



Cultural Contexts of Health and Well-being

Policy brief, No. 1

Principal author and editor
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Culture matters: using a cultural contexts of health approach to enhance policy-making



**World Health
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ABSTRACT

This policy brief has been developed in response to the increasing awareness among policy-makers and the public health community of the important relationship between culture and health. By exploring the three key public health areas of nutrition, migration and environment, the policy brief demonstrates how cultural awareness is central to understanding health and well-being and to developing more effective and equitable health policies. Consequently, it argues that public health policy-making has much to gain from applying research from the health-related humanities and social sciences.

KEYWORDS

CULTURAL COMPETENCY

CULTURE

HEALTH KNOWLEDGE, ATTITUDES, PRACTICE

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BACKGROUND

This policy brief was developed through the WHO Regional Office for Europe. The cultural contexts of health team of the Division of Information, Evidence, Research and Innovation, including Claudia Stein (Director), Nils Fietje (Research Officer) and Signe Nipper Nielsen (Consultant), was responsible for and coordinated its development.

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Summary

In the WHO European Region, the roll-out of the policy framework Health 2020 effectively reintroduced well-being as a central concern for WHO, re-engaging public health with the full complexity of subjective, lived experience and opening the door to a more systematic engagement with the cultural contexts of health and well-being. This shift was reinforced by the adoption of the 2030 Agenda for Sustainable Development, which provides an additional mandate for seeking to understand and address cultural contexts. Like Health 2020, the 2030 Agenda asserts that tackling some of the most pressing global problems – health inequities included – requires people-centred, whole-of-society approaches as well as multidisciplinary and multisectoral partnerships. It calls for a new evidence base that affirms the relevance of cultural contexts of health and well-being to policy development.

This policy brief, developed through the WHO Regional Office for Europe together with its expert group on the cultural contexts of health and well-being, forms part of a larger project aimed at promoting a culturally grounded approach to enrich policies related to health and well-being. The project on the cultural contexts of health and well-being argues that incorporating cultural awareness into policy-making is critical to the development of adaptive, equitable and sustainable health care systems, and to making general improvements in many areas of population health and well-being.

Recognizing that population health and well-being are to a large degree influenced by policies and actions external to health care systems, this policy brief also advocates for a health-in-all-policies approach, and an enhanced understanding of how policies in non-health domains can foster or constrain a culture for health and well-being.

To these ends, it presents a robust definition of culture and outlines key options for health policy-makers to consider. Among them is the strong recommendation that policy-makers critically examine their own shared values and priorities related to health and well-being, and how these influence daily practices and decision-making. This involves reevaluating assumptions about what constitutes evidence, and supporting strategies that integrate the complexities of lived experience into an expanded evidence base. Such strategies include efforts to more fully recognize and include findings from the health-

related humanities and social sciences, and from broader public health and health services research.

While culture is highly applicable to a broad range of issues both within and outside the health sector, this brief explores three key areas where shared conventional beliefs, practices and values can have profound impacts on health and well-being: nutrition, where giving and receiving nourishment is deeply social; the environment, where spaces are diversely understood and shared; and migration, where conventional understandings of health and well-being converge or diverge in multicultural contexts.

Addressing the ways in which values are embodied and lived out in these and other areas can have a significant impact on health and well-being outcomes. With this in mind, the policy brief encourages policy-makers to engage critically and creatively with the material presented here, and to adopt an inclusive approach to improving health and well-being policies by taking cultural contexts into account.

Executive Summary

Background

In 2015, upon acknowledging the importance of culture to health and well-being, the WHO Regional Office for Europe convened its first expert group on the cultural contexts of health and well-being (1). This came as a response to a growing body of evidence demonstrating that the best medical care in the world remains limited if its provision does not align with the priorities and perceived needs of those it seeks to serve. Indeed, the authors of the 2014 Lancet Commission on Culture and Health argued that “the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide” (2).

The Regional Office’s new focus on culture is reflected in the two strategic frameworks that underpin the project on the cultural contexts of health and well-being: the European policy framework Health 2020 (3) and the 2030 Agenda for Sustainable Development (4). With the adoption of Health 2020, WHO’s strategic emphasis shifted towards a values base that emphasizes a life-course perspective, multisectoral and interdisciplinary engagement, and a people-centred, whole-of-society approach to health and well-being. The 2030 Agenda and its Sustainable Development Goals reinforce this values base, and call for alternative ways of empowering and giving voice to marginalized groups. In this quest, narrative and qualitative research as well as culture-centred approaches from the humanities and social sciences have much to offer.

In 2001, the United Nations Education, Scientific and Cultural Organization defined culture as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group ... [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (5). This definition highlights the fact that culture comprises not only the physical artefacts around which group identity emerges, but also the conventions that frame our sense of reality. While shared and coherent, culture is not a static set of beliefs and practices, but rather an ever-emerging array of collective values, ethics, assumptions and ideals. Other cultures are as dynamic as our own.

Though the shared values of cultural contexts are complex, understanding them is critical to health and well-being policy development for several reasons.

First, an awareness of cultural contexts shows people the relative nature of values we often assume to be universal. In examining them we challenge ourselves to assess what we take for granted, and to rethink our inductive assumptions about what will make us all healthier.

Second, an awareness of cultural contexts allows us to better understand the compounding influences of diverse but interrelated determinants, such as socioeconomic status, environmental conditions, age, gender, religion, sexual orientation and level of education (6). While alienation and marginalization are key upstream determinants for any number of illnesses and vulnerabilities, cultural understanding can be a source of health resilience in a rapidly changing world.

Third, because pathways of care are built upon a foundation of shared values, an awareness of cultural contexts offers new models of care that take into account more than just biology and medicine.

Fourth, because diverging value systems, health beliefs and views about sharing can either promote or limit the equal distribution of health resources, an awareness of cultural contexts is critical to health equity.

Our experiences of health and well-being are fundamentally influenced by the cultural contexts from which we make meaning. These frameworks inform the beliefs and actions of policy-makers and health care practitioners as much as the people they serve. For this reason, policy-makers must seek not only to understand the values they attribute to others, but also to critically examine their own cultures – their perceptions, daily practices and processes of decision-making – and their effects on people who may or may not share the same values and priorities.

Cultivating this self-awareness involves recognizing that all forms of knowledge and practice – including scientific and medical – are influenced by culture. This calls for a careful examination of assumptions about appropriate data collection and analysis methods, and about what constitutes evidence. Many researchers point out that

an historical bias towards quantitative studies in public health has resulted in an evidence base that, while offering much in the way of figures and statistics, provides less insight into localized, subjective experiences of well-being and illness, or perceived health risks and related human behaviours.

It is clear that randomized control trials based on a limited set of variables cannot yield a nuanced understanding of how risk factors are compounded in daily life (7). Furthermore, no degree of research – quantitative or qualitative – can adequately reflect the diversity and complexity of human societies and inform truly equitable policies when vulnerable groups face barriers to participation. Critical resources may be wasted when funnelled into reductive or inadvertently exclusionary studies, and into the limited policies and programmes that they inform.

There are, therefore, ethical, epistemological and economic imperatives for considering the cultural contexts of health and well-being.

With these imperatives in mind, the Regional Office's expert group urges policy-makers to engage with an expanded evidence base that incorporates mixed-methods research from the health-related humanities and social sciences. Such integrated work will contribute to a health evidence base grounded in people's lived experience.

With a heightened awareness of both the strengths and weaknesses of different kinds of research techniques and data, and a determination to support new forms of evidence, policy-makers will be better positioned to foster individual and community resilience in the face of emerging health challenges.

To this end, this policy brief sets out to do three things:

1. to make the case for attending to the cultural contexts of health and well-being;
2. to offer specific suggestions to help policy-makers understand and incorporate the cultural contexts of health and well-being into effective working practice; and
3. to provide examples of how cultural awareness can improve understanding of the drivers of health and well-being in three key domains: nutrition, the environment and migration.

Policy options and key themes

Section I of this policy brief examines the concept of culture, explores its interconnections with health and well-being, and identifies the pressing need for a new focus on integrated research methods. It presents the following eight policy options for consideration by all policy-makers working on issues related to the cultural contexts of health and well-being. While these options can be viewed as progressive steps, they are by nature iterative and interdependent.

1. Promote an understanding of the interrelationship between culture and health.
2. Develop clear opportunities and guidance for policy-makers to explore and reflect upon their own cultural conventions and how these influence perception and decision-making.
3. Support an expanded evidence base that includes research from the humanities and social sciences, with a focus on mixed-methods research on the social and cultural drivers of health and well-being.
4. Incorporate subjective definitions, experiences and measurements into health and well-being policy development in order to better identify and address the needs of diverse groups and to better interpret quantitative information.
5. Identify ethical dilemmas that may arise when systems of value related to health and health care diverge.
6. Support the development of instruments that increase knowledge of the importance of culture to health and well-being, and measures for evaluating the cultural competency of services and policies.
7. Increase capacity for working intersectorally by introducing well-being and culture as central elements of a health-in-all-policies approach.
8. Share good practices.

Section II of this policy brief demonstrates how cultural contexts impact health and well-being in both positive and negative ways within three key areas.

