Made to be unheard, uninvolved, unresponsive and unhealthy

An analysis of the performativity of Community Based Health Promotion

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BMI	Body Mass Index
CBHP	Community Based Health Promotion
CBPR	Community Based Participatory Research
FCB	Foote, Cone and Belding model
GGD	Gemeentelijke Gezondheidsdienst [Municipal Health Services]
GIDS	Gezond in de Stad [Healthy in the City]
GSB	Grotestedenbeleid [large cities policy]
HSES	High socioeconomic status
ICD	International Classification of Diseases
ID	Ilse Dijkstra, author of this thesis
JGZ	Jeugdgezondheidszorg [Dutch national Youth health care organization]
LSES	Low socioeconomic status
RIVM	Rijksinstituut voor Volksgezondheid en Milieu [Dutch National Institute for Public Health and the Environment Ministry of Health, Welfare and Sport]
STS	Science and Technology Studies
TRF	Thyrotropin-releasing hormone
VROM	Ministerie van Volkshuisvesting, Ruimtelijke Ordening en Milieubeheer [Dutch Ministery of Housing Spatial Planning and the Environment]
WHO	World Health Organization

Abstract

Today, there exists broad support among public health researchers and practitioners for the principles and objectives of community-based health promotion. Despite the widespread recognition of the key principles, of this approach, community-based health promotion faces considerable challenges to bring its values and principles into practice. Against the background of discussions about community-based health promotion, and informed by Science and Technology Studies, I analysed the performativity of one long term community-based health promotion intervention: B.Slim. I conducted a practice-oriented document analysis of 24 documents on this intervention. The analysis showed that hybrid entanglements of tools and networks were operative in performing the CBHP-approach of B.Slim, I identified five performative effects these hybrid engtanglements: the making of 1) a top-down determined risk group; 2) an area of problems; 3) a deviant target group; 4) unmotivated consumers; and 5) a muted target group. Together, these performative effects performed B.Slim's CBHP-approach in a way that mirrors the individual lifestyle-approach that CBHP aims to counter.

Placing these findings in light of STS studies on performativity, and explanations of community-based health promotion scholars on the importance of contexts, I conclude that B.Slim's acts of contexting made it, unintentionally and almost unavoidably, drift away from the values and principles of community-based health promotion. I argue that, as long as community-based health promotion interventions passively accept existing political, scientific and bureaucratic contexts as givens and their tools as inevitable, they might well be reproducing what they sought to counter: individualistic health promotion interventions in which participants remain unheard, uninvolved, unresponsive and unhealthy.

1. Introduction

Socioeconomically disadvantaged populations in western-Europe are facing a disproportionate burden of morbidity and mortality: people with a lower socioeconomic status live shorter lives with more chronic diseases than those who occupy a higher social position (Berkman & Kawachi, 2014; Smith et al., 2015). Addressing these inequalities is a major challenge for health promotion researchers and practitioners. Since the 1980's, they developed a wide variety of interventions to improve the health of populations in general, and of disadvantaged populations in particular (Siegrist & Marmot, 2009). Yet, what is considered a 'good' intervention has changed over time and still differs between various academic fields and subdisciplines (Bunton et al., 2003).

In the 1980s, growing disillusionment with the limitations of traditional, biomedical 'outside expert' and 'life style' approaches to understand and address complex health and social problems has placed a spotlight on the potential of the alternative health promotion paradigm: community-based health promotion (CBHP) (Bambra et al., 2011; MacDonald & Bunton, 2002). Today, there exists broad support among public health researchers and practitioners for the principles and objectives of CBHP, and this approach to health promotion has captured the interest of policy makers alike (Ansell, 2010; Laverack, 2009; Merzel & Afflitti, 2003). For instance, the World Health Organization based it's Healthy Cities Vision on the principles of CBHP (WHO, n.d.; Heritage & Dooris, 2009) and it formed the basis of the Health Action Zones programme in the United Kingdom (Bauld et al., 2005). Also in the Netherlands, CBHP is used as framework for the development of various health interventions (e.g. Harting & van Assema, 2007; Wagemakers et al., 2008, 2010).

In contrast to the lifestyle-approach, which is marked by an individualist and reductionist understanding of health, CBHP holds that health is a complex phenomenon that can only be understood and improved in relation to the physical, social, organizational and environmental contexts in which people live and work (Minkler & Wallerstein, 2008; Poland et al. 2009). Rather than by the biomedical and epidemiological background from which the life-style approach emerged, CHPB is inspired by the work of Paul Freire (1970, 1982) on empowerment education as means to social change for marginalized communities. As such, CBHP considers health improvement as ill-suited to top-down 'outsider'

interventions and aims to empower communities and promotes their own capacity to deal with health issues (Wallerstein & Duran, 2008).

CBHP is not a straight forward method for health improvement, but, rather, a diverse field of science and practice. Minkler and Wallerstein (2008) brought together the field's basic principles and key authors in their seminal work *Community-Based Participatory Research for Health: Advancing Social and Health Equity*. As the title suggests, this handbook mainly focuses on planning and conducting community-based participatory research (CBPR), but also provides information on the development of community-based participatory interventions. As such, it is used as valuable source and guidance for the development of CBHP-interventions (Minkler et al., 2008, see also Oetzel et al., 2017; Whitesell et al., 2020). One important contribution of the book is its overview of the key elements that all community-based approaches share. According to the authors (Israel et al, 2008), CBPR- and CBHP-approaches:

1) …are participatory
2) …are cooperative, as they engage community members and researchers in a joint process in which both contribute equally
3) …are co-learning processes
4) …involve local community capacity building
5) …are empowering processes through which participants can increase control over their lives
6) …achieve a balance between research and action

Despite the widespread recognition of these key principles, CBHP faces considerable challenges. Various scholars and policy makers have questioned the usefulness of CBHP for health reduction, as its impact on health is often regarded as hard to evaluate (Busch & Schrijvers, 2010) and its effect on health inequality is often regarded as 'weak' or 'meagre' (Cilsika et al., 2000; Nickel & von dem Knesebeck, 2020). Internally, the field struggles with a range of theoretical, methodological, practical and ethical challenges (Smith et al., 2004; Tricket et al., 2011; Wallerstein & Duran, 2006).

Against the background of discussions about CBHP I have studied the practice of one long term intervention in depth and this thesis present the results of my study. In the next section, I will first sketch the discussions about CBHP and the challenges of this field. Next, I will introduce the theoretical approach

of the study, Science and Technology Studies (STS), and the concept of performativity. After outlining the research questions, I will introduce the case and explain the methodology. Then I will present the results of my study. Subsequentially, I discuss these findings in light of STS studies on performativity, and explanations of CBHP-scholars on the importance of contexts, I will present the final conclusions of my study.

1.1 The challenges of CBHP

In this section, I situate CBHP conceptually and in practice. Based on a literature review into the CBHP's key principles outlined above, I identified five central concepts that are widely discussed in CBHP: 1) community; 2) disadvantage and empowerment; 3) participation; 4) health; and 5) evaluation. In the following, I sketch CBHP's interpretation of these concepts, and their added value to health improvement. I also outline the discussions related to these concepts and the challenges experienced by CBHP-scholars and -practitioners to bring CBHP-principles into practice.

