



## Cultural Contexts of Health and Well-being, No. 2

Second meeting of  
the expert group

Copenhagen, Denmark,  
4–5 April 2016

# A focus on culture: developing a systematic approach to the cultural contexts of health in the WHO European Region



**World Health  
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## ABSTRACT

Over the past 20 years, a range of conceptual frameworks has been developed to examine how social and economic determinants intersect with health and well-being. While the importance of cultural contexts is frequently referenced in these frameworks (in a positive or negative way), the concrete ways in which value systems, traditions and beliefs affect health and well-being are often unacknowledged, as are the frequently positive, protective effects that culture can have in the face of certain health challenges. In January 2015, the WHO Regional Office for Europe convened its first expert group meeting on the cultural contexts of health, thereby initiating a project that seeks to build a platform for research from the health-related humanities and social sciences to support the implementation of the European policy framework Health 2020. The second meeting of the expert group was convened in April 2016 to further explore how research from the humanities and social sciences can inform policy-making, and where this research can shed light on the subjective, human experiences of health. This report outlines the recommendations made by the expert group in relation to these objectives.

## KEYWORDS

CULTURAL COMPETENCY

CULTURE

EVIDENCE-BASED MEDICINE – METHODS

HEALTH KNOWLEDGE, ATTITUDES, PRACTICE

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## Executive summary

With the introduction of Health 2020, the European policy for health and well-being (1), the WHO European Region has firmly embraced a values-based approach to health. As a consequence, the WHO Regional Office for Europe has also acknowledged the significant impact of culture on all aspects of health. An expert group on the cultural contexts of health (CCH) was therefore convened in January 2015 to discuss the various ways in which culture affects well-being and well-being measurement (2). The meeting was a unique opportunity to bring new voices and new forms of research from the humanities and social sciences into the arena of WHO policy-making. It was particularly inspired by the observation of the 2014 Lancet–University College London Commission on Culture and Health 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” (3).

The expert group now advises the Regional Office’s CCH project, which aspires to broaden WHO’s work beyond a biomedical focus on disease to include a more positive and participatory model of health (see, for example, Box 1), and thus inform health-related policy-making.

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### **Box 1. Radio Nikosia: a participatory approach to mental health care**

*Radio Nikosia is a community project and radio program broadcasting weekly on an independent radio station in Barcelona, Spain, that is produced and directed entirely by people in psychiatric treatment.<sup>1,2</sup> The project aims to foster a cultural identity among its participants, and to create a new social dynamic of active participation and social integration outside the narrow confines of existing mental health care services and patient–therapist relations. Through the active production of media content (both for radio and, increasingly, television), as well as involvement in a number of cultural projects, Radio Nikosia pursues two objectives: to deconstruct the social stigma surrounding mental illness and to develop spaces of normality in which people with a diagnosis of mental illness can become – and represent themselves through the media as – active social subjects rather than passive objects of psychiatric intervention. The Radio Nikosia community promotes, among other things, an antistigma campaign called Labels are for Clothes and Red sin gravedad (Network without heaviness), an initiative in Barcelona community centres in which workshop participants do not know who has or does not have a diagnosis of mental illness.*

<sup>1</sup> Radio Nikosia [website]. Barcelona: Radio Nikosia; 2015 (<http://www.radionikosia.org>, accessed 5 August 2016).

<sup>2</sup> Santé mentale et citoyenneté [website]. Montreal: L’Alliance internationale de recherché universités-communautés; 2011 (<http://www.aruci-smc.org/fr/>, accessed 5 August 2016).

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The CCH approach seeks to take into account people's beliefs, emotions, values, meanings and culture in the highly diverse European Region.

Since the first meeting, the project has taken important steps. It has secured financial and institutional support from the Regional Office, Member States and other partner organizations; communicated its approach through publications and presentations; commissioned policy documents; and moved towards the establishment of a WHO collaborating centre at the University of Exeter, United Kingdom.

Substantial momentum has been generated in support of the Regional Office's work on CCH. In order to capitalize on this momentum, attention must now focus on articulating a CCH approach and demonstrating its usefulness to health policy-makers, for instance, in the area of cultural competency and particularly in relation to migration and health. To this end, the second meeting of the expert group looked to move towards more concrete CCH recommendations.

The objectives of this meeting were to:

- create a strategic framework for the Regional Office's CCH project;
- strengthen CCH advocacy and expand the CCH network;
- provide technical feedback on draft outputs, particularly the draft policy brief; and
- recommend CCH approaches in the context of four focus areas: the environment, nutrition, mental health and migration.

Good progress was made across all objectives. The expert group agreed on a strategic framework for the CCH project and explored ways of strengthening advocacy. They also provided substantial technical feedback for several CCH publications, which will be carefully integrated into subsequent revisions. Finally, the expert group made five key recommendations for next steps.

1. Finalize the CCH strategic framework, taking into account the need to balance research and advocacy and to link the work on CCH more directly to the Sustainable Development Goals (SDGs) (4).
2. Enhance the CCH policy brief and the Health Evidence Network (HEN) synthesis report on narrative approaches with carefully chosen case studies from across the entire European Region.

3. In collaboration with Regional Office programme managers, articulate ways in which CCH can systematically contribute to various programmatic activities.
4. Develop a toolkit of humanities and social sciences methodologies with a focus on a particular health challenge.
5. Continue mapping and connecting scholars in the humanities and social sciences working on the intersection of culture and health.

Importantly, the meeting also strengthened the partnership between the Regional Office and the United Nations Educational, Scientific and Cultural Organization (UNESCO) Section for Intangible Cultural Heritage. The aim is now to work towards closer collaboration between the two organizations to further explore the intersection of culture and health.

For a more detailed overview of all new CCH project actions, as well as the current version of the 2015–2018 action plan, see Annex 1.

For a complete list of speakers and presentations, see Annex 2.

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## Introduction

The second expert group meeting on the cultural contexts of health (CCH) was convened by the WHO Regional Office for Europe on 4–5 April 2016 (see Annex 2 for the programme). It brought together leading academics in the humanities and social sciences, public health experts and representatives of relevant organizations whose focus is on the intersection of culture, health and well-being (see Annex 3).

Participants were welcomed to the meeting by Dr Claudia Stein, Director, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe; and by the chair of the CCH expert group, Mark Jackson, Professor of the History of Medicine, University of Exeter, United Kingdom. Both the WHO Secretariat and the Chair thanked the Wellcome Trust for its generous contribution towards financing the meeting. Dr João Rangel de Almeida, Humanities and Social Sciences Portfolio Development Manager at the Wellcome Trust, also greeted participants and expressed the Wellcome Trust's enthusiasm for this work as part of its wider partnership with the Regional Office. 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.

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## Update on progress

The CCH project has made significant progress since the previous expert group meeting in January 2015. Strong support for the work has been expressed among programmes and units within the Regional Office, WHO European Region Member States and partner organizations such as the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the University of Exeter (which is currently applying to become the WHO Collaborating Centre on Culture and Health). The Regional Office has also secured three-year funding from the Wellcome Trust, which has allowed for the formal establishment of the CCH expert group with Professor Mark Jackson as its chair.

In terms of outputs, the Regional Office included a chapter entitled “Well-being and its cultural contexts” in the *European health report*

2015 (5), and staff have presented the CCH work at key conferences and summits. The Regional Office has also produced a draft communications strategy and commissioned several new publications, including two Health Evidence Network (HEN) reports – the first on narrative methods in the health sector and the second on cultural bias in well-being measurements. Members of the expert group are preparing a policy brief outlining the CCH approach to policy-making. Finally, the CCH project team at the Regional Office has become the focal point for the WHO Collaborating Centre for Global Health Histories (GHH), and will be hosting several GHH seminars to examine key health challenges within their cultural contexts.