1. **Nutrition:** effective policy-making on nutrition means understanding how cultural contexts impact food choices that lead to better or worse outcomes, and how food practices can reinforce or destabilize health and well-being, social trust, and community resilience.
2. **The environment:** effective policy-making on the environment means investigating how relationships to our surroundings are culturally mediated, how this impacts health and well-being, and how to ensure equitable access to health-promoting natural spaces.
3. **Migration:** effective policy-making on migration and health means examining how culture mediates both caregiving and care receiving in cross-cultural and multicultural contexts, and addressing the urgent need for culturally sensitive assessments of health and well-being as well as relevant approaches to health care delivery.

References

1. Beyond bias: exploring the cultural contexts of health and well-being measurement. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0008/284903/Cultural-contexts-health.pdf, accessed 13 February 2017).
2. 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.
3. 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>, accessed 13 February 2017).
4. The Sustainable Development Agenda [website]. New York: United Nations; 2017 <http://www.un.org/sustainabledevelopment/development-agenda/>, accessed 13 February 2017).
5. UNESCO Universal Declaration on Cultural Diversity [website]. Paris: United Nations Educational, Scientific and Cultural Organization; 2001 (http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html, accessed 13 February 2017).
6. Social determinants of health [website]. Copenhagen: WHO Regional Office for Europe; 2017 (<http://www.euro.who.int/en/health-topics/health-determinants/social-determinants>, accessed 13 February 2017).
7. Adams V, Burke NJ, Whitmarsh I. Slow research: thoughts for a movement in global health. *Med Anthropol.* 2014;33(3):179–97. doi:10.1080/01459740.2013.858335.

Section I: Understanding culture, health and well-being

What is culture?

In 2001, the United Nations Education, Scientific and Cultural Organization (UNESCO) defined culture as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group ... [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” (1). This definition stresses that culture is not limited to national, racial, ethnic or religious affiliation – it is comprised of overt beliefs and practices as well as the subtle and taken-for-granted conventions that frame our sense of reality, define what is normal and abnormal, and give our lives a sense of direction and purpose (2).

Culture, in other words, is something all humans have and depend upon for making meaning. It sets the diverse and shifting parameters within which decisions and actions unfold in the context of families, communities, workplaces, peer groups and environments. The creative practice of culture in daily life influences how we perceive ourselves, one another and our place in the natural world – and yet culture itself can be remarkably difficult to see.

Precisely because culture concerns more than what we acknowledge explicitly, recognizing it involves the difficult work of scrutinizing assumptions, questioning perceived truths and appreciating how shared group values can, for better or worse, sharply diverge: for better when difference helps us creatively to adjust our assumptions; for worse when difference leads to misunderstanding and conflict.

"Culture is not limited to national, racial, ethnic or religious affiliation – it is comprised of overt beliefs and practices as well as the subtle and taken-for-granted conventions that frame our sense of reality."

Organizations, educational institutions and professions also develop cultures and microcultures that display particular patterns of thought and practice (3–5). Without concerted efforts to explore, understand and challenge the interplay of overt and covert beliefs at work within organizational cultures, counterproductive biases and behaviours can persist. Many public health professionals recognize that failing to consider the cultural contexts of their professional actions can impede their ability to improve working practices, and to identify productive innovations and scale them up. This has weakened the capacity of

public health systems to respond effectively to the health needs of diverse populations, and subsequently sparked a renewed interest in developing a culturally informed approach to health and well-being.

The European policy framework Health 2020 emerged within this context of increased cultural awareness (6). Recognizing the relevance of shared values for well-being, it explicitly calls for new well-being measurements that account for the effects of culturally mediated experiences of illness and health. Developing these measurements involves understanding, validating and actively supporting the ways in which diverse and interrelated cultural practices can enhance solidarity and resilience. As outlined in Sustainable Development Goal 17, it also involves working across diverse cultural sectors, professional groups and domains of policy expertise (7). This requires nothing short of a whole-of-society and whole-of-government approach – one that builds on the shared values of individuals to foster new forms of critical thinking, everyday cooperation and sustained social trust both locally and globally.

Expanding the evidence base on the cultural contexts of health and well-being

In traditional health impact assessments, policy-makers use broad mortality and morbidity data to inform policy recommendations, often without a clear understanding of the cultural contexts that influence individual and societal behaviours. The resulting reports and policies, though based on carefully compiled statistical evidence, can be out of step with people's subjectively defined experiences and perceived needs, as well as what is feasible at the level of policy.

In response to this frequent disconnect between evidence, social need and health policy, Member States in the culturally diverse WHO European Region agreed on a framework of indicators for measuring and reporting on both objective and subjective health and well-being. However, these measurements are principally built on indices that, while useful in assessing levels of perceived satisfaction and happiness in a given population, fall short of illuminating the shared meanings and values on which well-being is based. In the absence of a clear understanding of the cultural contexts that influence both the questionnaires and participants' responses to them, assessing what such measures actually mean becomes difficult and at times conjectural (8).

"It is clear that innovative and adaptive mixed-methods research is essential to advancing human health and well-being."

In addition, vulnerable populations often lack opportunities to become involved in well-being studies or feel reluctant to do so, particularly when their situation leaves them feeling alienated or when daily survival is a pressing concern. When this is the case, tools for measuring well-being can unintentionally reinforce power imbalances that deny certain groups a voice in the decision-making processes that affect their lives.

Such biases in data collection are particularly evident in transitional or otherwise unstable social settings, such as those impacted by food scarcity, climate change, economic hardship, large-scale migration and/or unanticipated human conflict. Under these pressures, vulnerabilities and inequalities can intensify in ways that are not amenable to traditional methods of data collection; without an evidence base that can shape an appropriate inquiry into local forms of suffering, numbers can be as deceptive as they are informative.

In order to produce relevant and adaptive health policies and programmes, policy-makers must examine how communities, as cultures of practice, adjust to diverse and complex stressors. Here, measuring inequality becomes impossible without a close assessment of vulnerability and resilience as they emerge locally. This being the case, qualitative research strategies provide the best frameworks for informing the interpretation of quantitative data, controlling for unconscious biases, and assessing the appropriateness of measurement instruments as well as assistance efforts. In this light, it is clear that innovative and adaptive mixed-methods research is essential to advancing human health and well-being (9,10).

Policy options

To support the development of balanced and integrated data collection and analysis, the following eight policy options are offered for consideration by policy-makers. While they can be viewed as progressive steps, they are by nature iterative and interdependent.

1. Promote an understanding of the interrelationship between culture and health. This requires a definition of culture that resists conflation with race or ethnicity, and underscores that all thought and behaviour is informed by cultures of value and practice.

2. Develop clear opportunities and guidance for policy-makers to explore and reflect upon their own cultural conventions and how these influence perception and decision-making. These could include a range of self-evaluative workshops, diversity education training programmes and other activities that build heightened self-awareness and enhanced communication skills regarding shared practices and perceptions.
3. Support an expanded evidence base that includes research from the humanities and social sciences, with a focus on mixed-methods research on the social and cultural drivers of health and well-being. This requires the inclusion of diverse voices, the development of methods for asserting the place of lived experience as recognized and valued evidence, and the integration of qualitative findings into quantitative data sets.
4. Incorporate subjective definitions, experiences and measurements into health and well-being policy development in order to better identify and address the needs of diverse groups and to better interpret quantitative information. This requires the development of new vulnerability and resilience assessment strategies, and could involve the use of interactive communication platforms to facilitate ongoing exchanges among researchers, individuals and communities related to perceptions of health, well-being, illness and treatment practices.
5. Identify ethical dilemmas that may arise when systems of value related to health and health care diverge. This requires the creation of inclusive public settings (for example, open policy forums and policy-driven web-based discussions) in which those with a lesser voice can directly inform policy-makers about obstacles to adherence and prevention, and/or the training of new professionals to assess, understand and represent the health needs of culturally diverse communities.
6. Support the development of instruments that increase knowledge of the importance of culture to health and well-being, and measures for evaluating the cultural competency of services and policies. Such instruments could include cultural competency toolkits, training workshops, knowledge translation platforms and other support mechanisms. Such

initiatives should be evaluated both quantitatively (using appropriate indicators) and qualitatively (for example, using narrative methods).

7. **Increase capacity for working intersectorally by introducing well-being and culture as central elements of a health-in-all-policies approach.** This must be demonstrated through significant, visible commitment on the part of policy-makers to a whole-of-society and whole-of-government approach.
8. **Share good practices.** A culturally grounded approach to health and well-being benefits from a multiplicity of perspectives, and from new settings in which good practices can be shared. As communities experiment with new strategies and practices, it will be critical to document and disseminate successful innovations that are replicable and scalable.

Section II. Key themes

1) Nutrition, culture and health

Understanding food as culture

In 2014, UNESCO included the Mediterranean diet on its 2013 Representative List of the Intangible Cultural Heritage of Humanity. The list describes this diet as “a set of skills, knowledge, rituals, symbols and traditions concerning crops, harvesting, fishing, animal husbandry, conservation, processing, cooking, and particularly the sharing and consumption of food” (11). In making this designation, and in asserting that this diet “emphasizes values of hospitality, neighbourliness, intercultural dialogue and creativity, and a way of life guided by respect for diversity” (11), UNESCO acknowledges that eating with others forms the basis of cultural identity and community cohesion throughout the Mediterranean basin.

While the concept of a homogenous or pristine Mediterranean diet is contested, UNESCO’s designation of a whole approach to eating (rather than merely a particular dish) as a form of cultural heritage affirms that eating is never just about nutrition. The tasks of sourcing and preparing meals, the ways in which we share them and the messages they convey are all core aspects of what food is. Eating effectively roots us within communities of shared tastes, common habits and collective histories.