1.1.1 Discussing community

Community is a central concept of CBHP. With 'community', CBHP-scholars refer to 'communities of identity' (Israel et al., 1998). This means that communities are considered to be based on social interaction. Members identify with each other on the basis of shared values and norms, common interests and a joint commitment to meeting shared needs (Israel et a., 1994, 2008; Steuart, 1993). Communities of identity may overlap with geographical spaces, such as neighbourhoods, but can also be made up of members of a geographically dispersed group of people with a common identity, such as people who share a religion, or people who identify as transgender (Israel et al., 2008). Also, inside spatial or geographic communities, residents have made their own groups and boundaries (Becker et al., 2005). Therefore, in what might be treated as a single spatial community, multiple non-spatial communities can be found (Israel et al, 2008, p. 49). The concept of 'communities of identity' acknowledges this.

In comparison to other health promotion approaches, CBPH treats communities uniquely in at least two respects. First, for CBHP, communities are partners. This means that communities are not just the setting in which an intervention is carried out, but partners with equal power and valuable knowledge

about the social determinants that cause health and disease (Ansell, 2010; Higgins & Metzler, 2001; Wallerstein et al., 2005). CBHP, thus, does not work *on* communities, but *with* them (McLeroy et al., 2003). Second, CBPH regards communities as a recourse in the sense that they provide the starting point for interventions: concerns of the community serve as the main direction for the intervention, even if these problems are not strictly health issues (Metzler et al., 2003). This stands in sharp contrast to many other health promotion approaches that often treat communities merely as target to address their intervention upon to reduce specific health risks (McLeroy et al., 2003).

To make the development and implementation of interventions more democratic, community-representatives are invited to work with health practitioners and other stakeholders throughout the project (Israel et al., 2013). Representatives are perceived to have 'insider knowledge' about their community. As such, they can identify topics of interest to the community and to provide scholars with the perspective of community-members (Ortega et al., 2018). Also, they are gatekeepers to the community, keeping scholars and other stakeholders from (unintendedly) harming it (Israel et al., 2001).

It is a challenge to get to know a community in ways that are consistent with the principles CBHP: in order to work with a community it should be defined, but researchers and health practitioners are not supposed to work with predefined operationalizations or to direct communities in how they define themselves (Blumenthal, 2011; Israel et al, 2008). Therefore, in order to find a partner-community, health practitioners use community-assessments, such as the Action-Oriented Community Diagnosis (Eng & Blanchard, 2006; Laverack, 2009). This procedure starts with a broad conceptualization of 'the target community' and slowly, question by question, works towards a community-definition that is workable for practitioners and consistent with the community's own perception of identity. In the process, practitioners use secondary data, windshield tours, and information provided by local agencies and local informants to come to a definition, which is presented and discussed with the community, and, if necessary, redefined.

The representation of a community also poses important challenges to CBHP (Jewkes & Murcott, 1998; Wallerstein & Duran, 2008). Scholars have expressed the concern that representatives, who are often found in community-based organizations, are not equal to other members of the community in terms of class, income, education, gender, ethnicity, and other relevant characteristics. Members of such organizations might have taken up their task because they have more time, resources or flexibility in their

personal lives then other community-members (Becker et al., 2005). Community-representatives have articulated other concerns with regard to their representativeness (Ortega et al., 2018; Safo et al., 2016). In a study of Ortega et al. (2018), community-representatives described various circumstances through which their representativeness wasn't optimal, such as a lack of consistent instructions of their roles and responsibilities, the fact that the representatives were invited at only a few occasions throughout the project, and the limited amount of communication between the representatives and the academics in between these meetings. Also, work and personal life formed a barrier for representatives to be more involved with the intervention, even if they wanted too.

1.1.2 Discussing disadvantage and empowerment

Social epidemiological research has provided ample evidence of a correlation between disadvantage and health (Berkman and Kawachi, 2014; Smith et al., 2015).[1] Therefore, CBHP-interventions do not target 'just' a community, but explicitly aim to improve the health of disadvantaged populations (Clements-Nolle & Bachrach, 2008; Minkler & Baden, 2008). Yet, where conventional health promotion tends take the disadvantage of its target groups as a given and as something that makes them particularly 'vulnerable' (e.g Blum et al., 2002; Mohajer & Earnest, 2010), CBHP aims to fight disadvantage by empowerment. The field does so because it holds that socio-economic disadvantage comes with a lower control and power in life that negatively affects health and wellbeing (Chávez et al., 2003; Garrett, 2000; Hogue et al., 2000). Hence, in order to truly improve the healht and wellbeing of communities, disadvantage needs to be redressed.

One of the main strategies in CBHP to tackle the disempowering effects of socioeconomic disadvantage is to empower communities so they can increase control over their own lives (Aronson, et al., 2007; Springett & Wallerstein, 2002). Empowering processes include the sharing of information,

[1] What a is considered to be a 'disadvantaged community, however, largely depends on national socioeconomic and research contexts. For instance, in Canada, New Zealand and Australia, 'disadvantaged communities' are often equated with indigenous populations (e.g. Mead et al., 2013; Parker et al., 2006; Steward, Reilly & Ward, 2018). In the United States, black and Latino communities are often considered as 'disadvantaged' (e.g. Nord et al., 2007). In Western Europe, 'disadvantaged' is usually associated with a low socioeconomic status (LSES) based on low income, education and/or occupation (e.g. Everson-Hock et al., 2013).

decision making powers and resources among all stakeholders[2] (Israel et al., 1998; Jones & Wells, 2007), but also implies a focus on the strengths and resources – rather than merely the risks and vulnerabilities – of a community. At the individual level, these strengths and resources include assets such as knowledge, lived-experiences, self-esteem and social competence (Freudenberg et al., 2005; Minkler, 2005; Wallerstein & Duran, 2006, 2010). At the community level, they include supportive networks, community cohesion and intergenerational solidarity (Davies & Ziglio, 2010; Morgan & Ziglio, 2007; Springer & Evans, 2016). According to Chávez et al. (2003), as well as others (Minkler & Wallerstein, 2008; Tengland, 2012) tapping into strengths and resources might itself enhance health, as it reduces dependency on professionals that further diminish people's control over their live.

CBHP has been applauded for its focus on empowerment of disadvantaged communities (Israel et al., 2005). Some scholars, however, have emphasized the great challenges that the empowerment principle poses to the field. There are, for instance, many theoretical debates about the meaning of empowerment, not only in the field of CBHP, but also amongst various stakeholders in CBHP-interventions. Baum (2003) underlined that 'empowerment' means something else to the World Bank than to non-governmental organizations such as Oxfam, and again something else to government departments and to community workers. Chávez et al. (2008), as well as others (Erzinger, 1994; Leger, 2008) underlined that 'empowerment' can also mean something else for different community members, depending on – amongst others – their age and cultural background. Also, as Leger (2008) pointed out, funders of healht promotion interventions often want quantitative outcome measures. Empowerment, however, is difficult to measure. How should it be operationalized? Fetterman et al. (2007) brought up the issue that 'empowerment' seems to imply that communities need to be empowered by others. However, as the authors stated, in CBHP 'no one empowers anyone. People empower themselves' (p. 182). At the same time, scholars like McIntosh (1998) and Chavéz et al. (2008) point at the fact that CBHP-interventions are developed and implemented by educated professionals - who are often white - working in 'disadvantaged' and 'disempowered' communities. Hence, in the end, the disadvantaged communities are those in need of empowerment, while the need to empower professionals remains unconsidered.

[2] More on these aspects of empowerment can be found under the heading 'Discussing participation'.