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## Further developing the CCH strategic framework

Members of the expert group discussed the strategic framework for the work on CCH at the Regional Office and subsequently agreed on the following vision: to enhance public health policy-making through a nuanced understanding of how cultural contexts affect health and health care.

They established the following objectives for the work.

- Create a focus for culture and health at the Regional Office, in order to contribute to the implementation of the European policy framework Health 2020 (1) and to strengthen the Regional Office's position on achieving the health-related Sustainable Development Goals (SDGs) targets (4).
- Strengthen action-oriented humanities and social sciences research and policy analysis.
- Promote the validity and use of an interdisciplinary evidence base for health-related policy and practice.

The expert group identified three main priorities for the next three years: (i) advocacy, (ii) research and development and (iii) knowledge translation. Although work in all areas will continue throughout the timeframe, a different area will be highlighted each year.

A draft communications strategy was presented and discussed. It aims to promote CCH, raise its profile among policy-makers and build an active network of stakeholders both internal and external to the Regional Office. The guiding principle of the communications strategy is to use an interactive approach to secure active stakeholder engagement.

During their discussion of the strategic framework and the communications strategy, members of the expert group asked if research, rather than advocacy, should be the first priority: would it be best for the CCH project to focus on the development of a research base before seeking the attention of policy-makers – or to present several clear policy recommendations at its launch in order to facilitate the commission of further research? They agreed that research and advocacy will likely advance hand-in-hand during the next three years. Public health experts did express, however, a clear desire for the Regional Office's work in CCH to focus more explicitly on policy deliverables, particularly in policy areas linked to Health 2020 and the SDGs (1,4).

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## Recommendations

The expert group made the following three recommendations for further developing the CCH strategic framework.

1. Finalize the strategic framework, taking into account the need to balance research and advocacy and to link project outputs more closely to Health 2020 and the SDGs.
2. Produce a newsletter, blog, and other CCH communications pathways.
3. Collect a database of CCH case studies with an emphasis on the four focus areas (the environment, nutrition, mental health and migration) in order to better illustrate the importance of culture in health.

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## Policy brief on the importance of CCH

The CCH policy brief that is currently in development aims to emphasize the importance of shared values as areas where culture interacts with public health, provide a number of examples that demonstrate the cultural contexts of health and identify policy options that highlight how attending to culture can improve health outcomes.

The policy brief broadly follows the UNESCO definition of culture, set out in its Universal Declaration on Cultural Diversity (2001), as: “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group ... [that] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (6). This definition clarifies that culture consists not only of overtly shared conventions, but also of customs and taken-for-granted assumptions. In order to build a better health evidence base and catalyse better policy-making, a more nuanced understanding of cultural drivers is necessary. To illustrate this, the policy brief provides case studies taken from the four CCH focus areas – the environment, nutrition, mental health and migration – all of which show how culturally contextualized policy-making can provide better health outcomes.

Professor David Napier’s work on the policy brief was praised for its interesting and insightful focus. Members of the expert group suggested that the brief be more concise<sup>1</sup> and that – crucially – it reflect the rich diversity of the Region, which includes subregions and countries of different sociocultural landscapes. They also asked that the brief articulate concrete policy options, and that it links explicitly to the SDGs and critical policy issues facing the Region (for example, the ongoing refugee crisis).

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## Recommendations

The expert group made the following two recommendations for the development of the policy brief.

1. Identify a range of case studies to demonstrate the importance of CCH to health policy.

2. Aim to finalize the policy brief in time for the 66th session of the WHO Regional Committee for Europe (September 2016) without compromising the quality of the report.

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## HEN report on narrative methods

During the first CCH expert group meeting in January 2015, participants advanced the key recommendation that health reporting be enhanced – both as a communication output and a policy tool – through input from narrative research. In response, the Regional Office commissioned a HEN report to investigate the following question: "What is the evidence base for using narrative methods to illuminate the experience of health and illness in individuals and communities?"

Members of the expert group proposed that the HEN report undertake a systematic hermeneutic review – that is, a review based on an iterative process of analysis and interpretation in search of understanding – to explore the strengths and limitations of narrative approaches to evidence.

Their discussion explored the importance of stories to health initiatives such as the women's health movement of the 1960s and the HIV/AIDS patients' movement of the 1980s. In both of these social movements, narrative evidence challenged conventional power structures and filled the vacuum left by a lack of participatory engagement with affected communities (see Box 2). Members of the expert group pointed out that a narrative approach to health initiatives raises additional ethical and political questions: whose voices are heard, and whose are not? People with important stories may not have a voice, and those recording stories – even with the best intentions – cannot completely avoid imposing their own narrative biases. Despite these potential shortcomings, narrative approaches can access the insight and experience of marginalized communities and improve policy-makers' understanding of realities on the ground, including practical impediments to and opportunities for more effective policy implementation.

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<sup>1</sup> Members of the expert group suggested that the policy brief follow the 1:3:25 principle. This refers to a report structure that presents a one-page outline of main messages, a three-page executive summary and up to 25 pages of findings and methodology, all written in clear and accessible language.

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## Recommendations

The expert group made the following two recommendations for the HEN report on narrative methods.

1. Identify case studies that demonstrate the value of narrative methods for health policy and practice.
2. Explore the possibility of running a workshop based on the findings of the report.

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### **Box 2. The importance of narrative in HIV/AIDS patients' movements**

*Since the early days of the HIV/AIDS epidemic, narrative approaches have played a central role in empowering people living with HIV and AIDS. Community activism, triggered in part by the unwillingness and unease of politicians, the media and mainstream society to engage with the challenges posed by the epidemic, has opened up new spaces in which the voices of those affected can be heard.<sup>1</sup> In the 1980s, for example, the People With AIDS (PWA) self-empowerment movement in the United States of America was among the first to insist that those diagnosed with HIV and AIDS should participate in the decisions that directly affect their health and lives.*

*Elsewhere, social movements have used narratives to garner public and political support for their campaigns. In South Africa, for example, the work of the Treatment Action Campaign has not only helped to make antiretroviral treatments more affordable within low and middle-income countries, but also to reintegrate large numbers of isolated and stigmatized people into a caring and widespread activist community.<sup>2</sup>*

*The voices from the early HIV/AIDS patient movement continue to resonate today. For example, narrative-based initiatives – such as Project SIGMA in the United Kingdom, which conducted research on homosexual behaviour by engaging men who have sex with men to keep daily journals of their activities – are providing valuable insights into the problems arising from increased reliance on biomedical HIV prevention.<sup>3</sup>*

*As well as providing an important critique of biomedical and sexological approaches to HIV/AIDS, these narratives have highlighted how culture can shape the meaning of sexual experience and how people interpret and understand sexual practices. They have led to more informed sexual health programming and have inspired a range of other health-related social movements worldwide*

<sup>1</sup> Keogh P, Dodds C. Pharmaceutical HIV prevention technologies in the UK: six domains for social science research. *AIDS Care* 2015;27(6):796–803. doi: 10.1080/09540121.2014.989484.

<sup>2</sup> Robins S. Rights passages from “near death” to “new life”: AIDS activism and treatment testimonies in South Africa. *IDS Working Paper 251*. Brighton: Institute of Development Studies; 2005.

<sup>3</sup> Aggleton P, Parker R, Thomas F, editors. *Culture, health and sexuality: an introduction*. Abingdon: Routledge; 2015.

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## Towards a CCH methodology toolkit

The Regional Office obtained funding to create a knowledge translation tool over the next three years that will aim to give policy-makers clear guidance on how methods and approaches of the humanities and social sciences might be used for measurement, analysis and/or reporting. The toolkit could be structured around broad, crosscutting themes, such as public health research, public health reporting and knowledge translation, or health communication in support of public health programmes. All of these areas require a more sustained culture-centred approach.