Research confirms that the act of receiving food – the first behaviour through which humans learn to create and sustain relationships with others – is infused with meaning and symbolism that emerges socially and culturally (12). As a concrete vehicle for building relationships, the shared meal has immeasurable sociological significance (13–20). Values related to hunger, satiety, excess, pleasure, satisfaction and restraint are all expressed through the experience of imbibing food with others, and have direct impacts on food choices and health outcomes. As such, alimentary health, and the attempts of policy-makers to support or improve it, must be viewed within the framework of culture.

"Alimentary health, and the attempts of policy-makers to support or improve it, must be viewed within the framework of culture."

Moving beyond nutritionism

Customary shared eating practices are altered, distorted and sometimes lost through processes of migration, urbanization and globalization. These alterations in traditional food sharing practices are often propelled by the demands of modern life, in the face of which symbolic group meals can disappear or become relegated to periodic feasts where the consumption of traditional foods may, paradoxically, be exaggerated. As people shift away from traditional and symbolic sharing habits, they are more likely to treat the consumption of food as a basic nutritional necessity. This is evidenced in the increasingly common practices of eating out and eating alone. It is also reflected in new understandings of the function of food, and in particular a strong focus on the biological value of its isolated nutrients – on *what* we eat rather than *why* we eat what we do.

This ideology, known as nutritional reductionism or nutritionism, bypasses the social meaning of food in favour of measuring nutritional content and making related recommendations regarding healthy food intake. This science-oriented shift in the way people assess the value of food manifests in the norms of counting calories, recommended daily allowances, macro and micronutrients, assumed health foods, etc. While understanding nutritional content is important for healthy eating, this objectification of food not only strips it of its historical and cultural meaning, but also frequently leads to disagreement and confusion regarding what constitutes a healthy diet (21–27). Nutritionists and policy-makers tend to address this with calls for more research on nutrient intake and new labelling requirements designed to encourage better food choices, and yet eating behaviours do not always follow suit (28).

The nutritionist approach appeals to individuals as rational beings engaged in free and autonomous decision-making processes, unconstrained by cultural, economic, environmental or social factors. Given the deep social and cultural importance of food, however, an exclusively nutritionist focus is problematic (29). While many people are acutely aware of nutritional information and dietary guidelines, daily food choices are powerfully mediated by economic concerns and food availability as well as family habits, personal tastes, cultural preferences and beliefs about food safety (30–32). In other words, health messaging based on biology and chemistry alone will fail to transform food choices unless following

recommended guidelines is feasible or already conventional for individuals and their families.

Even when nutritional information is fully understood, social factors may prove more relevant to health than counting calories or servings of fruits and vegetables. Studies among individuals who participate in controlled experiments designed to test the health effects of particular diets, for example, show that, after programmes end, participants stop adhering to recommended regimes (33–35). The same holds true for those who participate in controlled studies on the effects of exercise programmes: adherence drops sharply once group engagement ends and the strong influence of shared social meaning and support is absent (36). Indeed, some evidence points to greater weight gain after a year of following a diet in up to 80% of cases (37). These outcomes point to the powerful impact of shared conventions and social integration on health.

Value systems and other cultural factors, such as education and income, also play critical roles in shaping people's short- and long-term responses to health messages. Shared values and assumptions can form barriers when, for example, people perceive that only particular social groups purchase so-called health foods (38). Thus, a culturally grounded approach to nutrition is not only necessary for understanding the various ways in which individual behaviour is influenced in real life; it can also be a critical lever in dismantling perceived barriers and helping people to develop a sense of shared identity around health-promoting choices and behaviours.

The national food guidelines of Brazil's Ministry of Health offer an excellent example of a culturally grounded approach (39). The guidelines are explicitly food-based, rather than nutrient-based, and enshrine people's right to access sustainably produced and culturally appropriate food throughout the life-course. In focusing on valued healthy foods in addition to nutritional content, the guidelines build on the acknowledgement that the health benefits of particular diets stem in large part from the social and cultural settings in which food is infused with meaning. These contexts of meaning include how food is grown, raised, gathered, prepared, shared and, ultimately, enjoyed.¹ The Brazilian model clearly promotes the concept that healthy eating includes much more than caloric input. As with the Mediterranean diet, conviviality, identity, belonging and memory are also important ingredients in a truly nourishing meal.

¹ Brazilian nutritionists developed the guidelines with a wide variety of sources, including anthropology, gastronomy and political activism. This diversity of perspectives contributes to the holism of the guidelines, which speak of both biology and culture; of food practices rather than eating habits; of meals rather than food consumption; even of pleasure.

While calculations of nutritional content have undoubtedly contributed to raising public awareness and strengthening population-level interventions, an exclusively nutritionist approach that decontextualizes food and food habits obscures the experiential settings in which we make sense of nutritional advice and consider altering our behaviours (see Box 1). Nutritionism's implicit emphasis on biological functionalism also reinforces social values related to personal responsibility and the perfectibility of the body, rather than the myriad ways in which food acts as a medium for caring, social connectivity and memory (40,41). In doing so, it replaces a culture of sharing with one of individual action.

Though nutritional advice appears value-neutral, it too is constructed within the context of a belief system about health self-management. As an ideology, nutritionism is a cultural phenomenon – a determining force that has transformed not only the way we experience food, but also the kind of research that is valued, funded and referred to in policy decision-making. Seeing nutritionism as a culturally generated ideology can help to explain why the evidence base for the powerful role of cultural factors in food-related noncommunicable diseases is still so weak (2,8,28,33,38), and why policy-makers are just beginning to grasp the degree to which cultural approaches can change unhealthy habits.

Engaging critically with the food marketplace

In providing a convenient framework for marketing processed foods, nutritionism has also played a key role in the commodification of food production and consumption (42). By exploiting and expanding the ideology of nutritionism, food corporations are able to promote packaged products using reductive nutrition claims that are not always verifiable (21–23). As these food brands are aggressively advertised – particularly to children – traditional food cultures that have sustained population health in culturally and ecologically appropriate ways for centuries are rapidly transformed, displaced or stigmatized as outdated (43,44).

At the same time, the rapid industrialization of food systems is dramatically altering cultural approaches to eating. Food is now promoted as a privatized commodity, rather than a common public good (20), and family meals are being replaced with prepackaged, shelf-stable foods for consumption (and overconsumption) anywhere and at any time. Fresh and minimally processed foods are harder to source

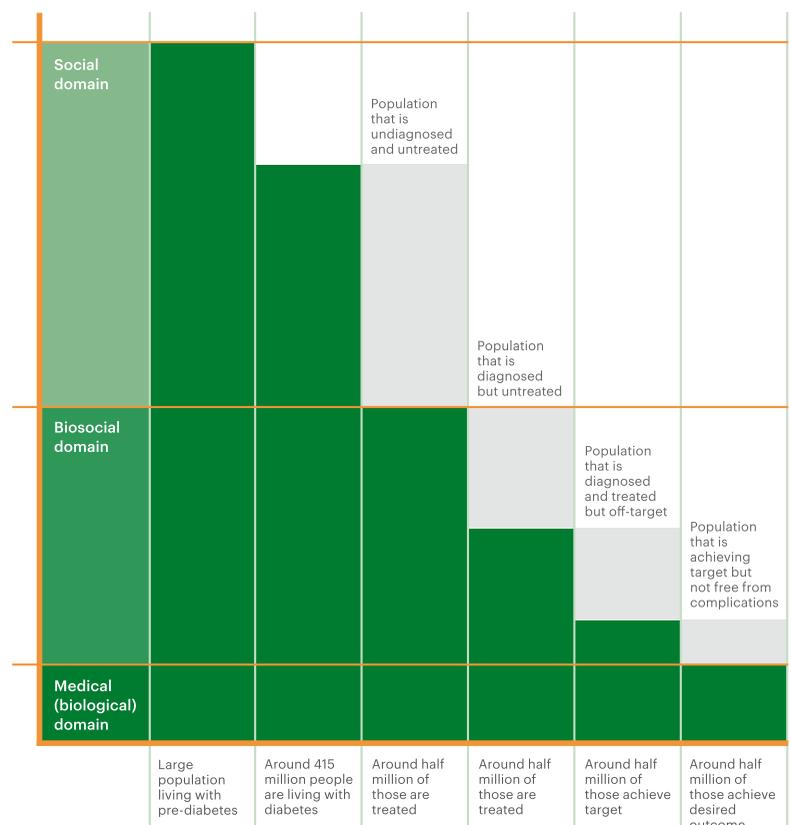
Box 1. Sociocultural aspects of the diabetes epidemic

WHO estimates that 415 million people across the globe currently live with diabetes.¹ To put this number in perspective, if these people were to form a country, it would be the third-most populated country the world. What's more, a single risk factor for diabetes – overweight and obesity – is a reality for about 2.1 billion people: 30% of the planet's population. If not reversed, diabetes-related mortality and morbidity are predicted to crush entire health care systems in the next 15 to 20 years. The cost of this epidemic in terms of both human suffering and economic burden is devastating.