1.1.3 Discussing participation

In some way, all community interventions, also in conventional health promotion, involve participation: people are participating in the intervention's activities. A participatory approach, however, involves more than participation by 'just' partaking in an intervention. It refers to equitable involvement of community members in the design, implementation and evaluation of interventions (Koelen & van der Ban, 2004). For CBPR-inspired health promotion, participation means an equal and collaborative relationship between health professionals and community members (Horowitz et al., 2009; Jull et al., 2017). By means of participation, CBHP aims to 'de-centre expertise': community members' 'lay'-knowledge is as legitimate and expert in nature as scholars' knowledge. As such participation is seen as critical means to reduce communities' dependency on professionals (Jewkes & Murcott, 1998, Wallerstein & Duran, 2008).

Encouraging equitable participation in CBHP requires the use of methods and approaches that foster processes in which diverse groups of people - members of a community with a shared identity, representatives of organizations that work with the community, and academic researchers - become partners in exploring and addressing issues relevant to the community (Becker et al., 2005). These may include collaborative mapping of community indicators, risks, and assets (Hancock & Minkler, 2004); individual and small-group work as support for bringing community voices to the foreground (Minkler & Wallerstein, 2008; Becker et al., 2005), shared leadership (Israel et al., 2001) and simply taking time to develop mutual trust (Becker et al., 2005).

CBHP is not ignorant of the discomfort that community members may feel in stakeholder groups characterized by major status differences and the potential for stereotyping (Wallerstein et al., 2005;). To avoid this, and to confront such situations when they do arise, scholars are expected to treat communities with what Tervalon and Murray-Garcia (1998) termed *cultural humility*. This term refers to 'a lifelong commitment to self-evaluation and self-critique' to redress power imbalances and 'develop and maintain mutually respectful and dynamic partnerships with communities' (p. 118).

Researchers, practitioners, and community partners who have participated in CBHP-projects have noted the benefits that emerge when all stakeholder successfully and equitable participate (Israel et al., 1998; Lantz et al, 2001; Schulz et al., 2003). Many have also noted, however, that the actual practice of equitable participation remains complex. This is partly due to practical matters: it is often a lot easier to attract professionals and policymakers to board meetings than to get community members such as parents

and low-wage workers to attend regularly, as they have time commitments and demands that will likely not be in sync with an academic calendar (Becker et al., 2005; Wallerstein et al., 2005). At a more fundamental level, power and privilege differences can hinder equitable participation. Although it is suggested that true participation would be sufficient to overcome dependency on professionals, power and privilege differentials can and often do remain substantial (Jewkes & Murcott, 1998; Wallerstein & Duran, 2008). That is, generally speaking, researchers, health professionals and other scholars are ascribed the power base of being experts with 'scientific knowledge'. Unintentionally, this might delegitimize knowledges that exists in the target community of the intervention. In addition to scientific knowledge, academics of the have the power of resources, including grant money, subcontracts for organizational partners, and jobs and tasks for community members (Wallerstein & Duran, 2006). With these power and privilege differentials, stereotyping and discrimination can hardly be avoided (Chavez et al., 2008; Wallerstein & Duran, 2006). Thus, while it is the aim of CBHP to consider academics and communities as co-workers and equals, in practice, the hierarchy between academics and community members is not easily flattened out (Damon et al., 2017; Faridi et al., 2007; Muhammad et al., 2014).

1.1.4 Discussing health

Health promotion interventions of any type seek, by definition, to improve a population's health. Yet, CBHP differentiates itself from perspectives on health in conventional health promotion by at least three features. First, health in CBHP is not a predetermined concept. Rather, communities are actively engaged to determine relevant health concerns and their perceptions ad meanings of health are taken seriously. This closely relates to the principle of participation. As Arcury et al. (1999) explain, '[t]he most powerful aspect of community participation in health intervention projects is that it forces the projects to address the health concerns of community members rather the concerns of health professionals' (p. 564). Several instruments have been developed to aid stakeholders to determine communities' health concerns, such as survey methodologies (Schulz et al., 2005); photovoice (Wang et al., 2008); focus groups and interviews (e.g. Bermúdez-Millán et al., 2013; de Jong & Wagemakers, 2019) and Community Health Development (Burdine et al., 2010).

Second, CBHP adopted an ecological orientation to health that pays attention to individuals, their immediate context (such as families, communities and social networks) and to the larger contexts in

which communities exist (Israel et al., 2005; Ayala et al, 2005; Springett & Wallerstein, 2003). Ecological models of health promotion understand health, as Dooris (2006, p. 55) wrote, as determined by 'a complex interplay of environmental, organizational and personal factors'. In practice, this means that CBHP-approaches to health not only consider biomedical and physiological determinants of healht, but also its social, economic, cultural and physical components and the dynamics between individuals, groups and their socio-physical milieus (Israel et al., 2005). In effect, communities are no longer not simply seen as a producer of disease and individual consumers of health and health services, but, rather, as coproducers of health (Morgan & Ziglio, 2007).

Third, CBHP is characterized by a salutogenic perspective on health (Israel et al., 2003; Judd et al., 2001).[3] This implies a consideration of how health – rather than disease – is created and maintained inside the community, and a focus on the available strengths and resources that create health (Antonossky, 1987) . Doing so, CBHP opposes the traditional pathogenic health model, which focuses is on risk, disease, prevention and treatment (Morgan & Ziglio, 2007). It also makes CBHP at odds with a strong emphasis on individual responsibility for health (Judd et al., 2001).

CBHP has been applauded for having moved beyond narrow definitions and individualistic conceptualizations of health (Roberson & Minkler, 2010). At the same time, this direction has not been without contestation. Various health promotion scholars have outlined the ideological conflicts that come with the holistic and more positive perspective to health (Friedli, 2012; Muller, 1988). For instance, Friedli (2012) stated that a focus on people's capacities to improve health, rather than on their risks, draws away the attention from the root causes of inequalities. This, Friedli argued, leads to a health promotion that attempts to reproduce assets – optimism, positive thinking and self-reliance - that are actually tied to material and social advantage, while leaving existing power imbalances and unequal privileges intact.

[3] A salutogenic perspective on health is not exclusive to CBHP, there are more stands of health promotion that embraced this view. However, in CBHP salutogenesis is the standard, rather than an experiment or exception.

1.1.5 Discussing evaluation

The evaluation phase is considered a particularly essential part of any health promotion intervention to trace and understand its effects, so that more comes to be known about 'what works why'. This is not different for CBHP (Springett & Wallerstein, 2008; Guttmacher et al., 2010). As in other branches of health promotion, CBHP-evaluation is in part driven by the demand for accountability in the public sector (Henkel, 1991; Judd et al., 2001). At the same time, evaluation in CBHP distinguishes itself from evaluation in other fields of health promotion by making it participatory (Springett, 2001b). Participatory evaluation, as Springett and Wallerstein (2008), outlined, means that all who have a stake in the outcome – whether it is as funder, project worker or participant – take part in each step of the evaluation. The aim here is to let every voice be heard and – at the very least – taken in consideration when drawing conclusions.

While participatory evaluation is a process rather than a technique, Fuerstein (1988) managed to list ten vital steps in this process. These steps include, amongst others, that all those involved decide what the objectives of the evaluation are; that all those involved in the project take part in the evaluation process; that the collected information is analysed by all those involved; and that participants co-decide how the results will be used (see also Springett & Wallerstein, 2008). Judd et al. (2001, p. 369) added to this list that in CBHP-evaluation, health is not a quantitative end in itself but, rather, a means to 'an equitable social environment, a convivial community, a liveable environment' and quality of life. Therefore, health is evaluated in with healht experiences and values as perceived by the community. Together, these components ensure that the evaluation indicators and outcomes are meaningful to and useful for all concerned (Macgillavray, 1998; Wallerstein, 2000; Wallerstein et al., 2002).