The Regional Office currently uses several different types of toolkits. These include long and broadly focused publications, shorter documents focused on particular areas, online tools and simple, one-page information sheets. Members of the expert group agreed that a very general toolkit of approaches from the humanities and social sciences would be vague and impractical. They pointed to the migration crisis as a policy area where a focused CCH toolkit could be particularly helpful to policy-makers. This toolkit could bring together information, methods, evidence and guidance on issues related to cultural mediation and cultural competence to assist Member States in developing strategies, programmes and activities to more effectively meet the health and well-being needs of their diverse populations.

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### Recommendations

The expert group made the following two recommendations for the development of the CCH methodology toolkit.

1. In consultation with staff at the Regional Office, develop a focus for the toolkit and circulate a proposal to the expert group.
2. Present an update at the next full meeting of the CCH expert group in 2017.

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## Exploring a CCH approach to health policy-making in four key areas

It is clear that most, if not all, areas of the Regional Office's work could benefit from a CCH approach – the design and communication of vaccination programmes and screening activities are just two examples. It will be essential to develop focus areas within which to explore the broader issues of, for example, culture-centred health communication, reporting or education. With this in mind, members of the expert group identified four key areas where a CCH approach could be particularly useful for the Regional Office and its Member States: the environment, nutrition, mental health and migration.

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### Environment and CCH

Environmental challenges, such as those associated with climate change, can have serious health consequences. Air pollution, for instance, claimed 600 000 lives last year in the European Region alone, while water-related diseases account for 3.4 million deaths globally per year (7). The natural environment also includes a wide variety of assets and services, ranging from green spaces and places for recreation to complex ecosystem services such as pollution sinks and protection from flooding and erosion. These are essential for maintaining and enhancing health and well-being. When policy-makers understand the cultural contexts of environmental factors that negatively and positively influence health, they are better positioned to respond to both challenges and opportunities.

The WHO Collaborating Centre for Health Promoting Water Management and Risk Communication has taken notable steps towards embracing a cultural approach to water-management. The Centre contributed to the work of the World Water Forum (2003), which concluded that, without understanding and considering the cultural aspects of issues such as water shortages or water pollution, no sustainable solutions can be found. Furthermore, the Centre's *StadtBlau Projekt* (Blue Spaces Project) (2015) explored the health benefits that come from people's cultural experience of water as a source of social connection, symbolic and sacred value, and contemplative experience (see Box 3).

In general, however, the role of culture in mediating the manifold health impacts of water and other environmental factors is still underestimated or ignored in various discourses on environment and health. At the WHO European Centre for Environment and Health (ECEH), work on many determinants is based on available evidence, often of a quantitative nature; however, efforts towards more holistic and participatory approaches – such as health impact assessments that are mindful of cultural factors – are underway. ECEH also contributed to World Water Day (2006), which explored how culture and water are connected both positively (in terms of the meanings

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### **Box 3. The cultural dimension of the water–health nexus**

*Access to adequate freshwater – in terms of both quantity and quality – is broadly recognized as an irreplaceable factor in the health and prosperity of individuals and societies. Yet water also has an omnipresent cultural dimension. How water is culturally managed and used, for example, has a strong impact on the occurrence and burden of water-related diseases. The value people place on water also constitutes an integral part of their cultural identity and plays an important role in their well-being. To this effect, (i) physical activity, (ii) contemplative experience, (iii) social connectedness and (iv) symbolic values are all health-relevant dimensions to how water is experienced and used.<sup>1</sup>*

*For those living close to the many revitalized urban river promenades in the European Region, for example, health and well-being can be impacted through: rowing, running and skating; visual, acoustical and even olfactory enjoyment of the riverine landscape; meetings with friends, colleagues and relatives along the shore; and remembering, experiencing and reflecting on the symbolic potencies of water.<sup>1</sup> These health-relevant dimensions of water have been empirically confirmed in very different settings and among diverse populations, for example, inhabitants of east African wetlands.<sup>2</sup> In health discourses, however, these manifold health impacts of the cultural dimensions of water still tend to be underestimated or even ignored.*

*Healthy blue spaces – health-enabling places and spaces where water is at the centre of a range of environments with identifiable potential for the promotion of human health and well-being – comprise the relationships and bodily experiences of health and place. They are relational spaces of intersubjective encounter, diverse physical activity and shared, deep-rooted meanings for individuals, groups and populations.<sup>3</sup>*

<sup>1</sup> Foley R, Kistemann T. Blue space geographies: enabling health in place. *Health Place* 2015;35:157–65. doi: 10.1016/j.healthplace.2015.07.003.

<sup>2</sup> Anthonj C, Rechenburg R, Kistemann T. Water, sanitation and hygiene in wetlands. The case of the Ewaso Narok Swamp, Kenya. *Int J of Hyg and Environ Health* (in press). doi: 10.1016/j.ijheh.2016.06.006.

<sup>3</sup> Völker S, Kistemann T. The impact of blue space on human health and well-being – salutogenetic health effects of inland surface waters: a review. *Int J of Hyg and Environ Health* 2011;214(6): 449–60. doi: 10.1016/j.ijheh.2011.05.001.

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and values people attach to water) and negatively (in terms of how cultural practices can help spread water-related diseases).

Members of the expert group suggested that the CCH project could explore different approaches, mediated by cultural practices, to waste management and sanitation. They discussed the critical policy issues of human-caused environmental damage and climate change, and the great extent to which culture is a factor in galvanizing popular action to manage and mitigate consequent health and well-being risks. So-called hard quantitative evidence is clearly not enough to mobilize people to put pressure on their governments; narratives that tap into shared cultural beliefs and traditions are also needed.

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## Nutrition and CCH

Nutrition is a crucial aspect of improving health in the European Region and beyond. Of the four major types of noncommunicable diseases – cardiovascular diseases, cancers, diabetes and respiratory diseases – diet contributes to the first three. Obesity, particularly childhood obesity, is also a serious problem throughout the Region: one in three 11-year-olds is now overweight or obese (8). The *European Food and Nutrition Action Plan 2015–2020* (9) has a mission to reduce dramatically the negative impacts of diet-related noncommunicable diseases and malnutrition (including obesity). Because culture and nutrition are so inextricably linked, this inevitably involves a cultural approach to nutrition.

The area of nutrition consequently offers particularly juicy "low-hanging fruit" for illustrating the CCH approach to policy-making. As nutritionist Patricia Crotty wrote in her 1993 publication *The value of qualitative research in nutrition*, "the act of swallowing divides nutrition's 'two cultures': the post-swallowing world of biology, physiology, biochemistry and pathology, and the pre-swallowing domain of behaviour, culture, society and experience" (10). Nutrition is about more than nutrients – it is based on cultural traditions, structural conditions and personal histories of production and consumption. It is also an especially intimate area of life, tightly linked to conceptions of identity and ethics.

In what areas could a CCH approach to nutrition be particularly useful? First, members of the expert group suggested school meals, pointing to a growing body of research exploring how the so-called choice

architecture of school canteens can gently nudge children towards healthy selections (11). Second, they offered school gardens as a good example of a culture-informed nutrition intervention and pointed to the work of Michelle Obama, First Lady of the United States, in this area. Originally pioneered in Europe, school gardens were once abundant – in 1900, for example, Sweden had over 2000 (12) (see Box 4). Third, participants identified the Italian slow food movement as a useful case study emphasizing the health-promoting elements of local food traditions. The traditional foods championed by the movement stand in stark contrast to globalized, processed foods high in trans fats and empty calories (13).

Members of the expert group also explored other successful nutrition interventions – in Brazil and Sweden, among others – which have tended to avoid finger-wagging and chosen instead to use stories, images or (in the case of Mexico’s tax on sweetened soft drinks) direct legislation to guide people’s dietary choices. Their discussion covered the myriad connections between nutrition and the environment as well as well-being, pleasure, social connection, meaning and ritual. Participants also highlighted the so-called Mediterranean diet as a theoretically healthy cultural bias, although some questioned whether such a stereotypical diet still exists, pointing to high levels of child obesity in Mediterranean countries.