Most of us think of diabetes as principally a clinical illness, and yet, in some countries, more than 90% of diabetes mortality and morbidity is socially and culturally mediated either by non-diagnosis or by non-adherence to treatment. According to the so-called rule of halves, only half of those living with diabetes have been diagnosed; among those who are diagnosed, only half are treated; among those receiving treatment, only half are adhering to recommended regimens; and finally, among those who adhere, only half are achieving treatment targets.²

The rule of halves (illustrated below) is merely a broad framework against which performances in various health care settings can be measured and compared, but it provides a graphic representation of how only a very small proportion of people's experience of diabetes is biomedical. It sheds light on the failure of clinical care to single-handedly address the diabetes epidemic, and on the critical importance of nonclinical determinants for health. The rule of halves reminds us that, regardless of an individual's social, cultural, psychological, environmental and economic context, medical care alone cannot manage their illness well.

The social, biosocial and medical domains and the rule of halves



¹ WHO Noncommunicable diseases factsheet [website]. Geneva: World Health Organization; 2015 (<http://www.who.int/mediacentre/factsheets/fs355/en/>, accessed 10 February 2017).

² Hart JT. Rule of halves: implications of increasing diagnosis and reducing dropout for future workload and prescribing costs in primary care. *Br J Gen Pract.* 1992;42(356):116–19.

and often more expensive, and the cooking skills required to prepare them are vanishing. Entire urban neighbourhoods are now classified as so-called food deserts – areas where affordable and nutritious foods are no longer accessible without sufficient income and/or access to an automobile (45).

Industrialization has also had a deep impact on farming cultures around the world, enticing or pressuring farmers to abandon ecologically sound growing methods to enter and compete in global cash-crop economies (46). Such rapid change threatens both biological and culinary diversity: where local farmers and foragers may once have provided hundreds, even thousands, of different nutritionally and culturally significant foods for local and regional communities, industrial farms now produce only a handful of high-yield, transport-hardy crops destined for immediate export (47–49).

The implications of these changes for the health and well-being of food producers themselves are startling. In India, for example, thousands of suicides are attributed to small-scale farmers' inability to afford the continual purchase of patented, genetically modified seeds and accompanying pesticides on which their incomes, and depleted soils, have come to depend (50).

Such profound shifts demand that policy-makers engage critically with the industrialized food cultures now being promoted across the globe, and with the ways in which evidence about what counts as good food is constructed and promoted (51).

Policy options

In addition to the broad policy options outlined above, the following five specific policy options for those working in nutrition-related programmes are put forward.

1. Support research for an evidence base that affirms food and eating as expressions of culture.
2. Recognize how the cultural contexts of food selection, preparation and sharing can strengthen community health and well-being, and consider how these social contexts can be supported at the level of policy.

3. In partnership with communities, identify food promotion strategies that build on cultural practices that enhance health and well-being.
4. Ensure that healthy-eating messaging addresses the experiential contexts in which people make sense of nutritional advice and change their behaviours.
5. Engage critically and from a variety of perspectives (historical, social, ethical) with the industrialized food marketplace.

2) Environment, culture and health

Cultural conceptions of the environment

While human health is directly linked to that of the environment through air, water, sunlight and soil, ideas of nature and the place of humans within it are deeply influenced by social and cultural contexts. The same river, for example, may appear to different people as a pleasant backdrop for conversation and exercise, a sacred site for prayer or contemplation, a location for lucrative development, a link to personal memories or shared cultural history, the embodiment of group or individual identity, a convenient waste disposal site, a wild landscape to be protected from human influence, or a place to gather food. Just as a meal is never simply a collection of nutrients, a river viewed through human eyes is never simply flowing water.

Depending on what is considered normative, we may speak of the environment using metaphors from economics (“natural capital”), urban planning (“green space”), biology (“ecosystem”), or systems of kinship (“mother earth”) and related cosmologies (52). Through culturally mediated ideologies and linguistic systems, we see and relate to our environments differently, sharing and expressing collective values and engaging in seemingly self-evident and logical decision-making processes and actions. Diverse perceptions of the environment also shape thoughts about well-being and health behaviours in profound and often unconscious ways.

Like all relationships, those between people and environments are fluid and evolving. This evolution – at times slow and subtle, at others sudden and dramatic – is prompted by complex and interrelated

factors such as education; economics; urbanization; industrialization; migration; inequality resulting from individual greed, political oppression, or social or armed conflict; and hunger and scarcity brought on by population growth and related resource depletion. When critical demands are made upon people and landscapes, overuse or abuse can lead to broad scale and chronic environmental neglect, further intensifying pressure on human health and well-being – even on survival.

Understanding how cultural conceptions of the environment relate to human health and well-being has never been more critical. While global narratives of environmental preservation typically focus on sustainable development and resource management, human cultures display a wealth of different models of connectedness and, potentially, stewardship. Many indigenous peoples around the globe, for example, make a direct, causal link between the well-being of humans and the earth (see Box 2). Their healing systems often involve direct appeals to the natural world for physical and psychospiritual assistance, creating moral contracts between people and environments that are both profound and enduring.

Today, despite the recognition of so-called cultural ecosystem services – defined by the Millennium Ecosystem Assessment as “the nonmaterial benefits people obtain from ecosystems through spiritual enrichment, cognitive development, reflection, recreation, and aesthetic experiences” (53) – culturally based strategies for fostering health-enhancing connections to the environment remain largely unexplored. So, too, do possibilities for scaling up related models of environmental caring and stewardship.

Though such ways of perceiving and relating to nature may not be familiar to or endorsed by the majority of policy-makers, they are worthy of serious study. Utilitarian, management-based sustainability frameworks may not represent either the best or the most successful strategies for ensuring that healthy environments are preserved for and valued by future generations. Culturally sensitive explorations of environmental relationships, on the other hand, may reveal pathways to deeper and more sustainable bonds between people and the places they live in, and to healthier communities overall.

Special effort is required to document and learn from diverse cultural conceptions of the environment, many of which are now threatened by multiple factors (52). Research methods from the humanities and social sciences are well equipped to map these ways of seeing and their potential for informing health- and environment-related policies and programmes.

Box 2. Living well together

The Ashaninka peoples of the Peruvian Amazon believe that if all living beings are not in harmony with the earth (Aipatsite), humans cannot achieve fulfilment and happiness. The Ashaninka call this form of harmony “living well together” (kametsa asaiki), a concept that focuses more on the close relationship of humans to landscapes than on the distinction between nature and those who inhabit it.^{1,2}

According to the Ashaninka, “real Ashaninka people” (Ashaninka sanori) are incapable of becoming the good people they want to be unless their actions are in harmony with nature. Because the earth is where human and other beings interact on a daily basis, people are thought to be incapable of growing healthy food, finding new medicines or building sustainable houses and communities unless they respect its many gifts. This entails deciding when to stay away from the deepest forests out of respect for the spirits (maninkari) who they believe lead the souls of the dead to the afterlife. These culturally established protocols of respect and restraint ensure that certain forests are protected from depletion and overhunting, which in turn prevents illness and produces long-term well-being among Ashaninka peoples.

Indeed, many indigenous groups across the globe believe that the world can only avoid catastrophic disruption if humans breathe harmony into it. For such cultures, there can be no hard and fast separation between humans and the places they inhabit; there is an absolute obligation to sustain the environment because they are a part of it, and because they themselves cannot survive without being its responsible caretaker.

These highly responsible beliefs about stewardship and balance, however, are challenged by long-term social disruption, large-scale extraction of, for example, forests, oil and natural gas, and ongoing cycles of violence against those who protest such mindless destruction.³ This begs the question: how might integrating environmental policies with local cultural values encourage deeper commitments to protection and stewardship?

¹ Sarmiento Barletti, JP. “It makes me sad when they say we are poor. We are rich!”: of wealth and public wealth in indigenous Amazonia. In: Santos-Granero F, editor. Images of public wealth or the anatomy of wellbeing in Indigenous Amazonia. Tucson: University of Arizona Press; 2015 (139–160).

² Sarmiento Barletti, JP. The angry earth: wellbeing, place, and extractivism in the Amazon. *Anthropology in Action* 2015;23(3):43–53.

³ Survival [website]. London: Survival International; 2017 (<http://www.survivalinternational.org/conservation>, accessed 10 February 2017).

Encouraging cultures of connection to green and blue spaces

Cultural representations of the association between human health and the environment can be traced back to the earliest societies. Conceptions of paradise have long been associated with gardens (54), and temples dedicated to healing were commonly situated on hilltops overlooking the sea (55). Today, a growing body of evidence attests to the multifaceted benefits people derive from time spent in or near natural landscapes (56–58). Research shows that, while protecting, establishing and maintaining them requires significant planning and financial commitment, failing to do so may pose an even greater threat to long-term health and well-being. A low level of exposure to natural areas, for example, appears to put people at higher risk of poor mental health, and lack of open spaces is associated with low-activity lifestyles, poor diets and the sharp rise of noncommunicable diseases (58).

In response to these findings, many policy-makers are placing a renewed emphasis on people's connection to so-called green spaces (urban parks, woodlands and other natural areas) and blue spaces (shorelines and waterways). The importance of green and blue spaces to health and well-being is now expressed in the WHO European Healthy Cities Network (59), the European Landscape Convention (60) and Natura 2000 (61), as well as many intersectoral research programmes on urban health (62,63) and country-level health and well-being agendas. This trend has also influenced health services in important ways, and many hospitals, mental health institutions and care homes for the elderly have been built to incorporate the therapeutic presence of sunlight and fresh air as well as views of trees, water and open vistas (64–66).