Participatory evaluation has several strengths in comparison to traditional evaluation. First, it involves enhancing control of the community over the factors that promote good health. In that sense, participatory evaluation can be a health-promoting intervention itself (Merzel & D'afflitti, 2003; Vanderplaat, 1995; Wallerstein & Duran, 2006). Also, participatory evaluation focusses on knowledge creation in the context of practice and action, and assumes that people can generate knowledge based on their own categories and frameworks (Wallerstein, 2007, Springett & Wallerstein, 2008). In this way, evaluation naturally merges evaluation into an intervention (Springett & Leavey, 1995; Springett & Wallerstein, 2008). This, according to Springett and Wallerstein (2008), makes participatory radically

different from positivist evaluation methods, where the emphasis is on theory creation. Finally, participatory evaluation is not only outcome driven, but also focussing on the processes and relationships between various stakeholders. In this way, it can counter marginalization and exclusion (Goodman et al., 1993; Springett and Wallerstein, 2008)

Participatory evaluation knows various challenges. Many of these stem from the need to balance the values and requirements of participation with the use of appropriate, rigorous, verifiable, and valid tools and techniques, and the practical demands of the public sector (Crishna, 2007; Springett, 2010). The first issue is the balance between expert and 'lay' involvement. Whereas the strength of CBHP is to combine 'lay'- knowledge with that of scholars, technical expertise still carries the greatest credibility in the 'outside world'. Tied up with this issue is the need to negotiate who owns the evaluation findings. Even if the intention is to let to findings be owned and practically used by the community, academics face their own requirements to publish. Excluding community partners from this step in the evaluation flies in the face of the ideology of participation and easily reinforces academic hegemony, but cowriting with community members is often challenging, time consuming and practically infeasible exercise (Gaventa, 1993; Springett, 2001b). A second challenge is that, often, the values against which a CBHP-intervention is being assessed are not those of the field and of communities, but the quantitative epistemic ideals of evidence-based medicine (Leger, 2008; Springett, 2001a). Tones and Green (2004) underlined that common evaluation strategies are firmly rooted in an individualist biomedical understanding of health, from which CBHP-approaches distanced themselves. Common evolution strategies are based on randomised controlled trial models, but randomisation in experimental and control groups in CBHP is basically impossible. In effect, CBHP-interventions are often considered 'too hard to evaluate' (Crishna, 2007). Wallerstein (1999) examined an evaluation process she had been involved and showed how the communities whose projects were being evaluated felt they were being judged on criteria unacceptable to them. In that sense, evaluation in CBHP is considered to be a 'tradeoff between credibility, opportunity, relevance (and) replicability of evaluation results' (De Salazar, 2007).

As outlined in this section, the central concepts of CBHP – community; disadvantage and empowerment; participation; health; and evaluation – are widely discussed in the field. While CBHP-scholars generally agree upon the key principles related to these concepts, they also acknowledge that it is challenging matter to bring these principles into practice: CBHP needs to navigate through difficult ethical and methodological terrain, addressing issues of power, trust and conflicting agendas. Also, the field has to leverage sufficient funding while funding requirements often conflict with CBHP-principles. At the same time, CBHP holds a promise for insuring that health promotion focuses on topics that are relevant to communities, and is conducted in ways that can build community capacity and work to reduce health inequalities. These discussions and promises raise the question how CBHP is performed on the ground. In the next section, I will introduce a theoretical perspective that enables the study CBHP-interventions in practice: Science and Technology Studies.

2. Theoretical background: Science and Technology Studies

Health promotion practices are developed at the interface of science, polities and society. To explore these practices I will mainly draw from Science and technology Studies, a field that is dedicated to the study of relationships between knowledge and practices. In the following, I introduce the key principles and authors of this academic field that are of particular relevance to this thesis.

In their renowned book *Laboratory Life: The construction of Scientific Facts*, the STS scholars Latour and Woolgar (1979) examined how laboratory work was conducted to produce scientific facts about the structure of a particular hormone, TRF (thyrotropin-releasing hormone). The authors invited their readers to follow 'a fictional character, "the observer" in his attempts to use the notion of literary inscriptions as a principle for organizing his initial observations' (p. 45). By following these inscription devices – that is, all the tools and technologies used in the laboratory to transform the material substances (in this case purified brain extracts) into figures, diagrams and texts - Latour and Woolgar showed how the TRF structure was not a given reality, but constructed through how it was studied. A crucial argument in *Laboratory Life* is that these inscription devices function as dominant technology in the laboratories and, hence, that 'facts' are the consequence of scientific work, rather than its cause. Scientific activities in the laboratory, in other words, did not discover the hormone structure, but produced it.

Latour (1999) asserted that the process of 'black boxing' is key to the production of facts. The concept of the black box originates from cybernetics, where it is used in diagrams as a quick way of alluding to some complex process: in its place, one draws a box and indicates only the input and the output. In this way, the need to detail the contents of the box itself is sidestepped. In STS, this metaphor is used to describe the construction of uncontested scientific facts, with any history of contest or controversy in its production hidden in the black box. Since it is invisible, this constructed nature becomes taken for granted, and complexity can be reduced into theories, rules and facts (Latour, 1987, 1999; Latour & Woolgar 1986). Once constructed, black boxes are rarely opened. It is not only time consuming and expensive to do so, it is also very difficult, as withing one black box there are often many more, each one closed, fixed and stable worlds (Latour, 1988). The functioning of a laboratory, for instance, can be seen as a black box, but also the elements within it: scientific papers, technologies, procedures and machineries. Therefore, Latour (1999, p. 304) described the making of a black-box as 'the way scientific and technical

work is made invisible by its own success' and stated that, paradoxically, 'the more science and technology succeed, the more opaque and obscure they become.'

In *The Pasteurization of France*, Latour (1988) argued that reality is not only constructed through scientific practices, but by scientific work as it happens in a wider network. Latour investigated the social and historical processes that made Pasteur and his inventions – pasteurization and bacterial vaccines - so successful that they transformed the world's methods to deal with harmful bacteria's. He showed that Pasteur's ability to triumph with his methods over that of others depended on a whole network of actors and socio-political forces, including the public hygiene movement, the medical profession, cattle and bacteria. As these actors and their interests allied in a socio-historical context of epidemics and colonial interests, Latour argued, they constructed a stable network through which Pasteurian innovations left nothing untouched. According to Latour (1991) and other STS=scholars (Callon, 1984; Star & Griesemer, 1989), the construction of stable networks and the uncontested uptake of new facts is only possible through what they call 'translations': in order to create scientific authority, principle actors like Pasteur enlist allies from a range of contexts, negotiate and re-interpret their concerns to fit their own goals and succeed to establish themselves as gatekeeper for the network

Extending this line of argument, Bowker and Star (1999) further developed the ideas on networks as sociotechnical structures that organize social reality. They start by stressing that 'to classify is human' (p. 1): humans cannot live without ordering and classifying the world. However, they assert that classification are not out there to be discovered, but, instead, the result of human practices. Even though they are constructed, classifications can become materialized, again through human work, in socio-technical infrastructures that shape everyday practices in accordance with these classifications. Typically, such infrastructures are taken for granted, and not reconsidered or reflected upon at the start of a new enterprise:

> A chef does not need to know everything about the infrastructural network of pumps, sewers, reservoirs, filters, and regulations to fill a stockpot with water for soup – she turns the handle and clean, potable water comes out of the faucet. In much the same way, a librarian does not need to rebuild his classification scheme each time he wants to add a new book to the collection. Electricians and contractors, with their infrastructure of regulations and formal standards, do not

> worry that their building projects will fail to connect to the relevant grids or be accessible by vehicle when connected to local roads — the work of interoperability and access has already been done (Slota & Bowker, 2017 p. 529).

