



03



Well-being and its cultural contexts

Key messages

By adopting Health 2020, Member States mandated the WHO Regional Office for Europe to measure and report on the well-being of the European population in a holistic manner.

Well-being is a unifying concept that is relevant to many government sectors. Engaging with well-being provides an important opportunity to take a whole-of-government approach to improving the health of the European population.

A growing body of evidence shows that:

- well-being can be reliably measured at the local and national levels;
- this shows something not captured by other metrics; and
- designing policies that take account of well-being can improve the delivery of health-related programmes, services and benefits.

Well-being is experienced at the subjective, individual level; it can also be described objectively through several indicators at the population level, such as education, income and housing. Engaging with the full complexity of subjective well-being demands a multidisciplinary, integrated health-research approach. This will require a more sustained use of different types of qualitative evidence to enhance the quantitative data available from well-being surveys.

Comparing subjective well-being data between groups from very different cultural contexts remains a challenge. Since cultural contexts strongly influence well-being, their importance to well-being and health more generally must be investigated more systematically.

A more participatory approach grounded in the local voices of communities should be adopted to communicate information about well-being. Top-down reporting frameworks are likely to miss out on the rich diversity of cultural contexts within which health and well-being are situated.

In January 2015 WHO launched a review of the cultural contexts of health (CCH), which seeks to synthesize the evidence about the impact of culture on well-being and on health more broadly. One of its longer-term objectives is to create a richer set of tools and methodologies for measuring and reporting on well-being.

Introduction

More and more governments in Europe and across the world are beginning to take an interest in understanding, measuring and improving the well-being of their populations. Drawing on decades of work in well-being research and related fields, an expanding evidence base suggests that well-being can be measured reliably; that it says something not captured by other metrics; and that designing policies which take well-being into account can improve the delivery of programmes, services and benefits in a variety of sectors.

In a world where the interconnectedness of society has become increasingly apparent, well-being is appealing, as it is a highly unifying concept. As a compass by which society can orient itself, well-being is proving to be just as relevant, for instance, to education and finance as to the arts and culture sector. The concept is critical to the way in which WHO's definition of health is being energized.

This chapter considers some of the challenges that arise when trying to quantify an inherently qualitative concept such as subjective well-being and how these can be addressed. Chief

among them are the ways in which cultural contexts affect well-being (and health more broadly). In fact, the important ways in which culture mediates perceptions of, and access to, health and health care have become increasingly clear in recent years.

The chapter concludes by explaining why it is important for WHO to explore CCH and well-being, and why this is essential given the whole-of-government and whole-of-society approaches advocated by Health 2020. It also explores how a more interdisciplinary approach to measuring and reporting on well-being (and health) can help policy-makers understand the specific health and well-being needs of culturally diverse groups of people.

Well-being and health

The relationship between health and well-being is fundamental and reciprocal, and the well-being of populations has important implications for the health sector for several reasons.

- Well-being offers a more integrated model of health – one that does not separate the mind from the body.
- Well-being as a concept is meaningful to the public.
- Higher levels of well-being are associated with decreased risks of disease, illness and injury, better immune functioning, speedier recovery and increased longevity (63, 82, 83).
- Well-being has a predictive value. For instance, life satisfaction scores can predict behaviours such as suicide (84).

In addition, just as income indicators are an insufficient proxy for the progress of society, disease and mortality figures cannot provide a holistic picture of a population's health. Evidence clearly indicates that people can live well in spite of mental illness and, conversely, that their quality of life can be poor even though they may exhibit good mental health (85).

Connecting Health 2020 and well-being

Well-being has always been at the heart of WHO's definition of health, given in the preamble to the Organization's constitution as "a state of complete physical, mental and social well-being and

not merely the absence of disease or infirmity” (86). Although the definition has not changed since 1948, it has proved difficult to operationalize. Over the decades WHO has made significant attempts to promote health in the holistic fashion to which the definition aspires (most notably via the Declaration of Alma-Ata and the subsequent Health for All movement, as well as the Ottawa Charter for Health Promotion (87, 88)). The predominant focus, however, has continued to be on reducing death, disease and disability rather than on measuring complete physical and mental well-being.