The social and cultural heritage embodied in landscapes can also provide a sense of continuity across generations and contribute to healthy identity construction, which can in turn have a protective effect on health and well-being. Ethnographic studies of reduced health inequalities in deindustrialized and relatively deprived coastal areas of northeast England, for example, suggest that strong cultural and historical links between community members and their environment partially explain better-than-expected health outcomes (67).

Additionally, green and blue spaces can provide important common spaces in which to foster new relationships. Some research argues, for example, that strong emotional attachment to them can play an

important role in the integration of migrants to urban areas (68–70). Efforts to link people with health-promoting green and blue spaces in meaningful ways may also serve to heighten awareness of ecological degradation and, in turn, strengthen local cultures of sustainability and environmental stewardship (71).

Not surprisingly, then, loss of familiar environments or alterations to cherished landscapes can also have a direct effect on experiences of well-being and contentment. Research has found that communities tend to resist hydraulic fracking not only because they fear the immediate health impacts of pollution and contamination; they also consider the potential for altered or damaged landscapes to be a threat to their overall sense of well-being (72).

The same holds true for communities subject to the persistent noise and loss of local wildlife from wind farms (73). The decision to replace more dangerous nuclear power plants with large-scale wind farms can have a corrosive effect on well-being when rural communities are forced to accept the presence of turbines in order to offset government-subsidized energy use in urban and industrial areas. Laudable efforts to promote more environmentally friendly forms of power generation may fail when local cultures are not fully considered.

Yet simply protecting natural areas or providing green and blue spaces is not enough – they must be maintained in culturally sensitive contexts that take into account and enhance accessibility, public safety, and new eating and exercise practices. Diverse, innovative initiatives to foster these cultures of connection offer new models of engagement, some of which could be replicable and scalable. For policy-makers, they represent a critical new evidence base for informing environment- and health-related planning and decision-making.

Ensuring equity and access

Health-enhancing natural areas are not equally available to everyone (74), and as communities negotiate different relationships to them, misunderstanding and conflict over access and use can quickly arise. In the 19th century, for example, policy-makers' acknowledgement of the cultural value of natural environments led to the establishment of many celebrated parks and conservation areas in Europe and the United States. Yet, in some areas, a culturally biased approach involved displacing indigenous communities whose subsistence and

stewardship practices were perceived as disruptive (75,76). While privileged social groups were encouraged to take advantage of those parks for recreation, indigenous people were denied access to the life-ways that kept their communities and the land in good health for thousands of years.

Today in the WHO European Region, despite widespread recognition of the multiple benefits of coastal areas to health, reflected in cultural practices across countries, many coastal communities feel excluded from, or are unable to access, these health-promoting blue spaces (77). This sense of exclusion can arise from a lack of free time for recreation, or perceptions of these coastlines as places for “others” (for example, tourists). Research in Glasgow, Scotland, also found that deprived populations do not always perceive nearby green spaces as available to them (78,79). Indeed, similar patterns underlie a lack of engagement with green and blue spaces among ethnic minorities across Europe (80).

Box 3. Perceived barriers to green spaces

In 2014, Copenhagen was named the Green Capital of Europe. Ninety-six per cent of the city's residents live within a 15-minute walk to a park or recreation area, and citizens have access to the best network of urban cycling paths in the world. In addition to being situated within a country that boasts the highest happiness ratings, strong policy measures support active lifestyles and the city has relatively low levels of lifestyle diseases.¹

Many cities across the globe have looked to Copenhagen for sustainable models of urban development. Much of the success of Copenhagen's health and environmental policies has been linked to the endorsement of a culture in which healthy and sustainable lifestyles are highly valued.

However, recent anthropological research shows that these norms and values are not universal among residents of Copenhagen. Women from low-income communities, for example, may associate certain healthy and sustainable activities with a particular lifestyle that they feel is difficult to achieve. These residents are less likely to benefit from the celebrated green spaces within their city.

The lesson from Copenhagen is clear: unless policy-makers strive actively to address issues of social exclusion, inequalities may persist even in seemingly egalitarian environments.

¹ Thomas F. The role of natural environments within women's everyday health and wellbeing in Copenhagen, Denmark. *Health Place* 2015;35:187–95. doi:10.1016/j.healthplace.2014.11.005.

Furthermore, even when natural landscapes or green and blue spaces are available, their health-giving aspects may be depleted or damaged by human activities. Sadly, polluted air, water and soil, elevated levels of radiation and more frequent extreme weather events due to climate change are now realities for many communities. Different groups experience these threats more or less, depending on their geographic location, their socioeconomic freedom, their civil liberties and their freedom of choice. Disadvantaged groups often suffer the impacts of environmental degradation to a greater degree than others (81), as well as the indignity of seeing their local landscapes eroded (82).

Policy-makers must engage with diverse communities – particularly those who are marginalized – to gain a better understanding of how culturally mediated perceptions of the environment influence behaviour in positive and negative ways (83). More mixed-methods research is needed to identify why health- and sustainability-related policies fail among certain groups, and how more adaptive and inclusive ones can be developed (84).

Policy options

In addition to the broad policy options outlined above, the following four specific policy options to all those working on environment- and health-related programmes are put forward.

1. Investigate how cultural contexts influence perceptions of and engagement with the environment, and how strong cultural bonds between people and the places they value enhance human health and well-being.
2. Develop methodologies that allow for the integration of complex evidence of cultural value(s) into health- and environment-related decision-making.
3. Recognize and build on cultural practices that promote positive engagement with green and blue spaces.
4. Address inequities and perceived barriers that prevent certain groups from forging meaningful connections with, and thus benefiting from, green and blue spaces.

3) Migration, culture and health

Understanding the impacts of migration and marginalization on health and well-being

Many countries across the globe are in the midst of transformations brought about by mass migration. As people move in great numbers from one country to another, distinct values and ways of life can merge, evolve, clash or coexist. Migrants often struggle to develop strategies for organizing everyday life in unknown environments with unfamiliar rules, social values and customs. Receiving countries can find their everyday virtues tested when efforts to assist seem to come at the cost of other responsibilities and obligations. When diverse systems of value are brought together in such pressurized situations, serious challenges can quickly arise.

Countries across the WHO European Region diverge significantly in terms of how they respond to the health needs of migrants. Some, feeling burdened or overwhelmed, develop strategies of exclusion, pushing migrants back into bordering states or returning them to countries of origin. Others, energized by the call to action and determined to remain open to migrants, focus on equitable resettlement – a process that demands new kinds of policy-informing evidence that existing health data and traditional research strategies alone cannot provide.

When migrants transition through countries, the multiple hurdles they encounter can be different and yet equally great. These are compounded by a lack of incentive to establish foundations for mutual understanding when migrants wish to be elsewhere and countries do not perceive them as locally invested. In such contexts, building trust may be impossible, and delivering fair and culturally competent health care is difficult at best.

The unsettled nature of migration tells us that the experience of belonging is a critical factor in the development of competent care. Longitudinal data, for example, show that when migrants are distributed across a receiving country but not readily integrated on equal terms – that is, when they still feel marginalized or excluded – they tend to seek opportunities for voluntary resettlement in more welcoming and familiar-feeling communities (2). These communities of choice tend to be areas populated by others from their place of origin who share their values, and where social services are better equipped

"For policy-makers focused on migrant care, there is clearly an urgent need to prioritize a cultural understanding of migrant populations."

for and accustomed to serving their health and welfare needs in a culturally sensitive manner.

Such patterns of secondary, internal migration may provide enhanced security and well-being for migrants in the short term. Yet, they may also have adverse consequences in the longer term, as when a receiving country's wider population perceives cultural differences negatively, or when migrants and their children find that isolation from broad society becomes a key barrier to leading meaningful lives. Indeed, when migrants feel isolated, the health consequences are significant: they often present late for clinical care; they tend to present with already-chronic conditions, rather than conditions that can be effectively treated or reversed; and they are likely to present at emergency facilities rather than more affordable, primary-care settings focused on prevention (85).

Finally, data suggest that migrants who are not well integrated (those who are both unemployed and undereducated) experience disproportionately high levels of certain noncommunicable diseases. In Denmark, for example, where health care registration is mandatory, rates for certain noncommunicable diseases are still as much as nine times higher for marginalized, late-presenting migrants as for health-educated citizens of European descent (86).

The implications of increased illness and suffering for migrants, as well as the financial burden created by their reliance on costly emergency care, create both ethical and economic imperatives for ensuring that migrants feel safe, respected and understood within the health care systems of their host countries. For policy-makers focused on migrant care, there is clearly an urgent need to prioritize a cultural understanding of migrant populations – one that goes beyond a focus on equality of access to address the deeper challenge of ensuring equity in health care systems.

Moving beyond stereotypes

When markers such as nationality or religion, or physical signs such as skin colour, are thought to indicate difference, people can quickly conflate cultural identity with place of origin or ancestry. Here, unexamined assumptions about perceived difference can determine whether an encounter with an individual or group is experienced

"To significantly improve health services for migrants, policy-makers must examine how reductive cultural stereotyping hinders practical understanding of illness and suffering."

as a threat, or as an opportunity for learning and exchange (87). In pressurized situations where people in positions of authority lack cultural sensitivity training, poor decisions and misunderstandings based on stereotypes become more common (88–90). Over time, stereotypes embedded within health care systems can limit or undermine quality, efficiency and efficacy of care (91,92).