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## Mental health and CCH

Mental health is another major challenge for Member States in the European Region: neuropsychiatric disorders are the third leading cause of disability-adjusted life-years (after cardiovascular diseases and cancers). Yet, the percentage of health budgets that go to mental health services is much lower than the disease burden seems to require. This disequilibrium means that, in the United Kingdom, for example, only 24% of those with a mental disorder receive treatment. This is compared to 78% of those with heart disease and 91% of those with high blood pressure (14). Still, the United Kingdom’s annual per capita spending on mental health services is 300% higher than that of some Member States, where annual per capita spending can be as low as US\$ 1 (15). WHO placed mental health at the heart of Health 2020 (1), and released *The European Mental Health Action Plan 2013–2020*, which states that “everyone has an equal opportunity to realize mental well-being throughout their lifespan” (16).

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#### **Box 4. School gardens, nutrition, and CCH**

*Changing eating habits is difficult, but efforts to improve nutrition have a better chance if they work with, rather than against, local food cultures. Within the European Region, poor nutrition (under- and overnutrition) is correlated with declines in traditional diets and increases in the consumption of inexpensive processed foods. This includes so-called children-friendly foods, which tend to have more calories but less nutritional value.*

*One effective way to improve nutrition is to develop school gardens in connection with local cuisines and traditions. These gardens can reintroduce children to traditional foods, encouraging them to incorporate them to their diets. While school gardens trace their origins to 1840s Sweden, today they are most plentiful in Italy and the United States. Since 2003, Italy's Orto in Condotta initiative has sponsored hundreds of school gardens in partnership with local associations dedicated to promoting seasonal and mindful eating. The densest concentration of gardens, involving thousands of students, is around Turin and in the Piedmont region.*

*School gardens can contain a variety of fruits, vegetables, legumes and even small animals. They (i) help students conceptually connect food production with consumption, (ii) improve students' nutritional knowledge and consumption of fruits and vegetables and (iii) integrate multiple pedagogical subject areas with practical applications.*

*School gardens provide a multidisciplinary and multisensory platform for primary and secondary education. In the Italian model, school gardens form the basis of an integrated three-year curriculum covering environmental studies, biology, agricultural economics and food cultures. Studies have shown that school gardens and an integrated curriculum can significantly increase primary school children's nutritional knowledge.<sup>1</sup> Research has also shown that this results in an improved range of fruit and vegetable preferences as well as an increased quantity and variety of vegetables eaten.<sup>2,3</sup> One study of Latino youths involved in a gardening, nutrition and cooking program in Los Angeles revealed improved diet and decreased rates of obesity.<sup>4</sup>*

*While school gardens can provide a significant source of high-quality food for lunch programs, they can also educate, inform and engage students in ways that change nutritional attitudes and behaviours. Students eat better while at school, but they also learn how to eat better in their lives beyond it.*

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<sup>1</sup> Morris JL, Zidenberg-Cherr S. Garden-enhanced nutrition curriculum improves fourth-grade school children's knowledge of nutrition and preferences for some vegetables. *J Am Diet Assoc.* 2002;102(1):91–3. doi: 10.1016/S0002-8223(02)90027-1.

<sup>2</sup> McAleese JD, Rankin LL. Garden-based nutrition education affects fruit and vegetable consumption in sixth-grade adolescents. *J Am Diet Assoc.* 2007;107(4):662–5.

<sup>3</sup> Ratcliffe MM, Merrigan KA, Rogers BL, Goldberg JP. The effects of school garden experiences on middle school-aged students' knowledge, attitudes, and behaviors associated with vegetable consumption. *Health Promot Pract.* 2011;12(1):36–43. doi: 10.1177/1524839909349182.

<sup>4</sup> Davis JN, Ventura EE, Cook LT, Gyllenhammer LE, Gatto NM. LA Sprouts: A gardening, nutrition, and cooking intervention for Latino youth improves diet and reduces obesity. *J Am Diet Assoc.* 2011;111(8):1224–30. doi: 10.1016/j.jada.2011.05.009.

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Culture – including cultural attitudes and stigmas, culturally nuanced treatments and different cultural understandings of mental illness and well-being – is inextricably linked to mental health policy. Cultural contexts are therefore key explanatory factors of the aetiology, course, prognosis and treatment of mental disorders. In order to improve mental health policies and promote patient and public participation, health professionals must be aware of this domain.

Because there are so many areas where culture can inform mental health policy, members of the expert group noted that the Regional Office's contribution to the understanding of CCH and mental health depends upon selecting a focus. The CCH project team could choose to develop a more granular understanding of stigma in a specific cultural context that could subsequently enable more effective and localized mental health campaigns. They pointed to different cultural attitudes to psychosis across the Region as a potential area of focus (see, for example, Box 5). Many critical questions could be explored: Is someone who hears voices or sees spirits necessarily psychotic and in need of pharmaceutical treatment or hospitalization? Are there instances where hearing voices can actually bring meaning and inspiration? Why are there such marked cultural differences across the world in

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### **Box 5. An interdisciplinary approach to understanding voice-hearing**

*The Hearing the Voice project in the United Kingdom addresses multifaceted questions about what it means to be hearing voices in the absence of a speaker. It does this by taking an interdisciplinary approach that recognizes the heterogeneity of voice-hearing and its embeddedness in personal, social and cultural contexts.<sup>1</sup> Voice-hearers are involved in every aspect of the work, from narrative research and stigma-tackling public engagement to experimental design and innovative partnerships with National Health Service clinicians and the international Hearing Voices Movement. The project aims to change the public and scholarly conversation about voice-hearing, showing how it is not merely a symptom of mental disorder but rather a rich and complex part of human experience.*

*Hearing a voice can be understood as an event in the brain, the manifestation of divine or creative inspiration, or as emotional communication from the past. Culture can profoundly affect what counts as reality, shape how a voice is experienced and influence the meaning-making that happens around it. As such, the humanities offer intellectual technologies that scientific approaches alone cannot provide.*

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<sup>1</sup> Hearing the Voice [website]. Durham: Durham University; 2015 (<https://www.dur.ac.uk/hearingthevoice/>, accessed 5 August 2016).

treatment outcomes for psychosis? How can health systems work best with community groups such as the Hearing Voices Network (17), and with faith groups?

In some European countries, treatment levels for mental illness are low partly because people prefer to turn to alternative or spiritual healers for help. In some cases, there may also be no other viable option. How do health systems respond to this reality? In east London, for example, local National Health Service psychiatrists are building relationships with Islamic ruqyah healers to improve dialogue, access and treatments for local residents (see also Box 6). These forms of collaboration open up important pathways for exploring the intersection of culture and mental health.

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### **Box 6. Collaborations between psychiatrists and healers in central Asia**

*Many consider the contemporary popularity of traditional healers in central Asia to be the result of major shortcomings in local health care systems and inadequate training of medical personnel, but researchers also emphasize the importance of cultural factors – locally shared beliefs, norms and values – in effective healing systems. Traditional healers are often asked for help with psychic disturbances whose aetiology is attributed to the influence of evil spirits or black magic. In addition, as ethnographic research reveals, communities may consider individuals diagnosed with mental illness by psychiatrists to be chosen by spirits and predestined to heal people.<sup>1,2</sup>*

*In this context, some psychiatrists and psychologists in Kazakhstan and Kyrgyzstan have developed a positive attitude to traditional healing, recognizing its value as a kind of psychotherapy that might be effective in many cases.<sup>2,3</sup> Collaboration between these professionals and traditional healers who work with the same patients has already started in Kyrgyzstan.<sup>4</sup> Good therapeutic effects have been noted, for example, in the treatment of post-traumatic disorders in those severely affected by the Osh and Jalal-Abad riots of 2010.*

<sup>1</sup> Penkala-Gawęcka D. Mentally ill or chosen by spirits? 'Shamanic illness' and the revival of Kazakh traditional medicine in post-Soviet Kazakhstan. *Central Asian Survey* 2013;32(1):37–51. doi: 10.1080/02634937.2013.771872.