Health 2020 seeks once more to redress this imbalance. The vision is to provide a health policy framework for the WHO European Region in which all people are enabled and supported to achieve their full health and well-being potential throughout the life-course. Health 2020 crystallizes the recent insights about the role of health. The framework elaborates how maximizing health is a fundamental right for all and not a privilege for the few. It emphasizes that good health through all stages of life is an asset and a source of economic and social stability, crucial to reducing poverty and creating sustainable development. Most importantly, good health cannot be seen as an outcome of one sector alone: sustainable and equitable improvements in health and well-being are the product of effective policy across all parts of government and collaborative efforts across all parts of society.

The Health 2020 monitoring framework: measuring well-being

Understanding, measuring and reporting on well-being is fundamentally relevant to Health 2020 and, if done in culture-centred and culturally sensitive ways, will be an important contribution to the policy’s successful implementation. Consequently, the monitoring framework developed in consultation with Member States included as one of its core aims the target to enhance the well-being of the European population (3).

Without a robust strategy for measuring and reporting on well-being quantitatively and qualitatively, one cannot assess the degree to which concrete policy interventions to enhance well-being have been successful. Furthermore, including well-

being measurement in the monitoring framework exemplifies Health 2020's focus on a whole-of-government approach. Given the unifying nature of the concept, the very act of measuring well-being opens up opportunities for intersectoral and interagency collaboration. For WHO, this has meant opportunities to share and exchange knowledge with various agencies for culture, environment and education, including work on urban greenhouse gas emissions and well-being as part of the Healthy Cities Network (89, 90).

Summary of work to date

The European health report 2012: charting the way to well-being marked the beginning of the WHO Regional Office for Europe's endeavour of engaging with well-being indicators. At the time of publication the Regional Office had begun the process of consulting with technical experts and Member States, from which one of the first outcomes was the following high-level working definition (91):

Well-being exists in two dimensions: subjective and objective. It comprises an individual's experience of their life and a comparison of life circumstances with social norms and values.

After the report's publication both subjective and objective indicators were identified through expert group meetings held in 2013–2014 (62, 92–94). In recommending appropriate indicators for well-being, the expert meetings were guided by some overarching principles, chief among which were important standard criteria such as face and construct validity. Given the differing levels of capacity for reporting, however, it was decided that another core requirement for the chosen indicators had to be their routine availability across most of the 53 countries in the European Region. Thus, the expert group recommended five core objective indicators and one core subjective indicator.

Indicators for objective well-being

The core indicators chosen for objective well-being cover four domains: social connectedness, economic security and income,

natural and built environment and education. Only two of the recommendations are exclusively linked to the Health 2020 target on well-being:

- availability of social support (domain of social connectedness);
- percentage of the population with improved sanitation facilities (domain of natural and built environment).

The remaining core indicators for objective well-being are also reported on via other parts of the framework, as outlined in Chapter 2:

- GINI coefficient (domain of economic security and income);
- unemployment rate, disaggregated by age and sex (domain of economic security and income);
- proportion of children of official primary school age not enrolled (domain of education).

Three further indicators were also seen as particularly relevant to measuring objective well-being, but because available data on these are generally lacking throughout the Region they are included as additional, rather than core, indicators. These are:

- percentage of people aged 65 years and over living alone (domain of social connectedness);
- total household consumption (domain of economic security and income);
- percentage of the population having completed at least secondary education (domain of education).

Core indicator for subjective well-being

Overall satisfaction with life was recommended as the core indicator for the subjective dimension of well-being. Although it affords only a minimum coverage of the concept, the expert group expressed broad agreement that life satisfaction was the most widely available indicator, making it best suited for the purposes of regional reporting (62).