Research shows that effective health care systems must move beyond assumptions about cultural difference to address the fluid nature of culture and the array of contributing and intersecting factors (socioeconomic status, age, ethnicity, sexual orientation, gender, education, profession, etc.) that put groups at risk of health inequalities (93–95). This is especially important in the context of migration, as cultural orientations, identities and value systems may suffer considerable changes throughout the migration process.

To significantly improve health services for migrants, policy-makers must examine how reductive cultural stereotyping hinders practical understanding of illness and suffering (96,97). In the process, they must remain sensitive to migrants' actual living conditions, day-to-day experiences and concerns about critical issues such as legal status (see Box 4).

Focusing on equity

Ensuring equity in health care is not just about increasing service provision and access. Policy-makers must recognize that a one-size-fits-all approach to care can lead to discrimination against those whose needs remain unrecognized or differ significantly from those of long-time residents (98) (See Box 5). In spite of the recent, large-scale influx of migrants to Germany from the war-torn Middle East, for instance, no systematic, country-wide psychological care for post-traumatic stress is available to migrants until their long process of gaining residency is complete.

When migrant needs appear extreme to those unfamiliar with the fear and suffering that cause refugees to flee their homes, anxiety over resources can increase. This is especially true among long-time inhabitants who may already feel neglected by society. In such cases, experiences of tension and distrust can have serious adverse effects on health and well-being.

Box 4. Cultural stereotyping in medical practice

A 10-year-old girl from a Lebanese family living in Germany was admitted to the hospital with diffuse stomach pain of unclear origin. Diagnostic tests did not reveal an organic cause for her complaints. Among physicians and nurses, a discussion evolved about culturally specific perceptions and expressions of pain. Some alleged that patients from the Mediterranean area “are known for their tendency to present with diffuse complaints” and an inappropriate “exaggeration” of pain.¹ In countries such as Belgium, Switzerland and Germany, health professionals use the term “Mediterranean syndrome” to describe what is elsewhere referred to as “culture-bound syndrome”.^{2,3}

During a conversation with the girl and her mother, a medical student learned about the living conditions and social background of the patient and her family. The girl had been born in Germany. Her parents were political refugees, but had been waiting for a definite decision about their asylum status for over 10 years. The student also heard about their constricted living space in a collective accommodation centre, and the adolescent brothers who disturbed the girl’s sleep. The girl explained that she had no retreat or quiet space for study, and that she suffered sleep deprivation and fear about her future. She also had problems in school, where teachers would repeatedly warn her to work more accurately and to make more of an effort. “The thing is that I know that,” she said. Classmates would bully her and shout: “You are not even supposed to be here.” “But I was born here,” the girl explained.

In advanced German, the mother described the gruelling insecurity, the guilt she felt towards the children and the fear about the uncertain future of the family. The girl’s father, who had grown up in a wealthy family and received a university education, was caring for the family as a poorly paid, “unskilled” worker.

As a result of this conversation, the physicians contacted a social worker known for her expertise in migration issues and migration laws to work towards a better living situation for the family as well as educational support for the girl. What was initially assumed to be a culturally specific presentation of pain was discovered to be a somatization of severe social problems linked to the prolonged asylum process of the child and her family.

¹ Strauss L. Gefangen im nirgendwo – die geschichte der kleinen patientin Malak und ihrer bauchschmerzen [Trapped in no-man’s-land – the story of the little patient Malak and her stomach pain]. In: In weiß – 2. Giessen: Institut für Geschichte der Medizin; 2013 (26–35) (in German).

² Ernst G. The myth of the “Mediterranean syndrome”: do immigrants feel different pain? In *Ethn Health* 2000;5(2):121–6. doi:10.1080/713667444.

³ Van Moffaert M, Vereecken A. Somatization of psychiatric illness in Mediterranean migrants in Belgium. *Cult Med Psychiatry* 1989;13(3):297–313.

Box 5. “We do this in a different way than you do.”

A 16-year-old boy from a Muslim family with Turkish background living in Germany was diagnosed with osteosarcoma, a severe bone cancer with no options for curative care. The physicians’ intention to inform the boy of his condition was met with strong opposition by the family. They explained that, according to their religion and culture, the patient must not receive this information. For the team of health professionals in the paediatric oncology department, this was an unbearable situation; telling the truth to a nearly adult patient and respecting the individual’s right to know were essential elements of the health professionals’ ethos. The family’s staunch resistance to informing the patient about his diagnosis and imminent death was thus perceived as “unacceptable”, and yet all attempts by the physicians and other members of the professional team, including nurses and social workers, to convince the family were rejected. Tension and distrust between health professionals and the family grew.¹

In an effort to mediate the conflict, a medical anthropologist asked physicians and other informants of Turkish Muslim background for their opinion on this case. A Turkish physician, who had worked in Germany for more than 20 years, replied with absolute clarity: “We do this in a different way than you do,” he said. The physician went on to describe the surprising opinion that the family was “right”, that patients should not get to know the hard truth directly.

Moreover, he drew a clear line between the “Turkish” and the “German” way to tell the truth: “German physicians inform the patients directly, with no compassion or sensibility, cold and tough. I have seen German physicians traumatizing patients and making them feel hopeless. We are used to doing it in a different way: the patient has to know the truth, but we communicate this in a more sensitive way, supporting and caring for him, with religious counselling. For us, supporting and taking care of the ill and the dying individual is most important.”

After sharing and discussing this perception with the health professionals, the task of truth disclosure was commissioned to a local Turkish paediatrician. The tension between staff and family decreased considerably. A few weeks later, the boy was discharged from the hospital to palliative care at home.

¹ Knipper, M. Vorsicht Kultur! Ethnologische Perspektiven auf Medizin, Migration und ethnisch-kulturelle Vielfalt [Caution, culture! Ethnological perspectives on medicine, migration and ethnic-cultural diversity]. In: Coors M, Grützmann T, Peters T, editors. Interkulturalität und Ethik. Der Umgang mit Fremdheit in Medizin und Ethik [Interculturalism and ethics. Dealing with otherness in medicine and ethics]. Göttingen: Edition Ruprecht; 2014 (52–69) (in German).

It is clear that viewing care in purely clinical terms leaves health systems ill-equipped to understand the psychological, social and cultural drivers of illness and health – not only within migrant groups, but also within local subpopulations who define themselves as disadvantaged. The economic and social costs of this systemic oversight can be startlingly high.

Responding effectively to the needs of diverse patients involves aligning caregiving practices with how care is understood and experienced by those receiving it. Yet it also involves developing contexts for social trust and belonging for all members of a community; everyone must feel they can trust the social contracts made formally as citizens and informally as community members.

This trust is critical to the creation of a culture for health and well-being, and for the development of compassionate, effective and economically viable health care systems for all. To foster it, health policy-makers and caregivers must reflect critically on their own perceptions and assumptions, and actively seek to understand the intersectoral nature of culture, migration, health and well-being. Additionally, they must ensure that positive changes receive support at systemic and organizational levels.

Policy options

In addition to the broad policy options outlined above, the following five specific policy options for enhancing migrant health and well-being are put forward.

1. Implement diversity training across all levels and professions of health care systems (with a particular focus on leadership and management staff) to endorse both the ethical and the economic imperatives for promoting culturally sensitive health care.
2. Increase awareness of unconscious stereotyping and of how cultural practices and related assumptions about others can lead to the marginalization of perceived outsiders.
3. Create programmes that educate and empower migrants to address their health needs preventively and proactively

by becoming involved in creating fully realized lives for themselves.

4. Support innovative mixed-methods research designed to build a new evidence base on health vulnerabilities that includes assessments of subjectively defined needs.
5. Develop inclusive strategies for building social trust and a culture for health and well-being.

"An expanded evidence base, enriched by subjective accounts of personal experience, will offer a more robust set of tools for improving health and well-being equitably, as well as a framework for further illuminating the working assumptions of policy-makers, providers and the general public."

Conclusion

As outlined in Health 2020 and the 2030 Agenda for Sustainable Development, incorporating cultural awareness into policy-making and policy implementation is critical to the development of adaptive, equitable and sustainable health care for all. Doing so requires that policy-makers cultivate a nuanced understanding of what culture is, and strengthen their capacity to identify biases and knowledge gaps that may interfere with effective working practice.

This also entails a conscious effort to engage with mixed-methods research from the health-related humanities and social sciences. Policy-makers must recognize and integrate the extensive body of existing knowledge into their decision-making processes, and also support the creation of new evidence. An expanded evidence base, enriched by subjective accounts of personal experience, will offer a more robust set of tools for improving health and well-being equitably, as well as a framework for further illuminating the working assumptions of policy-makers, providers and the general public. The broad areas of nutrition, the environment and migration offer important opportunities for meaningful research and engagement at the level of culture, but this is just the beginning.

As communities and countries experiment with culturally grounded approaches to fostering health and well-being, it will be essential to share these broadly. The Regional Office's expert group on the cultural contexts of health and well-being urges policy-makers and other health professionals to share their learning experiences and good practices openly. A multiplicity of voices is crucial to the work ahead.