<sup>2</sup> Molchanova ES, Horne SH, Kim EA, Ten VI, Ashiraliev NA, Aitpaeva GA et al. Status of counseling and psychology in Kyrgyzstan. *American University in Central Asia Academic Review* 2008;5(1):57–72.

<sup>3</sup> Adylov D. Healing at mazars: sources of healing, methods of curative impact, types of healers and criteria of their professional qualifications. In: Aitpaeva G, Egemberdieva A, Toktogulova M, editors. *Mazar worship in Kyrgyzstan: rituals and practitioners in Talas*. Bishkek: Aigine Cultural Research Center; 2007:377–94.

<sup>4</sup> Molchanova ES, Aitpaeva GA, Ten VI, Koga PM. Tselitel'stvo i ofitsial'naya psikhatriya Kyrgyzskoy Respubliki: vozmozhnosti vzaimodeystviya [Healing and official psychotherapy in the Kyrgyz Republic: possibilities of collaboration]. In: Kharitonova VI, editor. *Materialy Mezhdunarodnogo interdisciplinarnogo nauchnogo simpoziuma "Psikhofiziologiya i social'naya adaptatsiya (neo)shamanov v proshlom i nastoyashchem"* [Materials of the International interdisciplinary scientific symposium "Psychophysiology and social adaptation of (neo)shamans in the past and present"]. Moskva: IEA RAN; 2011:34–42.

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## Migration and CCH

Although the European Region has a long history of migration, large-scale migration (such as that experienced by Australia, Canada and the United States for centuries) has been stimulated by the strong economic growth of some European countries only since the 1950s–70s (18). The need for culturally centred health communication to reach migrant populations is thus a relatively new phenomenon. Today, with the mass movement of refugees from North Africa and the Middle East triggering what the European Union has called “the worst humanitarian crisis since World War II” (19), migration is clearly a policy area of acute importance for the Region.

Over one million refugees and migrants arrived in European countries in 2015 alone, including tens of thousands of unaccompanied minors (20). While migration presents an opportunity for countries with ageing and shrinking populations, this recent influx of undocumented migrants has triggered political tensions and anti-immigration campaigns focused on closing borders and lowering welfare spending across Europe. It has also presented European governments and public health systems with the great challenge of processing and supporting the health of these refugees. In some Member States, undocumented migrants have access only to emergency services; in others, they have full access to health care.

How can the Regional Office help Member States cope with these challenges? A coordinated and evidence-based approach to integrating migration-sensitive elements into public health care systems is needed, but improving cultural mediation and the cultural competence of health care officials is also critical. Attitudes to health care vary considerably according to culture, religion and individual personality. Cultural differences or misunderstandings, including those stemming from basic language barriers, can present serious obstacles to the effective provision of care. Issues also arise from diverging cultural perceptions of what comprises ethical health care, particularly in relation to the role played by the patient’s family and what is meant by personal autonomy and well-being (see Box 7).

Unfortunately, there is a distinct lack of cultural competence training for students at many medical colleges, and even for health care officials working at migration landing sites and in refugee camps. The Regional Office could adopt a CCH approach to more actively develop support

tools for cultural mediators and to ensure that these mediators are more frequently involved in encounters between migrants and health care personnel.

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### **Box 7. Linguistic and cultural barriers in patient–doctor encounters**

*Advances in medicine have led not only to better diagnosis but also to more accurate predictions about the future development of illnesses. As a result, unfavourable diagnoses are made more frequently and are accompanied by a need to communicate poor prognoses to patients. As the following case study demonstrates, linguistic and cultural barriers often play a central role in the processes leading up to clinical–ethnic conflicts in medical practice.<sup>1</sup>*

*A 23-year-old Turkish man living in Germany was diagnosed with malignant cancer. Several cycles of chemotherapy were unsuccessful and his health deteriorated; it became clear to doctors that his death was imminent. Both the patient and his family had only rudimentary knowledge of German, making effective communication with the medical team very difficult. With the help of an interpreter from the patient's extended family, the doctor in charge informed the parents of their son's hopeless situation. The son was also partly involved in this talk.*

*A nurse of Turkish descent overheard the conversation, and later informed the doctors that the interpreter had not given the patient information about his expected death, probably on the request of his parents. The doctors considered this to be a clear contravention of the patient's right to know about the state of his own health. With the help of a different interpreter, they arranged another conversation with the patient during which he was informed of the possibility that he may soon die. Two days later, the patient passed away. The parents later accused the doctors of being responsible for their son's death by contributing to the worsening of this condition and thus hastening his demise.*

*In this situation, neither party truly knew why the other had acted as they did, nor did they grasp the different sets of values underpinning each other's decision-making process. The story demonstrates the value of culturally sensitive communication in the process of reaching a mutual understanding of different values and attitudes. It also reinforces the importance of embedding intercultural competence within medical training and practice.*

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<sup>1</sup> İlkiliç I, Culture and ethical aspects of truth-telling in a value pluralistic society. In: Teays W, Gordon JS, Dundes Renteln A, editors. Global bioethics and human rights: contemporary issues. Maryland: Rowman & Littlefield; 2014:185–200.

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## Recommendations

The expert group made five recommendations based on their discussions of CCH approaches to policy-making in the four key areas.

1. Working with colleagues at ECEH, elaborate an environment and health project that would benefit from a CCH approach.
2. Investigate the feasibility of developing a Regional Office project on nutrition and the school environment using a participatory CCH approach.
3. Organize a workshop that explores the cultural drivers influencing mental health reform processes.
4. Commission a HEN synthesis report that provides a systematic review of the roles and functions of cultural mediators in relation to migrant and refugee health.
5. Consider developing two GHH seminars based on the four CCH focus areas to further raise the profile of CCH within the Region and beyond.

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## Conclusions

The Regional Office took several positive steps forward in the development of the CCH project, the most important of which was to secure funding over the next three years. In order to continue progressing along the trajectory set out in the CCH strategic framework, a vice-chair of the CCH expert group is needed. The vice-chair will engage in advocacy work for the project and advise on how CCH can be aligned with the 2030 Agenda for Sustainable Development and its health-related SDGs (4). The expert group elected Göran Tomson, Senior Professor of International Health Systems Research at Karolinska Institute, Sweden, for this position.

The expert group also emphasized the importance of interagency cooperation going forward. Given UNESCO's cultural mandate, the Regional Office and UNESCO are well positioned to work more closely together on the CCH project to the benefit of both organizations.

Finally, the group reiterated the need for a well stocked collection of CCH case studies demonstrating to policy-makers the importance of understanding health issues within their cultural context. To this end, the expert group recommended that the Regional Office build a strong network of CCH experts and accumulate comprehensible CCH case studies with a particular emphasis on the four focus areas.

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## Recommendations

Based on their concluding discussions, the expert group made the following three additional recommendations.

1. Develop a paper that positions CCH in the context of the SDGs and, if possible, present it at the 66th session of the Regional Committee.
2. Explore a framework for collaboration with the UNESCO Section on Intangible Cultural Heritage and consider holding the next CCH expert group meeting at UNESCO headquarters in Paris.
3. Continue mapping and connecting humanities and social sciences scholars working at the intersection of culture and health.