Monitoring subjective well-being: some challenges

Agreeing on life satisfaction as the most appropriate indicator (at this early stage) for subjective well-being may have been straightforward. Nevertheless, many conceptual and practical issues remain regarding the implementation of subjective well-being monitoring. Moreover, scepticism persists about whether subjective well-being can ever be a meaningful and sufficiently robust construct to be included in international accounts. Since a robust representation of subjective well-being is at the core of how WHO envisages reporting on well-being in the future, acknowledging these concerns and working to better understand and overcome any limitations inherent in the data are important tasks. Without such work, the perceived usefulness of subjective well-being data for policy-makers may be limited to national trends over time.

Building on the working definition of well-being

Supplementing the new working definition of well-being, the 2012 European health report outlined further details to clarify the concept. While people across countries may generally agree on the big picture of what aspects are important to their well-being (such as their health, the natural environment, education and so on), the degree to which these are important and the way in which they are in turn constituted are matters of considerable cultural variation. Consequently, governments wanting to measure the well-being of their populations have often found it necessary to begin with a period of public consultation to better understand the national character of the well-being concept. As a result of such a consultation, Italy, for instance, included “landscape and cultural heritage” as one of the 12 domains of national well-being, a factor that is not captured in other European countries (95).

Furthermore, the report pointed out that subjective well-being could be broken down into further domains beyond life satisfaction – for instance, emotional well-being (such as positive and negative affect), positive functioning (such as sense of

purpose and meaning) and social well-being (such as resilience). These concepts continue to play an important role in attempts by scholars and statistical offices to better define and capture subjective well-being. They also lead, however, to questions about the problems of comparability of data collected across different settings, given the important ways in which cultural values, beliefs and norms shape emotional responses and social expectations.

Subjectivity

One of the most basic challenges in relation to the validity of subjective well-being is the very nature of its subjectivity. As with any self-reported survey data, no factual truth exists against which an individual's subjective assessment of their own well-being can be compared; nor do externalities against which this assessment can be validated. Individuals answering the question "How satisfied are you with your life these days?" may even be unsure about the accuracy of their own responses.

The claim that subjective well-being indicators are robust may therefore seem counter-intuitive to many people. Nevertheless, the evidence from over four decades of research increasingly suggests that subjective well-being – and particularly measures of life satisfaction – can capture reliable, valid and important information that cannot be gathered by objective indicators alone (96). So much attention has been focused on how respondents answer questions on subjective well-being that in many cases more is now known about the mechanisms involved and the strengths and weaknesses of the data than about the ways in which, for instance, cultural factors mediate the gathering of epidemiological data.

Comparability

One of the main challenges for WHO's purposes in measuring subjective well-being relates to the cross-country comparability of the data. Important questions remain about the degree to which subjective well-being indicators are susceptible to distortions resulting from the cultural differences between populations. The challenges for cross-cultural comparability can be categorized

into two main types: methodological (the way surveys are constructed and respondents reply) and epistemological (the way respondents' systems of belief differ).

The methodological robustness – in terms of cross-cultural comparison – of questions that attempt to measure other dimensions of subjective well-being, such as positive and negative emotions (known as “affect”), is still frequently debated by researchers. Some examples of challenges often referred to in the academic literature are listed in Box 3.1.

Careful design and rigorous translation of the surveys can address most of these methodological issues. The more difficult challenges for cross-cultural comparability tend to be epistemological, as they relate to how different cultures construct ideal personhood. Thus, several studies have shown how cultures that place a higher value on modesty influence the way respondents answer questions about subjective well-being, resulting in lower explicit measures of self-esteem (97).

A general conclusion that has been drawn from research comparing individualistic cultures (often attributed to western

Box 3.1.

Factors affecting cross-cultural comparability of subjective well-being measures

Language

Semantic and conceptual equivalence challenges must 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. In addition, operational difficulties may arise when using emphasis in non-Latin-based scripts (such as use of capital letters).