Thus, infrastructures, despite the material heterogeneity of their physical appearances, shape our world and work. Once established, however, the infrastructural classifications fade into the background of social and technical arrangements and, in effect, become practically invisible. They become, in other words, black boxed (Blok et al., 2016; Bowker & Star, 1999). Bowker and Star (1999, 1998) showed that what goes for material infrastructures, also applies to infrastructures of classifications: although they might become invisible and treated as a given, infrastructures are the product of human moral work, they hold norms and values, and shape the very ways in which we understand the world. This is particularly evident in their example of the International Classification of Diseases, the ICD (see also Bowker, 1996).

The ICD is used worldwide to determine causes of death. To track down the casus of a death, however, one needs morbidity and mortality records in a standard terminology. This means that, in order to maintain the ICD as a good system of medical classification, a huge amount of information is needed from citizens. Only with these data collection systems in place, one can use the ICD to determine causes of death. By this picture, the ICD is a passive list, moulded by outside forces. However, when this classification was drawn up, it was based on a few pre-existing classification of mortality tables of six European countries. Naturally, then, little room was left for a whole range of tropical diseases. When European colonial powers imposed the ICD on their colonies, users there found that the list did not meet their reality as it was not possible to die for other causes than those listed in the ICD. In effect, the old statistics did not record wat were believed to be contributing causes of death. People with aids in the 1920's, for instance, might have died – according to the ICD-statistics – of any a number of opportunistic infections. This example shows that infrastructures - both as physical objects and as knowledge objects - encompass more than just a silent and objective background. Instead of a thing isolated from its use, infrastructures are related to practices and shape the organization of the social world (Bowker & Star, 1999; Star and Ruhleder, 1996). At the same time, it shows that infrastructures, because they are embedded within other social and technical arrangements, tend to become taken-for-granted, forgotten and invisible (Blok et al., 2016; Bowker & Star, 1999).

In order to make infrastructures visible, and to bring their effect on the social world into the light, STS scholars look closely at the technologies, instruments and arrangements that make up infrastructures (Jensen, 2008; Star, 2002). To this purpose, Callon et al (2007, p. 2) introduced the concept of 'market devices', that refers to 'the material and discursive assemblages that intervene in the construction of markets.' Callon et al., as well as MacKenzie (2006), state that market devices do not just describe the market, but help to shape it, to bring it into being, and consequently, to change the socio-cultural world. They are, in other words, performative. Pre-printed shopping lists, for instance, as well as shopping trolleys, score cards and weekly mailing lists – all of these are market devices to promote sales and, hence, shape markets' functioning and construct particular consumers as *homo economicus* (MacKenzie, Muniesa & Siu 2007; Poon, 2007).

While MacKenzie provided the conceptual structure, other STS scholars fleshed out the empirical details of performativity. They did not only focus on market devices and the construction of markets, but also on a wider set of devices and in other sectors. In the field of health, Meershoek and Horstman (2015) used the concept of 'market device' to analyse how the tools of public health sciences function as devices in the shaping of workplace health promotion. They argued that the public health measurement tools such as health checks and questioners on topics as the home situation and physical and mental health not simply identify 'given' employees at-risk for disease but, rather, create the at-risk employee. Lemos and Bitencourt (2017), showed how the FitBit as tracking device not only measured but also affected users' behaviours. That is, the original function of FitBits to count users' steps, actually made them walk more than they would normally do. In similar vein, Bauer (2013) described the performative effect of epidemiological tools in genomics: as risk figures computed via statistical modelling travelled from the epidemiology to the doctor's consultation room, they affected the doctor-patient relationships and the ways in which patients acted, for instance by quit smoking to lower their risks at disease. Horstman (2020) showed that the epistemic-political accountability web in which a Dutch health promotion intervention, 'Heartbeat Limburg', took place, had specific consequences for the project. The intervention was developed at the intersection of science and local politics: a quantitative evidence-based approach was considered to confer a mark of quality. In effect, the aims of the project were formulated in quantitative terms, such as '30% more reduction of high risks for coronary disease compared to the control group' while 'immeasurable' factors, such as stress, were not addressed.

Callon (1984) coined the term 'obligatory passage point' to emphasize that the use of certain infrastructures and their tools cannot be avoided. For instance, for market approval of medicines, the use of randomized controlled trials cannot be avoided (Rosemann & Chaisinthop, 2016). In similar vein, in the context of antimicrobial resistance, particular policy documents establish obligatory passage points to address this issue in practice (Kamenshchikova et al., 2021).

The different works discussed in this section provide five important messages that form the backbone of my study. First, truth and facts are practice-embedded. Reality is not out there to be objectively discovered or described, it is produced through the ways by which we study and describe it (Felt et al., 2017). Second, reality must be understood as constructed within a particular historical socio-political network in which various actors, actions, power-relations, forces and interests come together (Law, 2017). Third, classifying infrastructures are both material and symbolic and they matter, as they shape the world and our understanding of it profoundly and unavoidably (Slota & Bowker, 2017). Forth, infrastructural tools do actively perform the realities they aim to describe and represent, and they do this almost unnoticed and beyond the intentions and aims they are used and made for (Law, 2007). And, lastly, the use of certain infrastructures and tools can become obligatory passage points, making it impossible to avoid them.

Together, these works highlight the performative role of infrastructural networks and tools in the construction of reality. The angle of performativity can help to empirically study how infrastructural networks and their tools are involved in the construction of social reality. Instead of providing a normative theory on 'good practices', the focus on performativity puts a lens on how infrastructural practices and their tools come to shape the world.

2.1 Aim and research questions

Current trends in health promotion emphasize CBHP-approaches. CBHP explicitly aims to work *with* rather than on communities to address the social context in which health and disease occurs. As such, it has the potential to improve the health and wellbeing of communities, while fostering empowerment and social change. At the same time, the discussions in the field make clear that scholars and healht promotors struggle to put CBHP values and principles into practice, and, hence to realize CBHP's full potential. In light of these promises, discussions and struggles, it is interesting to follow how CBHP-interventions are performed in practice. Following the STS tradition, I understand CBHP as a practice that gets shape in infrastructural networks in which science, policy and society come together. Therefore, the main research question of this thesis is: how do the tools, practices and infrastructural network of CBHP perform CBHP-interventions?

3. Materials and methods

To answer my research question, I chose a single CBHP-intervention and analysed how its tools, practices and infrastructural network together performed CBHP. In this section, I introduce this intervention and outline my methods for the analysis.

3.1 Introducing the case study: B.Slim

This thesis provides and in-depth study of one particular intervention in the Netherlands, 'B.Slim beweeg meer, eet gezond' ['B.Slim move more, eat healthy,' in short: B.Slim]. B.Slim was launched in 2005 with the aim to reduce and prevent overweight amongst children in five low socioeconomic status (LSES) neighbourhoods in the municipality of Amersfoort, a city located the middle of the Netherlands. The project is still ongoing at the time of writing.

