email: flora.haderer@bmg.gv.at

Professor Mark Jackson (Chair)

Professor of the History of Medicine

Exeter University, Centre for Medical History

Amory Building, Rennes Drive

EX8 2HX Exeter, Devon, United Kingdom

Email: m.a.jackson@exeter.ac.uk

Professor Ilona Kickbusch

Director

Global Health Programme

Graduate Institute of International and Development Studies

Chemin Eugene-Rigot 2, 1211 Geneva, Switzerland

Email: ilona.kickbusch@graduateinstitute.ch

Professor Batja Gomes de Mesquita

Professor of Psychology

Center for Social and Cultural Psychology

University of Leuven

Tiensestraat 102 – Box 3727, Leuven 3000, Belgium

Email: mesquita@ppw.kuleuven.be

Mr Adolfo Morrone

Senior Researcher

Italian National Institute of Statistics (ISTAT)

Via dell'Oceano Pacifico 171, Rome 00144, Italy

Email: morrone@istat.it

Professor A. David Napier

Professor of Medical Anthropology

Director of Science, Medicine and Society Network

University College London, Gower Street, WC1E 6BT London,
United Kingdom

Email: d.napier@ucl.ac.uk

Dr Bosse Pettersson

Senior Adviser, Public Health Policy

The National Board of Health and Welfare

Rålambsvägen 3, 106 30 Stockholm, Sweden

Email: bosse.pettersson@socialstyrelsen.se

Dr Eduard Ponarin

Professor

National Research University Higher School of Economics

16 Soyuza Pechatnikov, St Petersburg, Russian Federation

Email: ponarin13@gmail.com

Dr Ivo Quaranta

Professor in Cultural and Medical Anthropology
University of Bologna
Via Zamboni, 33, 40126 Bologna, Italy
Email: ivo.quaranta@unibo.it

Dr Roger Smith

Institute of Philosophy
Russian Academy of Sciences
Volkhonka 14, R. 524, Moscow, Russian Federation
Email: rogersmith1945@gmail.com

Dr Dawn Snape

Head of Evidence and Analysis
What Works Centre for Wellbeing
c/o Public Health England, Skipston House, Health and Wellbeing
Directorate, Area 2C, Skipton House, 80 London Road, SE1 6LH London,
United Kingdom
Email: dawn.snape@phe.gov.uk

Professor Göran Tomson

Professor
Department of Learning, Informatics, Management and Ethics
Karolinska Institutet
Tomtebodavägen 18A, 171 77 Stockholm, Sweden
Email: goran.tomson@ki.se

Representatives of other organizations

Dr Carrie Exton

Policy Analyst
Organisation for Economic Co-operation and Development (OECD)
2 Rue André Pascal, Paris 75016, France
Email: carrie.exton@oecd.org

Ms Molly Steinlage

Culture for Development Indicators
Section for the Diversity of Cultural Expressions
United Nations Educational, Scientific and Cultural Organization
Email: m.steinlage@unesco.org

World Health Organization

Regional Office for Europe

Dr Isabel Yordi Aguirre
Technical Officer
Vulnerable Groups, Gender and Human Rights
Email: iyo@euro.who.int

Dr Nils Fietje
Research Officer
Division of Information, Evidence, Research and Innovation
Email: nfi@euro.who.int

Dr Fern Greenwell
Programme Manager a.i.
Health Monitoring and Analysis
Email: fgr@euro.who.int

Ms Tanja Kuchenmüller
Technical Officer
Division of Information, Evidence, Research and Innovation
Email: tku@euro.who.int

Dr Matthijs Muijen
Programme Manager
Mental Health
Email: mfm@euro.who.int

Dr Claudia Stein
Director
Division of Information, Evidence, Research and Innovation
Email: cls@euro.who.int

Headquarters

Dr Somnath Chatterji
Scientist
Surveys, Measurement and Analysis
Email: chatterjis@who.int

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania	Finland	Malta	Slovenia
Andorra	France	Monaco	Spain
Armenia	Georgia	Montenegro	Sweden
Austria	Germany	Netherlands	Switzerland
Azerbaijan	Greece	Norway	Tajikistan
Belarus	Hungary	Poland	The former
Belgium	Iceland	Portugal	Yugoslav
Bosnia and Herzegovina	Ireland	Republic of Moldova	Republic of Macedonia
Bulgaria	Israel	Romania	Turkey
Croatia	Italy	Russian	Turkmenistan
Cyprus	Kazakhstan	Federation	Ukraine
Czech Republic	Kyrgyzstan	San Marino	United Kingdom
Denmark	Latvia	Serbia	Uzbekistan
Estonia	Lithuania	Slovakia	
	Luxembourg		

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, Scherfigsvej 8, DK-2100,
Copenhagen Ø, Denmark
Tel.: +45 39 17 17 17; Fax: +45 39 17 18 18
E-mail: contact@euro.who.int
Web site: www.euro.who.int