Cognitive challenges

The Cantril Self-Anchoring Striving Scale (see the section on target 4 in Chapter 2) has proved to be cognitively challenging in different cultural contexts, in part because the wording that introduces the concept is relatively involved. The use of

metaphorical constructs may also not be equally useful in all cultures.

Contextual effects

In the case of experienced well-being, short-term events may have strong effects on scores. For example, if the reference period is a Sunday, experienced well-being ratings tend to be higher on average, although cultural variations exist: as might be expected, Friday ratings are higher for Muslim societies, since it is the day of prayer, when most people do not work.

Response bias

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.

Item function

Some items, such as those purporting to measure life evaluations in the next five years, may not function as well in some cultures.

Summary

Good survey methodology is essential to minimize measurement error: questionnaire design and validation, adequate translation practices (such as back-translation), cognitive testing and so on. Caution must 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 (96).

societies) and collectivist cultures (often considered to be found in east Asia), is that universality and cultural specificity are two facets of the same process. Thus, a universal concept such as life satisfaction is intimately connected to culturally specific determinants such as independence or interdependence. Consequently, the degree to which well-being is comparable between cultures is dependent on the degree to which ideal personhood is comparable between them (98, 99).

Reporting on well-being

While in theory the use of more time-consuming (and more costly) survey methods could minimize some of the shortcomings outlined above, the current reality is that life satisfaction is the only subjective well-being indicator on which WHO can report. Adopting a very high-level definition of well-being was a necessary first step towards taking it seriously. Nevertheless, based solely on one indicator, how can WHO actually say something meaningful about “being well” in its culturally diverse European Region?

A second, perhaps more significantly challenging question, is how WHO should approach its communications on well-being. Even if there were agreement on whether subjective well-being measurements in the abstract are valid across countries, it is unlikely to be possible (or even desirable, if cultural diversity is valued) that consistent universal correlates between well-being and its determinants will ever be established. More than most concepts, well-being not only benefits from bottom-up approaches but is fundamentally defined by them.

At its worst, well-being research can be riddled with an unhelpful amount of “normative naiveté” (100). Often, conventional well-being reports suggest that there is a “formula” for well-being, which those countries that rank highly in global well-being surveys have discovered. Such claims can strike sceptics as unhelpful and reductionist, seemingly championing a particular normative philosophy that may be inappropriate in other cultural contexts.

Moreover, these 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 ignores its value as a resource for building dialogues and bridges. Appropriate high-level policy should be formulated from this grassroots understanding of well-being.

Cultural contexts of subjective well-being measurement

A concept frequently invoked to explain differences between countries in relation to their subjective well-being data is “culture”. This usually takes two forms: cultural bias and cultural impact. Cultural bias is a process that influences the act of responding to a survey (but also relates, to some extent, to the very act of designing or translating that survey), thus producing undesirable variations in subjective well-being data (“noise”), particularly when making cross-country comparisons. The causes of this type of noise are multiple: they might, for instance, be the result of differences in language, number use or modes of emotional expression. For example, it has been noted that some European cultures may engage in self-serving biases that help maintain self-esteem, which would result in inflated scores when compared with other cultures that do not (such as some in east Asia) (101).

If cultural bias introduces noise, this must be accounted for as much as possible, either at the survey design stage or during analysis of the data. Increasingly, however, opinion seems to be converging – at least among statisticians (if not anthropologists) – that in fact meaningful cross-national comparisons are possible, and that well-being judgements are not completely relative (102).

If this is the case, then arguably the focus moves away from cultural bias and towards cultural impact. Culture stops being an instrumental factor relevant only to refining survey instruments and instead becomes an inherent good – one that is causally related to the experience of well-being. For instance, if it is possible to believe the comparative data that people in Latin America consistently report higher levels of life satisfaction than those in any other region, it might well be possible to conclude legitimately that cultural attitudes play a part in creating greater resilience in the face of economic hardships.