B.Slim forms an interesting case to study the real-life practices of the community-based approach in health promotion for several reasons. First, B.Slim is a long-lasting intervention, running since 2005 and still ongoing at the time of writing. Second, since 2012, the intervention is acknowledged by the National Institute for Public Health and the Environment [Rijksinstituut voor Volksgezondheid en Milieu, RIVM] as a 'theoretically sound intervention' (RIVM, n.d. a). According to the RIVM, acknowledged interventions are 'interventions that work', meaning that they are developed by experts, scientifically proven, substantiated with evaluation and tested for practical feasibility (Movisie, 2018; RIVM et al., 2018). As such, B.Slim serves as example for the development of other health interventions in the Netherlands. Lastly, partly because of its recognition by the RIVM, B.Slim has published numerous action plans, year reports, and evaluation studies that form a valuable basis for a document analysis. Before introducing this set of documents, and my approach to analyse these, I first explain my method for the analysis.

3.2 Method: practice-oriented document analysis

STS views documents not simply as describing an external, neutral reality but as tools that are constructed in a socio-political infrastructures, and, at the same time, take part in the shaping of these infrastructures (Shanar et al. 2014; Asdal, 2015). In STS, documents are seen as a defining feature for modern society. Therefore, document analysis provides a key method in STS to study constructing work in general and coproduction and performativity in particular (Law, 2010, 2014; Shanar, et al, 2014; Asdal, 2015).

Asdal and Reinertsen (2022) provided a systematic approach for doing document analysis. They hold that documents have more or less authority and, therefore, more or less strong performative effects: 'close to nothing of importance in our society happens without the involvement of documents' (p. 3). In line with STS theory, the authors assert that documents are the result of human work and carry norms, values and histories of controversy within them: 'Documents are never completely neutral. They come from somewhere and they are integral to the very issues and controversies that unfold in society. (…) [W]e may safely assume that documents do play a role in the case or issue that we are interested in' (p, 3). Therefore, they hold that understanding documents is a prerequisite to understand society. In the social sciences and humanities, there exists a plethora of methods for document analysis. The method offered by Asdal and Reinertsen, however, is different in the sense that is does not only attend to what happens in texts, but also to what texts *do* in society. Thus, instead of analysing the meaning of texts, or analysing texts in order to choose a policy option, this method views texts as practices and focusses on how documents intervene in the practices they describe. As such, this practice-oriented method provides a useful framework to analyse the performative effect of B.Slim on CBHP.

Asdal and Reinertsen presented their method in six conceptual and methodological elements: document sites; document tools; document work; document texts; document issues, and document moves. Each element sheds light on another aspect of documents and, hence, at on other performative effects. In this thesis, I use three of the framework's elements that fit my research question, data set as well as the time available for this study: 1) document sites; 2) document tools; and 3) document issues.

First, the element 'document sites' entails to think of tools as sites were something happens, where actions take place. The notion of 'document sites' encompasses both the fact that documents are part of specific sites – such as historical context, political practices, particular social debates, or an

academic field, hence, the sites which I referred to as infrastructures in the theoretical background of this thesis – and take part in the production of these sites. At the same time, the notion of 'document sites' allows to view documents as sites themselves that can be, analytically speaking, visited. According to Asdal and Reinertsen, ethnographic methods can help to analyse these three layers of document sites. Particularly relevant for this thesis is what the method they propose as 'document ethnography': spending time with the documents, getting to know them, and actively reflecting upon observations. Guided by questions such as 'what does the document say?', 'what is written here?', 'what does this document do?', 'what happens here?' and 'what are the practices unfolding here?' (p. 153) this approach bring interesting details and important nuances into view.

The second element of this framework, 'document tools', includes both looking at documents as tools in themselves as well as at the tools employed in documents. It means to look at how the material properties of documents give them their particular function. Documents such as government budgets, for instance, are mend to govern society. At the same time, this element entails to be sensitive to the unforeseen functioning of documents. The book *Paper Cadavers* by Kirsen Weld (2014) underlines this point. Weld followed a group of activists and historians in their work to restore an archive over persons who were kidnapped, tortured and killed by the state police during Guatemala's civil war. In her analysis, she showed how this archive has two functions. First, during the war, the document was mend as tool to control and strike down the opposition. Then, during the after-war process of reconciliation, the same document became a tool for justice for victims' families. Thus, documents as tools might serve multiple – even opposing – functions. To trace these functions, the analytical focus lies at questions such 'by whom was this document shaped?' and 'with which purpose was it made?' By such questions, the attention shifts from documents' context alone to also consider what the document is mend to do, and what it actually does and enables.

Documents are not only tools, they also employ tools themselves (Asdal & Reinertsen, 2022, p. 43, 98). Scientific reports, for instance, often show graphs in order to clarify or account for a certain statement. In similar vein, government budgets make use of numerical tools, such as calculations and graphs, account for financial decisions. As these examples show, tools in documents do not need to be highly visible or outstanding. On the contrary, they are often almost unnoticeable, not appearing as authoritative. In practical terms, however, they may still be forceful. The steepness and pointiness of a graph, for instance,

might incite a sense of urgency. The element of 'document tools' implies to analyse what such tools help us to see, how they make the world visible in a certain way. As with optical instruments such as lenses, microscopes and camera's, document tools they provide vision, enable us to see things that were not visible before (Reinertsen, 2016). The practice-oriented method to document analysis allows to study such tools in a detailed, practice oriented way by questions such as: 'What numbers are used, which stories do they tell?' 'Which graphs and other textual devices are used, and how does it affect the interpretation of the topic it concerns?' and 'Which forms of action do these tools propose as necessary?' (p. 98)

The third methodological element that I adopt from this framework, 'document issues', is oriented towards the issues that documents concern and work with. This element of the analytical framework implies an active exploration of how documents work upon and play part in the issues they are about. For Asdal and Reinertsen, the analysis of document issues can be guided by four different concepts. First, 'issue formations' concerns how an issue is established in a certain way in the document, for instance in neutral and non-emotional formulations, as a matter-of-fact, as something to be sorted out or as a controversy (Marres, 2007, 2014; Asdal & Reinertsen, p. 106). Asdal and Reinertsen underline that the issue formations allow for certain publics to be involved in the issue. A matter-of-fact style of writing, for instance, is often linked with professional knowledge, while the establishment of an issue as controversy invites allows for a wider audience to become involved, such as activists or injured parties. The second concept introduced by Asdal and Reinertsen is that of 'modifying work'. This means that the document can transform an issue into another one. The goal here is to neutrally signify how small-scale changes are made to the issue at hand, and how these come to matter for how the issue is understood, handled and intervened upon. The third strategy to analyse document issues is to attend to 'contexting' (Asdal & Moser, 2012; Asdal & Reinertsen, 2022, p. 116). This step is closely related to the earlier mentioned element of 'document sites' and includes an analysis of how documents incorporate their context, but also intervene upon their own context and make new links between actors, arguments and events and, hence, construct new contexts. The fourth and final concept relevant to the analysis of document issues is that of 'document objects'. This concerns the relation between the document and the issue and the things or objects they are concerned with and act upon in the social world. The questions that concern the construction of issues are those like 'How does a document issue emerge, 'behave' and get shape?', 'How do documents, their procedures and tools produce and work upon issues?', 'How are concrete cases and

objects turned into document issues, and with what effects and consequences for the cases and objects at hand?' (p. 104).

Drawing upon the approach of Asdal and Reinertsen, I consider these reports not as objective source to information about the B.Slim intervention, but as active performers of the 'issue' at hand: CBHP. Together, the three methodological elements outlined above – document site, document tools, and document issues – provide a comprehensive framework to empirically analyse how the B.Slim documents performed CBHP. In the next section, I introduce these documents.