References

1. UNESCO Universal Declaration on Cultural Diversity [website]. Paris: UNESCO; 2001 (http://portal.unesco.org/en/ev.php-URL_ID=13179&URL_DO=DO_TOPIC&URL_SECTION=201.html, accessed 13 February 2017).
2. 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.
3. Adams V, editor. *Metrics: what counts in global health*. Durham: Duke University Press; 2016.
4. Biehl J, Petryna A. *When people come first: critical studies in global health*. Princeton: Princeton University Press; 2013.
5. Brives C, Le Marcis F, Sanabria E. What's in a context? Tenses and tensions in evidence-based medicine. *Med Anthropol*. 2016;35(5):369–76. doi:10.1080/01459740.2016.1160089.
6. *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>, accessed 13 February 2017).
7. Sustainable Development Goal 17 [website]. New York: United Nations; 2017 (<https://sustainabledevelopment.un.org/sdg17>, accessed 13 February 2017).
8. Nussbaum MC. Who is the happy warrior? Philosophy poses questions to psychology. *J Legal Stud*. 2008;37(S2):S81–113. doi:10.1086/587438.
9. Napier AD. *The rapid assessment of vulnerable populations: a "barefoot" manual*. London: UCL Press; 2013 (<http://www.ucl.ac.uk/human-wellbeing/SMS>, accessed 13 February 2017).

10. Adams V, Burke NJ, Whitmarsh I. Slow research: thoughts for a movement in global health. *Med Anthropol*. 2014;33(3):179–97. doi:10.1080/01459740.2013.858335.
11. Mediterranean diet [website]. Paris: UNESCO; 2014 (<http://www.unesco.org/culture/ich/en/RL/mediterranean-diet-00884>, accessed 13 February 2017).
12. Coleman L, editor. *Food: ethnographic encounters*. London: Bloomsbury Academic; 2011.
13. Goody J. *Cooking, cuisine and class. A study in comparative sociology*. Cambridge: University of Cambridge Press; 1982.
14. Kraemer FB, Gracia Arnaiz M. Feed or nourish in a “popular restaurant” in Spain: reflections on commensality. *Demetra* 2015;10(3):455–66. doi:10.12957/demetra.2015.16173.
15. Mintz S. Food and its relationship to concepts of power. In: McMichael P (editor). *Food and agrarian orders in the world-economy*. London: Praeger; 1995 (3–13).
16. Fischler C. *L’omnivore*. Paris: Odile Jacob; 1990 (in French).
17. Ritter M, Frisbe D. Sociology of the meal. In: *Simmel on culture: selected writings*. London: Sage Publications; 2000:130–6.
18. DeVault ML. *Feeding the family. The social organization of caring as gendered work*. Chicago: University of Chicago Press; 1991.
19. Murcott A. “It’s a pleasure to cook for him”: food, mealtimes and gender in some South Wales households. In: Garmanikow E, Morgan D, Purvis J, Taylorson D, editors. *The public and the private*. London: Heinemann Educational Books; 1983 (78–90).
20. Fischler C. Commensality, society and culture. *Social Science Information* 2011;50(3–4):528–48. doi:10.1177/0539018411413963.
21. Scrinis G. On the ideology of nutritionism. *Gastronomica* 2008;8(1):39–48. doi:10.1525/gfc.2008.8.1.39.

22. Scrinis G. *Nutritionism: the science and politics of dietary advice*. New York: Columbia University Press; 2013.
23. Scrinis G. Reformulation, fortification and functionalization: Big Food corporations' nutritional engineering and marketing strategies. *The Journal of Peasant Studies* 2015;43(1):17–37. doi:10.1080/03066150.2015.1101455.
24. Yates-Doerr E. The opacity of reduction, nutritional black-boxing and the meanings of nourishment. *Food, Culture and Society* 2012;15(2):293–313. doi:10.2752/175174412x13233545145381.
25. Sanabria E. Circulating ignorance: complexity and agnogenesis in the obesity “epidemic”. *Cultural Anthropology* 2016;31(1):131–58. doi:10.14506/ca31.1.07.
26. Bouman LI, te Molder H, Koelen MM, van Woerkum CMJ. I eat healthfully but I am not a freak. Consumers' everyday life perspective on healthy eating. *Appetite* 2009;53(3):390–8. doi:10.1016/j.appet.2009.08.005.
27. Crawford RA. A cultural account of “health”: control, release, and the social body. In: McKinlay JB, editor. *Issues in the political economy of health care*. New York: Tavistock Publications; 1984.
28. Sanabria E, Yates-Doerr E. Alimentary uncertainties: from contested evidence to policy. *Biosocieties* 2015;10(2):117–24. doi:10.1057/biosoc.2015.17.
29. Fischer E, Benson P. *Broccoli and Desire*. Palo Alto: Stanford University Press; 2006.
30. Margetts B, Martinez J, Saba A, Holm L, Kearney M, Moles A. Definitions of “healthy” eating: a pan-EU survey of consumer attitudes to food, nutrition and health. *Eur J Clin Nutr*. 1997;51:23–9.

31. Holm L. Mad og sundhed i hverdagen [Food and health in everyday life]. In: Holm L, Kristensen ST, editors. Mad, mennesker og måltider – samfundsvidenskabelige perspektiver [Food, people and meals – perspectives from social sciences]. Copenhagen: Munksgaard; 2012:301–16 (in Danish).
32. Sanabria E. Sensorial pedagogies, hungry fat cells and the limits of nutritional health education. *Biosocieties* 2015;10(2):125–42. doi:10.1057/biosoc.2015.5.
33. Holm L. Cultural and social acceptability of a healthy diet. *Eur J Clinl Nutr.* 1993;47(8)592–9.
34. Micheelsen A, Havn L, Poulsen SK, Larsen TM, Holm L. The acceptability of the New Nordic Diet by participants in a controlled six-month dietary intervention. *Food Quality and Preference* 2014;36:20–6. doi:10.1016/j.foodqual.2014.02.003.
35. Nielsen A, Korzen S, Holm L. Inverting the food pyramid? Social and cultural acceptability of Walter Willett’s dietary recommendations among people with weight concerns. *Appetite* 2008;51(1):178–86. doi:10.1016/j.appet.2008.02.011.
36. Knowler WC, Fowler SE, Hamman RF, Christophi CA, Hoffman HJ, Brenneman AT et al. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet* 2009;374(9702):1677–86. doi:10.1016/S0140-6736(09)61457-4.
37. Risques sanitaires liés aux pratiques alimentaires d’amaigrissement [Health risks related to weight-loss dietary practices]. Maisons-Alfort: Agence Nationale de Sécurité Sanitaire de l’Alimentation, de l’Environnement et du Travail; 2010 (in French).
38. Warde A. Consumption, food and taste. London: Sage Publications; 1997.
39. Dietary guidelines for the Brazilian population. Brasília: Ministry of Health of Brazil; 2015 (http://bvsmms.saude.gov.br/bvs/publicacoes/dietary_guidelines_brazilian_population.pdf, accessed 13 February 2017).

40. Caplan P. Food, health and identity: approaches from the social sciences. London and New York: Routledge; 1997.
41. Counihan C, Van Esterik P, editors. Food and culture: a reader. Third edition. New York: Routledge; 2012.
42. Stuckler D, Nestle M. Big Food, food systems, and global health. PLOS Med. 2012;9(6):e1001242. doi:10.1371/journal.pmed.1001242.
43. Patel RC. Food sovereignty: power, gender, and the right to food. PLOS Med. 2012;9(6):e1001223. doi:10.1371/journal.pmed.1001223.
44. Monteiro CA, Cannon G. The impact of transnational “Big Food” companies on the south: a view from Brazil. PLOS Med. 2012;9(7):e1001252. doi:10.1371/journal.pmed.1001252.
45. Guthman J. Weighing in: obesity, food justice and the limits of capitalism. Berkeley, Los Angeles, London: University of California Press : 2012.
46. Pratt J. The rationality of rural life: economic and cultural change in Tuscany. Chur: Harwood Academic Publishers; 1994.
47. Rayner J, Hawkes C, Lang T, Bello W. Trade liberalization and the diet transition: a public health response. Health Promotion International 2007;21(S1):67–74. doi:10.1093/heapro/dal053.
48. Igumbor EU, Sanders D, Puoane TR, Tsolekile L, Schwarz C, Purdy C et al. “Big Food,” the consumer food environment, health, and the policy response in South Africa. PLOS Med. 2012;9(7):e1001253. doi:10.1371/journal.pmed.1001253.
49. The world we want 2015. Hunger, food security, and nutrition in the post-2015 development agenda. Rome: Food and Agriculture Organization of the United Nations; 2013 (http://www.fao.org/fsnforum/post2015/sites/post2015/files/files/Issues_Paper_Post_2015_Eng.pdf, accessed 20 February 2017).
50. Vasavi AR. Shadow space: suicides and the predicament of rural India. Gurgaon: Three Essays Collective; 2012.