The need for multidisciplinary approaches

The international movement to focus attention on well-being is generating new, interesting and valuable data (103). Being able to provide statistical evidence to demonstrate, for instance, that some aspects of well-being are associated with increased survival is a fundamental stepping stone towards convincing health ministries to take well-being seriously. At the moment, however, a more integrated approach to understanding and measuring well-being is missing in most countries.

Evidence suggests that social cohesion factors such as trust, tolerance and solidarity are important contributors to well-being. But these are complex, culturally specific and linguistically rich terms. They have also long been the object of study by academics across a wide range of disciplines. For example, it has been argued that Denmark regularly ranks among the top five happiest countries in the world because it has high levels of social cohesion (104). This kind of analysis is, however, of little value to policy-makers looking to promote specific interventions. What causes this social cohesion? What historical factors are in play? What does the cultural output of Denmark – such as its literature, architecture or media – say about the strong sense of Danish values?

To date, the big cultural narratives in relation to well-being research have come from cross-cultural psychology. They have revolved mainly around the idea that collectivist cultures (defined by the literature as those often considered to be found in east Asia) emphasize family, community and group values, while individualist cultures (often attributed to western societies) emphasize personal achievement and individualistic expression (105). This in turn affects how well-being is both perceived and articulated. There is, however, a vast literature in cross-cultural psychology that has proposed other constructs (such as indulgence versus restraint, universalism versus particularism, achievement versus ascription and so on) (106–108). The literature on culture and subjective well-being has engaged with these ideas only sparingly. To get a more rounded understanding of well-being (and especially the emotions that affect it), scholars argue for the importance of the need not only to move beyond the individualist/collectivist dichotomy but also to address

well-being in cultural contexts other than the arbitrary fault line that divides societies into eastern and western ones (109).

Beyond cross-cultural psychology, the impact of other disciplines on the well-being literature has been less visible. Anthropologists in particular have remarked that important anthropological research on the presentation of self and the value of affective behaviours at local levels remains largely ignored (110). Similarly, communication scholars have highlighted the idea of culture as the basis for the ways in which meanings of health and well-being are defined (111). For a movement that is avowedly interdisciplinary, there is of yet little reference to, or input from, well-being research in a wider array of disciplines beyond sociology, psychology and economics. And yet, in claiming that historical events, the meanings of words or shared conventions and practices affect the way countries, communities and individuals report on and experience life satisfaction (or indeed individual health), scholars with expert cultural knowledge of the societies whose well-being is being examined and compared should clearly be consulted (112).

At least in part, the reason for the limited interaction between those who analyse data (sociologists, economists, statisticians) and those who analyse context (literature and communication scholars, historians, anthropologists) stems from the definitional challenges. In order for culture to be quantifiable in relation to well-being it needs to be sharply defined. Anthropologists and humanities scholars would argue, however, that a sharply defined idea of what culture means ignores the inherently dynamic, changeable and porous nature of the concept. Anthropologists in particular have become resistant to the idea of talking in terms of “Russian” or “Spanish” culture, or even “eastern” and “western” cultures, preferring instead to think along the lines of cultural tendencies that are socially constructed (113–115). The realities, however, of having to measure very complex behaviour constantly force analysts towards a reductionist concept of culture, highlighting all the variables related to phenomena that are easier to measure and pushing into the background anything that is difficult to define, imprecise or related to immaterial and universal aspects of culture (116).

WHO's review of CCH

In the last decade a growing number of initiatives related to medicine and public health prepared the ground for a re-examination of the importance of cultural contexts in relation to health. The concept of culture is firmly embedded, for instance, in the post-2015 development agenda, and a recent concept note published by the United Nations Development Group highlights the significant contribution cultural dynamics can make in improving people's health (117). In late 2014 *The Lancet* published an extensive commission report on culture and health, in which the claim is made that the neglect of culture is the single biggest obstacle to developing equitable health care (118). Funders, as well as research councils, are ramping up support for a more multidisciplinary, integrated health-research approach (via the medical humanities, for instance). Together, these initiatives might be characterized as examples of what has been described as a "fifth wave" (119) in public health – a phase which seeks to engage public health with the full complexity of the subjective, lived experience.