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## References<sup>2</sup>

1. Health 2020: the European policy for health and well-being [website]. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>).
2. Beyond bias: exploring the cultural contexts of health and well-being measurement. First meeting of the expert group. Copenhagen: WHO Regional Office for Europe; 2015 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0008/284903/Cultural-contexts-health.pdf](http://www.euro.who.int/__data/assets/pdf_file/0008/284903/Cultural-contexts-health.pdf)).
3. Napier AD, Ancarno C, Butler B, Calabrese J, Chater A, Chatterjee H et al. Culture and health. *Lancet* 2014;384:1607–39. doi: 10.1016/S0140-6736(14)61603-2.

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<sup>2</sup> All references accessed 5 August 2016

4. Sustainable development knowledge platform [website]. New York: United Nations; 2016 (<https://sustainabledevelopment.un.org/post2015/transformingourworld>).
5. The European health report 2015. Targets and beyond – reaching new frontiers in evidence. Copenhagen: WHO Regional Office for Europe; 2015 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/288645/European-health-report-2015-full-book-en.pdf](http://www.euro.who.int/__data/assets/pdf_file/0006/288645/European-health-report-2015-full-book-en.pdf)).
6. 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](http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html)).
7. WHO Regional Office for Europe, Organisation for Economic Co-operation and Development. Economic cost of the health impact of air pollution in Europe: clean air, health and wealth. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/media-centre/events/events/2015/04/ehp-mid-term-review/publications/economic-cost-of-the-health-impact-of-air-pollution-in-europe>).
8. Obesity data and statistics [website]. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/data-and-statistics>).
9. European Food and Nutrition Action Plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2015 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/294474/European-Food-Nutrition-Action-Plan-20152020-en.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0003/294474/European-Food-Nutrition-Action-Plan-20152020-en.pdf?ua=1)).
10. Crotty P. The value of qualitative research in nutrition. *Annual Review of Health Social Science* 1993;3(1):109–18. doi: 10.5172/hesr.1993.3.1.109.
11. Hanks A, Just D, Wansink B. Smarter lunchrooms can address new school lunchroom guidelines and childhood obesity. *Journal of Pediatrics* 2013;162(4):867–9. doi: 10.1016/j.jpeds.2012.12.031.

12. Petter Å. Footprints of school gardens in Sweden. *Garden History* 2004;32(2):229–47 doi:10.2307/4150383.
13. Scaffidi C. Slow Food: the politics and the pleasure. *Development* 2015;57(2): 257–61. doi: 10.1057/dev.2014.83.
14. Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health. London: Royal College of Psychiatrists; 2013 (Occasional paper OP88; <http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf>).
15. Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P et al. Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry* 2016;3(5)415–24. doi: 10.1016/S2215-0366(16)30024-4.
16. The European Mental Health Action Plan 2013–2020. Copenhagen: WHO Regional Office for Europe; 2015 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0020/280604/WHO-Europe-Mental-Health-Acion-Plan-2013-2020.pdf?ua=1)).
17. Hearing Voices Network [website]. Sheffield: Hearing Voices Network; 2016 (<http://www.hearing-voices.org>).
18. Dustmann C, Frattini T. Immigration: the European experience. London: Centre for Research and Analysis of Migration; 2011 ([http://www.ucl.ac.uk/~uctpb21/doc/CDP\\_22\\_11.pdf](http://www.ucl.ac.uk/~uctpb21/doc/CDP_22_11.pdf)).
19. European Commission – Fact Sheet: EU support in response to the Syrian crisis. Brussels: European Commission; 2016 ([http://europa.eu/rapid/press-release\\_MEMO-16-222\\_en.htm](http://europa.eu/rapid/press-release_MEMO-16-222_en.htm)).
20. Migration and health [website]. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health>).

## Annex 1. Cultural Contexts of Health Action Plan (2015–2019)

### Priority area 1. Advocacy: Promoting awareness of the cultural contexts of health (CCH) in academia, civil society, government and the public health sector

Status	Activity	Product(s)	Contributors	Description of contributions
<b>Actions for 2015</b>				
Finalized	Organize the first CCH expert group meeting to initiate the CCH project.	Meeting report ( <i>Beyond Bias: exploring the cultural contexts of health and well-being measurement</i> ) with recommendations	1) WHO Secretariat 2) CCH expert group members	1) Provide logistical and organizational support; lead programme development; publish meeting report. 2) Provide feedback and review meeting report.
Finalized	Champion a CCH approach to well-being reporting in addition to using more traditional objective and subjective well-being indicators.	Chapter on the cultural contexts of well-being in <i>The European health report 2015</i>	1) WHO Secretariat 2) CCH expert group members	1) Research and develop draft chapter. 2) Provide feedback and peer review of draft; suggest supporting content in the form of text boxes.
Finalized	Organize two events at the WHO Regional Office for Europe with a panel of experts focusing on CCH in relation to two particular health challenges; broadcast these events to a wide audience, encouraging interaction on the internet.	WHO Collaborating Centre for Global Health Histories seminars on: 1) CCH and the Ebola virus 2) CCH and migration	1) WHO Secretariat 2) University of York (United Kingdom)	1) Propose topics and WHO speakers; coordinate logistics for the event and promote internally. 2) Propose topics and suggest external speakers; create marketing material.
Ongoing	Create a strategic framework for the CCH project.	Strategic framework	1) WHO Secretariat 2) CCH expert group members	1) Develop and refine a project vision, set of objectives and operational framework. 2) Provide feedback and agree on final wording of vision and objectives.

Ongoing	Map humanities and social sciences scholars across the WHO European Region.	Database of humanities and social sciences experts	1) WHO Secretariat 2) CCH expert group members	1) Develop the database; map experts via existing humanities and social sciences networks and web searches.  2) Provide names of relevant humanities and social sciences academics or networks.
Ongoing	Create a CCH policy brief that describes the impact of culture on health, illustrates CCH with case studies and provides policy options.	Published policy brief	1) WHO Secretariat 2) University College London (United Kingdom) 3) CCH expert group members	1) Draft terms of reference, support content development, coordinate feedback and manage the production of the report.  2) Professor David Napier to undertake research, develop content and deliver draft policy brief.  3) Provide possible case studies to underpin the policy brief.
Ongoing	Organize the second CCH expert group meeting with a focus on advocacy work.	Meeting report with recommendations	1) WHO Secretariat 2) CCH expert group members	1) Provide logistical and organizational support, lead programme development and publish meeting report.  2) Provide feedback and review meeting report.
<b>New Actions for 2016</b>				
Deliver by September 2016	Produce supporting communications material for CCH.	Brochure or pamphlet, banner, first CCH newsletter and possible long-form blog article	1) WHO Secretariat 2) CCH expert group members	1) Create content, layout and designs of various communications materials.  2) Provide input, feedback and support in disseminating products.
Launch by the fourth quarter of 2016	Collect and collate case studies from expert group members and humanities and social sciences researchers.	Blog collecting case studies of CCH	1) University of Exeter (United Kingdom) 2) CCH expert group members	1) Design blog, curate content and develop an update strategy.  2) Support the collection of CCH case studies.
Deliver by September 2016	Develop a position paper examining CCH in relation to the Sustainable Development Goals.	Presentation of paper at technical briefing during the 66th session of the WHO Regional Committee for Europe (September 2016), and possible publication in journal	1) WHO Secretariat 2) Vice-chair of CCH expert group	1) Coordinate research and draft terms of reference.  2) Conduct research and develop content.