51. Yates-Doerr E. *The weight of obesity: hunger and global health in postwar Guatemala*. Berkeley: University of California Press; 2015.
52. Díaz S, Demissew S, Carabias J, Joly C, Lonsdale M, Ash N et al. The IPBES Conceptual Framework – connecting nature and people. *Current Opinion in Environmental Sustainability* 2015;14:1–16. doi:10.1016/j.cosust.2014.11.002.
53. World Resources Institute. *Millennium ecosystem assessment. Ecosystems and human well-being: synthesis*. Washington: Island Press; 2005 (<http://www.millenniumassessment.org/documents/document.356.aspx.pdf>, accessed 13 February 2017).
54. Ward Thompson C. Linking landscape and health: the recurring theme. *Landscape and Urban Planning* 2011;99(3–4):187–95.
55. Steinberg E. *Healing spaces: the science of place and well-being*. Cambridge: Harvard University Press; 2009.
56. Maxwell S, Lovell R. *Evidence statement on the links between natural environments and human health*. London: Department for Environment, Food and Rural Affairs; 2015.
57. Horwitz P, Kretsch C, Jenkins A, Rahim AB, Burls A, Campbell K et al. Contribution of biodiversity and green spaces to mental and physical fitness, and cultural dimensions of health. In: *Connecting global priorities: biodiversity and human health*. Geneva: World Health Organization, Convention on Biological Diversity; 2015 (200–19).
58. *Urban green spaces and health*. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/__data/assets/pdf_file/0005/321971/Urban-green-spaces-and-health-review-evidence.pdf?ua=1, accessed 13 February 2017).
59. *Healthy cities. Promoting health and equity – evidence for local policy and practice*. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0007/262492/Healthy-Cities-promoting-health-and-equity.pdf, accessed 13 February 2017).

60. European Landscape Convention of the Council of Europe [website]. Strasbourg: Council of Europe; 2017 (<http://www.coe.int/en/web/landscape/home>, accessed 13 February 2017).
61. Natura 2000 [website]. Brussels: European Commission; 2016 (http://ec.europa.eu/environment/nature/natura2000/index_en.htm, accessed 13 February 2017).
62. Cities Changing Diabetes [website]. Bagsvaerd: Cities Changing Diabetes; 2016 (<http://www.citieschangingdiabetes.com>, accessed 13 February 2017).
63. Built Environment and Health [website]. Princeton: Robert Wood Johnson Foundation; 2017 (<http://www.rwjf.org/en/our-focus-areas/topics/built-environment-and-health.html>, accessed 13 February 2017).
64. Beauchemin KM, Hays P. Sunny hospital rooms expedite recovery from severe and refractory depressions. *J Affect Disord.* 1996;40(1–2):49–51.
65. Zeisel J, Silverstein NM, Hyde J, Levkoff S, Lawton MP, Holmes W. Environmental correlates to behavioral health outcomes in Alzheimer’s special care units. *Gerontologist* 2003;43(5):697–711. doi:10.1093/geront/43.5.697.
66. Devlin A, Arneill AB. Health care environments and patient outcomes: a review of the literature. *Environment and Behavior* 2003;35:665–94. doi:10.1177/0013916503255102.
67. Cairns-Nagi JM, Bambra C. Defying the odds: a mixed-methods study of health resilience in deprived areas of England. *Soc Sci Med.* 2013;91(0):229–37. doi:10.1016/j.socscimed.2013.03.014.
68. Jay M, Schraml U. Understanding the role of urban forests for migrants – uses, perception and integrative potential. *Urban Forestry & Urban Greening* 2009;8(4):283–94. doi:10.1016/j.ufug.2009.07.003.

69. Völker S, Kistemann T. "I'm always entirely happy when I'm here!" Urban blue enhancing human health and well-being in Cologne and Düsseldorf, Germany. *Soc Sci Med.* 2013;78:113–24. doi:10.1016/j.socscimed.2012.09.047
70. Völker S, Kistemann T. Developing the urban blue: comparative health responses to blue and green urban open spaces in Germany. *Health and Place* 2015;35:196–205. doi:10.1016/j.healthplace.2014.10.015.
71. The Natural Change Project: catalysing leadership for sustainability. Edinburgh: World Wildlife Federation Scotland; 2011 (http://assets.wwf.org.uk/downloads/wwf_naturalchange2.pdf, accessed 26 August 2016).
72. Kovats S, Depledge MH, Haines A, Fleming L, Wilkinson P, Shonkoff SB, Scovronick N. The health implications of fracking. *Lancet* 2014;383(9919):757–8. doi:10.1016/S0140-6736(13)62158-3.
73. Nissenbaum, MA, Aramini JJ, Hanning CD. Effects of industrial turbine noise on sleep and health. *Noise Health* 2012;14(60):237–43. doi:10.4103/1463-1741.102961.
74. Ernstson H. The social production of ecosystem services: a framework for studying environmental justice and ecological complexity in urbanized landscapes. *Landscape and Urban Planning* 2013;109(1):7–17. doi:10.1016/j.landurbplan.2012.10.005.
75. Survival [website]. London: Survival International; 2017 (<http://www.survivalinternational.org/conservation>, accessed 13 February 2017).
76. Wilson K. Therapeutic landscapes and First Nations peoples: an exploration of culture, health and place. *Health Place* 2003;9(2):83–93.
77. Bell SL, Phoenix C, Lovell R, Wheeler B. Seeking everyday wellbeing: the coast as a therapeutic landscape. *Soc Sci Med.* 2015;142:56–67. doi:10.1016/j.socscimed.2015.08.011.

78. Macintyre S, Macdonald L, Ellaway A. Lack of agreement between measured and self-reported distance from public green parks in Glasgow, Scotland. *Int J Behav Nutr Phys Act*. 2008;5(1):26. doi:10.1186/1479-5868-5-26.
79. Thomas F. The role of natural environments within women's everyday health and wellbeing in Copenhagen, Denmark. *Health Place* 2015;35:187–95. doi:10.1016/j.healthplace.2014.11.005.
80. Braubach M. Benefits of environmental inequality assessments for action. *J Epidemiol and Community Health* 2013;67(8):625–8. doi:10.1136/jech-2012-201390.
81. Pearce, JR. Richardson EA, Mitchell RJ, Shortt NK. Environmental justice and health: the implications of the socio-spatial distribution of multiple environmental deprivation for health inequalities in the United Kingdom. *Transactions of the Institute of British Geographers* 2010;35(4):522–39.
82. Monitor of engagement with the natural environment: the national survey on people and the natural environment. Annual report from the 2013–2014 survey (NECR122). Sheffield: Natural England; 2014 (<http://publications.naturalengland.org.uk/publication/5331309618528256>, accessed 13 February 2017).
83. Mäkinen K, Tyrväinen L. Teenage experiences of public green spaces in suburban Helsinki. *Urban Forestry & Urban Greening* 2008;7(4):277–89. doi:10.1016/j.ufug.2008.07.003.
84. Leppo K, Ollila E, Peña S, Wismar M, Cook S, editors. *Health in all policies: seizing opportunities, implementing policies*. Helsinki: Ministry of Social Affairs and Health; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf?ua=1, accessed 13 February 2017).
85. Llácer A, Amo JD, García-Fulgueiras A, Ibáñez-Rojo V, García-Pino R, Jarrín I et al. Discrimination and mental health in Ecuadorian immigrants in Spain. *J Epidemiol Community Health* 2009;63(9):766–72. doi:10.1136/jech.2008.085530.

86. Diderichsen F, Anderson I, Manual C, Nybo Anderson A-M, Bach E, Baadsgaard M et al. Health inequality – determinants and policies. *Scand J Publ Health* 2012;40(Suppl 8):12–105.
87. Quaranta I. Anthropology, health care and the transformation of experience. In: Napier AD, Hobart A, Muller R, editors. *Culture and wellbeing: new pathologies and emerging challenges*. Canon Pyon: Sean Kingston Publishing; 2017 (in press).
88. Green G, Davison C, Bradby H, Krause K, Mejias FM, Alex G. Pathways to care: how superdiversity shapes the need for navigational assistance. *Sociol Health Illn*. 2014;36(8):1205–19.
89. Hannah SD. Clinical care in environments of hyperdiversity: race, culture and ethnicity in a post pentad world. In: Delvecchio Good MJ, Willen SS, Hannah SD, Vickery K, Park LT, editors. *Shattering culture: American medicine responds to cultural diversity*. New York: Russell Sage Foundation; 2011 (35–69).
90. Green G, Bradby H, Chan A, Lee M. "We are not completely Westernised": dual medical systems and pathways to health care among Chinese migrant women in England. *Soc Sci Med*. 2006;62:1498–1509. doi:10.1016/j.socscimed.2005.08.014.
91. Mladovsky P, Ingleby D, McKee M, Recehl B. Good practices in migrant health: the European experience. *Clin Med*. 2012;12(3):248–52.
92. Thomas F, Aggleton P, Anderson J. "Experts", "partners" and "fools": exploring agency in HIV treatment seeking among African migrants in London. *Soc Sci Med*. 2010;70(5):736–43. doi:10.1016/j.socscimed.2009.10.063.
93. Clark R, Anderson NB, Clark VR, Williams DR. Racism as a stressor for African Americans. A biopsychosocial model. *Am Psychol*. 1999;54:805–16.
94. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav*. 1995;36:38–56.

95. Meyer IH. Prejudice as stress: conceptual and measurement problems. *Am J Publ Health* 2003;93:262–5.
96. Kleinman, A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. *PLOS Med.* 2006;3(10):294. doi:10.1371/journal.pmed.0030294.
97. Durieux-Paillard S, Eytan A. Du syndrome méditerranéen à la balkanisation des diagnostics: l'art difficile de la neutralité en médecine [Mediterranean syndrome and the balkanization of diagnostics: the difficult art of neutrality in medicine]. *Rev Med Suisse* 2007;3(113):1413–14 (in French).
98. Ingleby D. Introduction. In: Ingleby D, Chiarenza A, Deville W, Kotsioni I, editors. *Inequalities in health care for migrants and ethnic minorities (COST series on health and diversity – vol 2)*. Antwerp: Garant; 2012 (9–27).

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