3.3 Materials for the analysis

Based on the rationale that documents provide us a close look at the tools, practices and infrastructural networks involved in their performative capacity, my analysis deals with a set of relevant program descriptions, action plans, evaluation reports and scientific studies published by B.Slim on their own intervention. Initially, I collected these documents via the Google search engine, using the search terms 'B.Slim' and 'Amersfoort', combined with either 'evaluatie verslag' [evaluation report] or 'jaarplan' [year plan/program description] and any year between 2005 and 2022. Then, I searched the B.Slim webite[4] for the missing documents. Additionally, I added the documents referred to under the headings 'materials for implementation and recruitment' and 'materials for evaluation' in B.Slim's most recent program description (2018) to the data set. As not all these documents were available online, I contacted the current project leader of B.Slim and received the missing documents by email. Unfortunately, some relevant documents could not be traced. These included the interview- and evaluation forms made at the start of the intervention in each B.Slim neighbourhood; an evaluation report from 2009, called 'Overbruggingsplan Eemland'; and program descriptions from before 2018. This method yielded 24 documents that were all included in the dataset (box 1).

The period examined in this thesis is 2007-2020, from the first available B.Slim evaluation about the years 2005-2007, up until the action plan of 2021, published in 2020. Together, these documents provide a clear and comprehensive overview of the activities, actors, networks materials, tools and evaluation measures employed and made throughout the existence of B.Slim. All these documents are

[4] www.bslim.nu

written in Dutch. For the purpose of this thesis, I have translated quotes and concepts into English. In order to make a clear distinction between my dataset and other references, I refer to the documents by the codes provided in box 1. From the methodological elements outlined by Asdal and Reinersten (2022), combined with earlier STS work on the performativity of documents and/or health interventions (e.g. Bauer, 2013; Horstman, 2020), and Minkler and Wallerstein's (2008, p. 437) questions to think through the challenges of community-based approaches, I compiled key questions to aid the analysis of each document (box 2). All documents were read and reread in chronological order. These questions were used not to evaluate whether and how this B.Slim implemented the principles of CBHP more or less adequately, but how this intervention practice is performing CBHP. The interpretation of the data was discussed during several rounds with my thesis supervisor.

Box 1
Documents for the analysis

Year	Original title in Dutch [Title translated in English]	Type of document	Code
2007	Inhoudelijk verslag B.Slim in 2005 en 2006 [Substantive report B.Slim in 2005 and 2006]	Evaluation Report	A
2008	Inhoudelijk en financieel verslag B.Slim in 2007 [Substantive and financial report B.Slim in 2007]	Evaluation Report	B
2009	Inhoudelijk en financieel verslag B.Slim in 2008 [Substansive and financial report B.Slim in 2008]	Evaluation Report	C
2010	B.Slim Amersfoort in 2009. Inhoudelijk en financieel verslag [B.Slim Amersfoort in 2009. Substantive and financial report]	Evaluation Report	D
2011	B.Slim Amersfoort in 2010. Inhoudelijk en financieel verslag [B.Slim Amersfoort in 2010. Substantive and financial report]	Evaluation Report	E
2012	B.Slim Amersfoort in 2011. Inhoudelijk en financieel verslag [B.Slim Amersfoort in 2011. Substantive and financial report]	Evaluation Report	F
2013	B.Slim Amersfoort in 2012. Inhoudelijk verslag [B.Slim Amersfoort in 2012. Substantive report]	Evaluation Report	G
2014	B.Slim Amersfoort in 2013. Inhoudelijk en financieel verslag [B.Slim Amersfoort in 2013. Substantive and financial report]	Evaluation Report	H
2014	Evaluatieonderzoek onder Ouders over het Interventie-programma B.Slim [Evaluation study amongst parents about the intervention program B.Slim]	Student thesis	I
2014	Een determinantenonderzoek naar de gedragsintenties van ouders [A determinant study on the behavioural intentions of parents]	Student thesis	J
2015	B.Slim Amersfoort in 2014. Inhoudelijk en financieel verslag [B.Slim Amersfoort in 2014. Substantive and financial report]	Evaluation Report	K
2015	Actieplan B.Slim 2015-2017 [Actionplan B.Slim 2015-2017]	Action plan	L
2016	B.Slim in 2015. Inhoudelijk verslag [B.Slim in 2015. Substansive report]	Evaluation Report	M
2017	B.Slim Amersfoort in 2016. Inhoudelijk verslag [B.Slim Amersfoort in 2016. Substantive report]	Evaluation Report	N
2018	B.Slim Amersfoort in 2017. Inhoudelijk verslag [B.Slim Amersfoort in 2017. Substantive report]	Evaluation Report	O
2018	Evaluatie B.Slim. Projectperiode 2015-2017 [Evalution B.Slim. Project period 2015-2017]	Evaluation Report	P
2018	B.Slim. Werkblad beschrijving interventie. [B.Slim. Worksheet description of the intervention]	Certification worksheet	Q
2018	Plan van aanpak B.Slim 2018 [Action plan B.Slim 2018]	Action plan	R
2019	Jaarverslag 2018: Groen Doet Goed en B.Slim [Year report 2018: 'Groen Doet Goed' and B.Slim]	Evaluation Report	S
2019	Plan van aanpak 2019-2021 [Action plan 2019-2021]	Action plan	T
2019	B.Slim Jaarplan 2019 [B.Slim Action plan 2019]	Action plan	U
2020	B.Slim: terugblik activiteiten 2019 [B.Slim: review activities 2019]	Evaluation Report	V
2021	B.Slim: Jaarverslag 2020 [B.Slim: Year report 2020]	Evaluation Report	W
2020	B.Slim Jaarplan 2021 [B.Slim Action plan 2021]	Action plan	X

Box 2
Guiding questions for the analysis

Overall question: how do these documents together perform the day to day practices of CBHP?

Background, purpose and context
- Where does this document come from?
- With which purpose was it made?
- How are accounts other than that of the author(s) included in the document?
- Who is its intended audience?
- How does the document incorporate its context?
- How does the document intervene upon its own context?
- How does the document make links between actors, arguments and events, and construct new contexts?

Performing CBHP
- Who brought CBHP into the document, and for what reasons?
- How does the document, its procedures and tools work upon CBHP?
- Does the document transform CBHP into another issue? By means of which tools?

Performing objects and agents
- How are concrete agents and objects – participatory communities and health – turned into document issues, and with what effects and consequences for the agents and objects at hand?
- How was the community involved or consulted in the construction of participatory communities and health?
- What numbers are used, which stories do they tell about CBHP, participatory communities and health?
- Which graphs and other textual devices are used, and how does it affect the interpretation of the topic they concerns?
- Which forms of action do these tools propose as necessary?

4. Results

I analysed how B.Slim performed CBHP. During the analysis of the selected documents, I paid special attention to how the tools and methods used by B.Slim, and how these tools were related to the infrastructural networks in which B.Slim exists. Instead of analysing what B.Slim intended to do and to assess whether they have fulfilled these intentions, I analysed how B.Slim's methods and tools produced a specific reality. My analysis is thus not critical in the sense that I compare what B.Slim says with what they do, but it is constructivist: I study *what* they do, and *how* they do it, and I reflect on the performative effects of these actions – also, but not only, in relation to discussions about CBHP.

The analysis showed that hybrid entanglements of networks and tools were operative in performing the CBHP-approach of B.Slim, Bureaucratic-infrastructural formats, epidemiological tools, concepts, questionnaires, and other tools together made B.Slim's CBHP-approach. In the analysis I identified five performative effects of this hybrid entanglement, namely the making of 1) an top-down determined risk group; 2) an area of problems; 3) a deviant target group; 4) unmotivated consumers; and, lastly, 5) a muted target group. The analysis shows the large amount of work that is being done in the long-term intervention practice of B.Slim to make people 'move more and eat better', but also highlights the unintended performative effects of the program beyond – and even instead of – its original goal to work from a community approach.