**Priority area 2. Research and development: building a CCH evidence base and developing CCH methodologies that draw on humanities and social sciences research**

Status	Activity	Product(s)	Contributors	Description of contributions
<b>Actions for 2015</b>				
Ongoing	Apply for new WHO Collaborating Centre on Culture and Health at University of Exeter (United Kingdom).	WHO Collaborating Centre	1) WHO Secretariat 2) University of Exeter (United Kingdom)	1) Complete initiation document and support the drafting of terms of reference. 2) Propose work plan; complete and submit designation form.
Ongoing	Explore the viability of using narrative methods for the purposes of gathering health information and for delivering more informed health reporting.	HEN synthesis report on narrative methods	1) WHO Secretariat 2) University of Oxford (United Kingdom)	1) Draft terms of references and support the production of the report. 2) Professor Trish Greenhalgh to deliver a finalized draft by 27 July 2016.
Ongoing	Promote a better understanding of cultural bias in well-being reporting.	HEN synthesis report on culture bias in subjective well-being research	1) WHO Secretariat 2) Higher School of Economics, National Research University (Russian Federation)	1) Draft terms of reference, support the production of the report. 2) Professor Eduard Ponarin to deliver a draft to be discussed at the well-being indicator expert group in summer 2016.
<b>New Actions for 2016</b>				
Deliver by the first quarter of 2017	Organize third CCH expert group meeting jointly with UNESCO, focusing on research and development.	Meeting report with recommendations	1) WHO Secretariat 2) UNESCO Section on Intangible Cultural Heritage	1) Provide logistical support; lead on programme development. 2) Suggest possible dates; provide input for programme development.
Discuss options at virtual CCH meeting in the third quarter of 2016	Decide on a policy question that would form the basis of another HEN report and/or policy brief.	Various publications (policy briefs, HEN reports, etc.)	1) WHO Secretariat 2) CCH expert group members	1) Formulate proposals for areas where a Regional Office programmatic activity could benefit from a CCH approach, for example: <ul style="list-style-type: none"> <li>• the Healthy Cities project</li> <li>• WHO consultation on waste management</li> </ul> 2) Provide feedback and recommend most viable options.

Deliver by the fourth quarter of 2016	Organize a workshop in collaboration with the Regional Office's mental health programme that will explore the cultural drivers influencing mental health reform processes.	Joint CCH-mental health workshop and meeting report	1) WHO Secretariat	1) In collaboration with Regional Office programme managers and members, formulate scope and purpose, create list of participants and provide organizational support for the meeting.
Discuss terms of reference at virtual CCH meeting in the third quarter of 2016	Provide a systematic review of the roles and functions of cultural mediators in relation to migrant and refugee health.	HEN synthesis report on cultural mediation	1) WHO Secretariat 2) Academic partner (to be confirmed)	1) In collaboration with the Public Health Aspects of Migration in Europe project, draft terms of reference and support the production of the report.  2) Deliver a draft to be discussed at the next CCH expert group meeting.
Discuss project idea at virtual CCH meeting in the third quarter of 2016	Investigate the feasibility of developing a project on nutrition using a CCH participatory approach focusing on the school environment.	To be confirmed	1) WHO Secretariat 2) UNESCO Section on Intangible Cultural Heritage	1) In collaboration with the Regional Office's nutrition, physical activity, and obesity programme, develop a project proposal and costing plan.  2) Provide feedback and input from an educational standpoint.

### Priority area 3. Knowledge translation: facilitating the uptake of CCH-led evidence into policy and building a portfolio of good practice by and for Member States

Status	Activity	Product(s)	Contributors	Description of contributions
<b>Actions for 2015</b>				
Finalized	Describe how a more robust mandatory well-being section can be developed for the Profile of health and well-being country reports. Also, explore how a more systematic analysis of CCH plays out in a given national health setting.	Guidance notes for the well-being module in profile of health and well-being reports	1) WHO Secretariat 2) University of Exeter (United Kingdom)	1) Draft terms of reference, coordinate input and provide research support. 2) Professor Mark Jackson to deliver draft guidance notes.
<b>New Actions for 2016</b>				
Deliver by August 2018; discuss concept note at next CCH expert group meeting in 2017	Develop an accessible toolkit to provide clear guidance on how to use approaches and methods from the humanities and social sciences in public health and policy settings.	Publication of a toolkit of methodologies from the humanities and social sciences	1) WHO Secretariat 2) University of Exeter (United Kingdom) 3) CCH expert group members	1) Coordinate feedback from expert group members, develop terms of reference and provide research support. 2) Draft concept note for proposed area of focus (for example, migration). 3) Provide feedback and guidance.
Apply by 29 May 2016; if successful, organize teleconference with participants in mid-June 2016	Develop a workshop proposal based on the HEN synthesis report on narrative methods, to be presented at the European Public Health Association's next conference in November 2016.	2016 European Public Health Conference workshop (90 minutes)	1) WHO Secretariat 2) Oxford University (United Kingdom); Karolinska Institute (Sweden); Exeter University (United Kingdom)	1) Draft application and conceptualize the workshop. 2) Provide session input and feedback on application.

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## Annex 2. Programme

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Monday 4 April 2016

### **Opening**

Welcome by WHO Secretariat and Chair

Introductions

Election of Rapporteur

Mark Jackson: briefing on purpose and adoption of meeting programme

Claudia Stein: expected outcomes of the meeting

### **Session 1.**

#### **Overview of cultural contexts of health (CCH) activities**

Claudia Stein: overview of the European Health Information Initiative and summary of implemented recommendations from the previous CCH expert group meeting

Mark Jackson: a WHO collaborating centre on culture and health

João Rangel de Almeida: strategic developments in the health-related humanities and social sciences

### *Discussion and feedback*

### **Session 2.**

#### **Further developing the CCH strategic framework**

Claudia Stein: overview of the CCH strategic framework

- Discussing the vision and objectives for CCH
- Building on the previous CCH expert group meeting to define project priorities and focus areas
- Presentation of draft communication strategy
- Electing vice-chair for CCH advocacy

### Discussion

- *Is the project vision sufficiently ambitious? Are the objectives achievable? Are the focus areas well chosen?*
- *What should be some key advocacy outputs during Year 1?*
- *What academic and public health networks should the CCH project be tapping into in order to amplify its reach?*
- *How do we build an inclusive communications strategy?*

### Session 3.

#### **Policy brief on the importance of CCH**

David Napier: summary of the draft CCH policy brief

Göran Tomson: a policy perspective

Danuta Penkala-Gawęcka: a regional perspective

### Discussion

- *Are the case studies well chosen and informative?*
- *Is the policy brief accessible, inclusive, and relevant to Member States?*
- *What would be some key, actionable policy recommendations?*
- *How should the policy brief be promoted?*

### Session 4.

#### **Health Evidence Network (HEN) report on narrative methods**

Trish Greenhalgh: summary of the proposed HEN report on narrative methods in the health care setting

Ilona Kickbusch: a policy perspective

Victoria Zhura: a regional perspective

### Discussion

- *Is the proposed methodology robust?*
- *Will the report make an effective case for narrative evidence?*
- *What might a workshop based on the HEN report look like?*
- *What are the challenges in relation to survey design?*

### Session 5.

#### **Towards a CCH methodology toolkit**

Felicity Thomas: presentation of background document and preliminary scoping for a CCH methodology toolkit

Mohan Jyoti Dutta: methodologies based on a culture centred approach

Sarah Atkinson: methodologies from the critical medical humanities

#### *Discussion*

- *What methodologies should the toolkit focus on?*
- *How might the toolkit be presented (for example, online, via WebEx or in a printed publication)?*
- *What is a sample use case scenario for the report?*

#### *Conclusions day 1 (Chair)*

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Tuesday, 5 April 2016

#### *Summary of day 1 (Rapporteur)*

### Session 6.

#### **Environment and CCH**

Thomas Kistemann: culturally shaped experiences of the environment and their impact on health and well-being: the Blue Spaces example

Marco Martuzzi: the cultural contexts at the intersection of health and the environment in the WHO European Region

#### *Discussion*

- *How can cultural practices build resilience in the face of health challenges?*
- *How can the Regional Office promote (or celebrate) positive cultural practices?*

### Session 7.

#### **Nutrition and CCH**

Edward Fischer: the culture of food choices: a global perspective

Susanna Kugelberg: moving from behaviour change to culture change in policy-making

#### *Discussion*

- *What key policy questions can benefit from a CCH perspective?*
- *How might positive cultural practices in relation to nutrition be highlighted?*

#### **Session 8.**

##### **Mental health and CCH**

Angel Martinez-Hernández: the role of culture in mental health policies: what can the social sciences contribute?