As this chapter has tried to demonstrate, understanding, measuring and reporting on the well-being of populations is strongly influenced by cultural contexts; a better understanding of these contexts is thus vital if WHO is to carry out its mandate of improving well-being within the European Region. To help WHO think through some of the challenges involved, as well as to make suggestions on how they might be overcome, the WHO Regional Office for Europe launched a review of CCH and established an expert group that met for the first time in January 2015. The group comprises 21 advisors from a variety of disciplinary and professional backgrounds, including epidemiologists, statisticians and public health experts, but also academics from cultural studies, history, philosophy, anthropology, communication, geography, medical humanities and cultural psychology.

The expert group began its work by adopting the definition of culture published in the 2001 UNESCO Universal Declaration on Cultural Diversity (120), which reaffirmed that:

culture should be regarded 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.

In addition, the expert group recommended that WHO should:

- identify existing quantitative and qualitative research and narrative case studies that illustrate the impact of culture on health and well-being, as well as useful policy interventions;
- encourage more research into the cross-cultural measurement and comparability of subjective well-being data;
- enhance 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;
- explore culture-centred, participatory approaches that engage local communities in sensitive and measured ways to investigate what it means to be well and healthy, and foster avenues of communication for sharing cultural resources of well-being and health.

Incorporating narrative forms of health information

An innovative recommendation of the expert group was to encourage WHO to consider using other forms of evidence from a wider array of disciplinary perspectives to supplement its regional reporting on well-being. For example, systematically analysing historical records, anthropological observations or other forms of cultural output can yield a substantial amount of health information about the well-being of groups, communities and even nations. The preconception that this kind of information is too “soft” for the public health sphere must first be overcome, however. Instead, the focus needs to be on validity, as it would be with more conventional forms of data.

When WHO reports on well-being, taking advantage of a more multidisciplinary approach – one that benefits from the methodologies employed by historians, anthropologists and other cultural commentators – 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 concern about the current burden of reporting.

Second, the use of more culturally specific sources of evidence (gathered from, for instance, traditions, rituals or narratives) 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 (Box 3.2). For example, many of the current instruments for measuring well-being are based on self-reporting and so disenfranchise those who have no voice. This applies particularly to younger children, whose well-being is essential for future public health in a life-course approach.

Finally, an integrated multidisciplinary approach – one 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 builds understanding, for instance, of how all the attention on well-being (and happiness) is producing its own cultural

Box 3.2.

Narrative sources of evidence

Narrative sources of evidence offer policy-making communities several forms of situated and experiential knowledge not currently captured well through the leading sources of evidence in the conventional hierarchy (such as routine health information or household survey data). Although quantitative data are essential, they are often inadequate in promoting the acceptance of evidence-based practices and policies. For instance, in the policy debates about measles vaccinations, opponents of evidence-informed guidelines invariably draw on emotive narratives to promote their position. This frequently gives their narratives the edge, in spite of contravening the scientific evidence (122).

Narratives reveal and explore complexity and variation. This includes hidden contradictions, tensions and disagreements within what appears an uncontroversial or unitary set of policy interests or practices. They can indicate influence from and interaction with the wider context and history, along with possible unintended consequences of policy action. Moreover, narratives may challenge the underlying assumptions or framing of any given policy approach (123). Finally, narrative approaches facilitate “a progressive evidence-based policy agenda that incorporates the views of the public”, in that participants may be enabled to control both the issues and the framing within which they are discussed (124).