Matthijs Muijen: culture and mental health: challenges in the European Region

#### *Discussion*

- *Where are the knowledge gaps in relation to the impact of culture on mental health and well-being?*
- *How can we best promote the importance of CCH to mental health policy-makers?*

#### **Session 9.**

##### **Migration and CCH**

Ilhan Ilkilic: cultural and ethical challenges in the health care provision of refugees and migrants

Santino Severoni: the rising need for cultural mediators in the current refugee crisis

#### *Discussion*

- *What are the key areas where a CCH approach can contribute to the topic of migration?*
- *What practical support can CCH provide to the Public Health Aspects of Migration in Europe project?*

### Session 10.

#### Conclusions and next steps

Conclusions and actions from the past two days by Chair and WHO Secretariat

Generating an action plan and agreeing on next steps

#### Discussion

- *What are some other focus areas that the CCH project team should consider developing?*
- *What networks might the Regional Office be able to tap in to in relation to these new focus areas?*
- *What opportunities do the Sustainable Development Goals present for strengthening the case for a CCH approach to public health?*

#### Wrap up

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## Annex 3. List of participants

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### Temporary advisers

#### *Dr Peter Achterberg*

Senior Advisor

National Institute for Public Health and the Environment

PO Box 1, Bilthoven 3533 SE, The Netherlands

Email: peter.achterberg@rivm.nl

#### *Dr João Rangel de Almeida*

Humanities and Social Sciences Portfolio Development Manager

Wellcome Trust

Gibbs Building, 215 Euston Road, London,

NW1 2BE, United Kingdom

Email: j.rangeldealmeida@wellcome.ac.uk

#### *Professor Sarah Atkinson*

Professor of Geography and Medical Humanities

Department of Geography

Durham University

South Road, Durham, DH1 3LE, United Kingdom

Email: sj.atkinson@durham.ac.uk

#### *Professor Mohan Jyoti Dutta*

Provost's Chair Professor

Head, Communications and New Media

Director, Center for Culture-Centered Approach

to Research and Evaluation

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 the History of Emotions

Queen Mary University of London

Mile End Rd, London, E1 4NS, United Kingdom

Email: jules.evans@mac.com

*Professor Edward F. Fischer*

Professor of Anthropology  
Director, Center for Latin American Studies  
Vanderbilt University  
230 Buttrick Hall, Nashville, Tennessee, 37235-1806  
United States of America  
Email: edward.f.fischer@vanderbilt.edu

*Professor Trisha Greenhalgh*

Professor of Primary Care Health Sciences  
Nuffield Department of Primary Care Health Sciences  
University of Oxford  
Radcliffe Observatory Quarter, Woodstock Road,  
Oxford, OX2 6GG, United Kingdom  
Email: trish.greenhalgh@phc.ox.ac.uk

*Professor Ilhan Ilkilic*

Chair, Istanbul University Faculty of Medicine  
Department of History of Medicine and Ethics  
Istanbul University  
Hulusi Behcet Kütüphanesi Kat. 2, 34093,  
Istanbul/Çapa,, Turkey  
Email: ilhan.ilkilic@istanbul.edu.tr

*Professor Mark Jackson (Chair)*

Professor of History of Medicine  
Director, Centre for Medical History  
University of Exeter  
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: kickbusch@bluewin.ch

*Professor Thomas Kistemann*

Head, WHO Collaborating Centre for Health Promoting Water  
Management and Risk Communication  
Lead, GeoHealth Centre, Institute for Hygiene and Public Health  
University of Bonn  
Sigmund-Freud Str. 25, 53105, Bonn, Germany  
Email: thomas.kistemann@ukb.uni-bonn.de

*Dr Angel Martínez-Hernández*

Associate Professor  
Department of Anthropology  
Universitat Rovira i Virgili  
Room 3.17, Av. Catalunya, 35 43002, Tarragona (Catalonia), Spain  
Email: angel.martinez@urv.cat

*Professor David Napier*

Professor of Medical Anthropology  
Director, Science, Medicine and Society Network  
University College London  
Gower Street WC1E 6BT, London, United Kingdom  
Email: d.napier@ucl.ac.uk

*Dr Saodat Olimova*

SHARQ Research Centre  
7 Bofanda Street, dep. 9, 734042, Dushanbe, Tajikistan  
Email: olimov@tajik.net

*Dr Danuta Penkala-Gawęcka*

Associate Professor  
Department of Ethnology and Cultural Anthropology  
Adam Mickiewicz University  
Umultowska Street 89 D, 61-614 Poznań, Poland  
Email: danagaw@amu.edu.pl

*Dr Bosse Pettersson*

Senior Adviser, Public Health Policy  
The National Board of Health and Welfare  
Rålambsvägen 3, SE-10630, Stockholm, Sweden  
Email: bosse.pettersson@socialstyrelsen.se

*Dr Felicity Thomas*

Research Fellow, Medical Humanities  
Centre for Medical History  
University of Exeter  
Amory Building, Exeter, EX4 4RJ, United Kingdom  
Email: f.thomas@exeter.ac.uk

*Professor Göran Tomson*

Senior Professor of International Health Systems Research  
Department of Learning, Informatics, Management and Ethics  
Karolinska Institute,  
Solnavagen 1, 171 77, Solna, Sweden  
Email: goran.tomson@ki.se

*Professor Victoria Zhura*

Department of Modern Languages  
Volograd State Medical University  
1, Pavshikh Bortsov Sq., Volograd, 400131, Russian Federation  
Email: vzhura@gmail.com

*Professor Bojan Žikić*

Professor of Anthropology  
Department of Ethnology and Anthropology, Faculty of Philosophy  
University of Belgrade  
Čika Ljubina 18-20, Belgrade, Serbia  
Email: bzikic@f.bg.ac.rs

**Representatives of other organizations***Ms Cécile Duvelle*

Former Secretary  
United Nations Educational, Scientific and Cultural Organization  
(UNESCO) Convention for the Safeguarding of the Intangible Cultural  
Heritage (2008–2015)  
Email: cecileduvelle@gmail.com

*Dr Carrie Exton*

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

**WHO Regional Office for Europe***Dr Nils Fietje*

Research Officer

Division of Information, Evidence, Research and Innovation

Email: fietjen@who.int

*Dr Susanna Kugelberg*

Consultant

Division of Noncommunicable Diseases and Promoting

Health through the Life-course

Email: kugelbergs@who.int

*Dr Marco Martuzzi*

Programme Manager

Environment and Health Intelligence and Forecasting

Division of Policy and Governance for Health and Well-being

Email: martuzzim@who.int

*Dr Matthijs Muijen*

Programme Manager for Mental Health

Division of Noncommunicable Diseases and Health Promotion

Email: muijenm@who.int

*Dr Signe Nipper Nielsen*

Consultant

Division of Information, Evidence, Research and Innovation

Email: nielsens@who.int

*Dr Santino Severoni*

Coordinator

Public Health and Migration

Division of Policy and Governance for Health and Well-being

Email: severonis@who.int

*Dr Claudia Stein*

Director

Division of Information, Evidence, Research and Innovation

Email: steinc@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.

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## World Health Organization

### Regional Office for Europe

UN City, Marmorvej 51, Scherfigsvej,

DK-2100, Copenhagen Ø, Denmark

Tel: +45 39 17 17 17

Fax: +45 39 17 18 18

E-mail: [contact@euro.who.int](mailto:contact@euro.who.int)

Website: [www.euro.who.int](http://www.euro.who.int)

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