For instance, in the specific context of migrant population health, studies have indicated that these narrative forms allowed migrants to define well-being (among other categories) in a way that is relevant to their own experience. The resulting narratives show how, as a migrant population group, they tended to be represented as “minority other”, “culturally determined” and, at times, “backward”. The authors emphasize the importance of not pre-determining the essential characteristics of migrant populations. This “non-essentializing” approach challenges stereotypes and highlights the fluidity inherent in culture (124).

dynamics – dynamics that might themselves have negative side-effects (121).

Reporting and communicating about well-being

Because communication on well-being initiatives is fundamentally a two-way process, the expert group recommended that policy initiatives should be participatory and interactive, allowing room for personal choice and creativity. Well-being reports should be empowering, giving people data at the local level that informs their interactions with local services. To facilitate this, communication pathways need to be fostered to create opportunities for communities to share their stories of well-being. In short, a more culture-centred approach is essential to better report on and communicate about well-being (see Box 3.3).

Thus, the expert group recommended that WHO should explore ways to make well-being data available via its health information and evidence portal for Europe (see Chapter 4 for further details) in ways that are participatory and empowering for local communities. This might 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. 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.

Finally, the group suggested that it may be useful to focus on case studies of cultural practices in particular countries or communities that are linked to increased resilience. The important question, from a policy perspective, is whether these case studies may discover factors, skills, values or policy interventions that are transferable to other cultures and communities. To create spaces for acknowledging the positive role of culture in health and well-being, communication about culture and health needs to examine the structural limitations that disenfranchise cultural articulations of health.

Moving the well-being research and development agenda forward

Supported by the expert group, the CCH review will be conducted along three strands:

- **advocacy:** clarifying the concepts behind CCH and making the case for their importance;
- **research:** commissioning policy-relevant research that elaborates the influence of cultural contexts in specific public health initiatives, such as well-being measurement;
- **reporting:** developing a culture-centred approach to reporting on well-being.

An important outcome of this work will be 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 permit the identification of case studies that illustrate the impact of cultural contexts on health and well-being, allowing for potential policy options to be identified. The framework should also make the case for how research from the humanities and social sciences can add important value by

Box 3.3.

Culture-centred approaches to communication

The culture-centred approach suggests that voices of communities need to be foregrounded in health decision-making to develop solutions that are meaningful to these communities and responsive to local challenges. With an emphasis on listening to the voices of communities, the culture-centred approach emphasizes the concepts of dialogue, authenticity and reflexivity. Several basic points can be made.

- Opportunities for two-way communication are vital to hear voices and views that are otherwise silenced or ignored.
- Authentic communication about health must be rooted in truthfulness, transparency and the acceptance of cultural differences in understandings of health and well-being.

- Communication creates culture as much as it is constituted by it, via dynamic and ever-changing interactions. Therefore, communication about culture and health needs to examine the culturally defined parameters that set out how health can be articulated.

Rooted in this close examination of structures, emphasis needs to be placed on creating cultural networks of communication at the grassroots level that allow diverse understandings of culture, health and well-being to be voiced. Local communication platforms and infrastructures need to be created and sustained to enable the sharing of cultural stories of health and well-being (111).

One example of the culture-centred communication platform is the photovoice method, which draws upon the life experiences of local community members to inform health policy (125). Photovoice is a participatory action research method that involves placing cameras in the hands of community members so they may visually represent and communicate their lived experiences to internal and external stakeholders. With its emphasis on providing venues for voices that are typically silenced in the mainstream discourse, the photovoice method enables participants to share their emotions, feelings and insights about issues that are important to them through photographs.

providing a way of integrating subjective accounts of personal experiences into narratives of well-being and health.

The longer-term objective will be to create a richer set of tools and methodologies for WHO's reporting on well-being. Thus, in addition to the data already collected via the subjective and objective well-being indicators, future reports should be augmented by case studies examined from multidisciplinary perspectives and communicated using a culture-centred approach. If successful, this form of reporting may eventually be encapsulated in guidance documentation that countries can use to help them understand, report on and improve the well-being of their populations.