4.1 Making a top-down determined risk group

In this section, I first analyse how the administrative and scientific landscape of B.Slim made that what started as a community approach, ended up as a project focused upon a top-down defined target group. Then, I show how a mix of tools expanded the original target group, while the people in this group were not granted an opportunity to self-identify as a community.

B.Slim defined itself as a community approach: 'B.Slim's activities are based on the perceptions, wishes and needs of the target group (community approach) and a balanced mix of activities' (e.g. A, p. 2; C, p. 2; I, p. 9). In most of its evaluation reports, B.Slim the guiding principles for its community approach were outlined (box 3), and it is here that the community of B.Slim is introduced as a 'target group'.

Box 3
Guiding principles of B.Slim's community approach (A, p. 2. Translated by ID, emphasis added)

Guiding principles of the community approach:
- small-scale, easily accessible local activities in the own neighbourhood/area;
- in which the *target group* closely participates and activities meet their wishes and needs;
- which are connected to already existing initiatives, structures and groups;
- shaped in an outreaching manner, bringing both existing as well as new activities closer to the *target group*;
- by means of an intersectoral approach

Throughout the documents that provided the details of B.Slim's community approach, the concept 'target group' was consequently used, for instance in phrases such as:

'Keep connecting to the *target group*…' (A, p. 11)

'We successfully reached the immigrant *target group*…' (A, p. 20)

'B.Slim has been received positively in all neighbourhoods, both by the *target group* as well as by the main cooperation partners.' (B, p. 30)

'The interventions are geared to the *target group*…' (I, p. 2)

The replacement of 'community' by 'target group' is not uncommon in the academic and organizational landscape in which B.Slim was developed: there are many examples of articles on community-based health interventions in which this happens (e.g. Mielck et al., 2003; Prantl et al., 2011; Ramanadhan et al., 2013).The term 'target group' is utilized by the Dutch National Institute for Public Health and the Environment [RIVM] in its Register of Certified Health Interventions. Every organization or other entity that wishes to have a public health intervention formally recognized has to submit a detailed description of the intervention to the RIVM, formatted according to the RIVM's worksheet 'Intervention Description'

(RIVM, n.d. b). The questions of this standardized submission form are informed by handbooks such as *Planning of Health Promotion Programs* (Bartholomew et al., 2016) and *Gezondheidsvoorlichting en Gedragsverandering. Een planmatige aanpak.* [Health Education and Behaviour Change. A Planned Approach] (Brug et al., 2016), in which terms like 'target participants', 'target group', 'target group' are used interchangeably with 'community'. Following the steps of these models of planned promotion, the form demands a description of the 'target group' of the intervention.

From 2012, B.Slim was included in the Register of Certified Health Interventions and used the RIVM worksheet to describe, according to the worksheet's format, its community as target group (Q, p. 14):

Box 4
Description of B.Slim's target group on the RIVM worksheet (Q, p. 14, Translated by ID)

1.1 Target group
Ultimate target group – max 100 words
What is the ultimate target group of the intervention?
B.Slim is aimed at all children between the ages of 0 and 18 and their parents/caretakers who live in neighbourhoods where mostly residents with a low socio-economic status and/or a non-Western migration background live, the groups in which obesity is more common.

Hence, the RIVM recognition procedure required to label 'community' as 'target group'. While this terms might appear as neutral terms to describe the same group of people, the use of the latter instead of the former is not without consequences. Determining a 'community' is associated with an informal, bottom-up and participatory approach in which the community is invited to define itself. Selecting a 'target group', controlled by institutional choices and without consultation of this population, in contrast, is an (implicit) top-down approach that avoids discussions on identity and community spirit (Turner, 2009).

Over the years, a mix of research tools expanded B.Slim's target group and reified it as an administrative and top-down determined entity. As outlined earlier, the GSB funding made that B.Slim started as an intervention for children from 0-19 years old. Informed by the World Health Organization's population-based approaches to childhood obesity prevention (2010) and its Global Strategy on Diet, Physical Activity and Health (2017), B.Slim stated that it is of 'uttermost importance to start prevention of overweight as early as possible', because 'the longer unhealthy lifestyles exist, the harder it is to change it'

(P, p. 15). Indeed, during the first years, B.Slim directed its activities at breastfeeding mothers (B, p. 10), toddlers at day care and children at primary schools. In 2009, however, the initial funding structure expired (C, p. 26). From then, other forms of funding were sought and found, and the restriction to focus the intervention on children disappeared and more and other groups of people were added to B.Slim's target group. First, in 2009, in response to a gynaecologist's speech about the health risks of obesity during pregnancy, pregnant women and children from the age of -9 months were added to the target group:

> Then Jitze Duk, gynecologist at the Meander Medical Center took the floor. He stated that obesity is a major problem among young people, and that interventions should start as early as possible: among primary school children, among toddlers, but even among pregnant women. A B.Slim plan for pregnant women must therefore be established. (D, p. 32).

Indeed, in the following year, B.Slim set up a task force 'obese pregnant women', and from 2011 these women were added to the target group (E, p. 21; F, p. 1). In the same year, it was decided to include youngsters from 12-19 years old in the B.Slim target group, specifically those at the lower levels of the Dutch high school system[5] (F, p. 51). This choice was informed by statistics provided by the Municipal Health Services' 'Monitor Youth Health' [Monitor Gezondheid Jeugd] and its 'Youth Health Registration' as these reports indicated that overweight was more common amongst these pupils than amongst those at higher educational levels (Q, p. 7).

The target group also expanded twice through B.Slim's cooperation with other local social initiatives. In 2011, after contact with the Director of Stadsring51 [Citywall51], a regional debts assistance organization, participants of the (obligated) municipal Social Services' budgeting course were added to B.Slim's target group. Although the participants of this course are not cited in the list of target groups in the B.Slim worksheet (Q, p. 6-7), this group was mentioned as additional risk group for overweight and as target group for the B.Slim message from 2010-2017 (e.g. K, p. 59; M, p. 15; P, p. 4). By means of the same tool - cooperation between social initiatives -, elderly became included in the target group of B.Slim. In 2014, B.Slim organized an information meeting for elderly via Sociaal Vitaal ['Socially Vital'], an

[5] In Dutch, these schools are referred to as: 'VBMO-scholen', 'Praktijkscholen' en 'ROC's' (F, p. 51)

organization that aims to improve the physical activity of 'elderly people with a low educational degree and/or low income, aged 60-85, who are insufficiently physically active, are lonely and have little resilience to cope with aging' (Kenniscentrum Sport en Bewegen, n.d.). After this information meeting, B.Slim not only refered to elderly as caretakers of the children in their target group, as it did earlier (e.g. A, p. 5; B, p. 12), but as a target group itself (K, p. 16,; see also X, p. 2):

> In 2014, the project Sociaal Vitaal started in the Liendert/Rustenburg district [one of the priority neighbourhoods], aimed at inactive, lonely seniors. It was examined how a link could be made with the B.Slim program, as Sociaal Vitaal reaches the grandfathers and grandmothers of the children.

This analysis shows how a combination of tools – epidemiological statistics, the RIVM form, expert knowledge, and cooperation with other initiatives – reshaped and expanded B.Slim's initial community into a much broader target group, defined in terms of healht risks. These enlargements reified B.Slim's top-down approach to determine its community: the inclusion of these new groups was decided on the basis infrastructural tools and the peoples' (assumed risk at) overweight, rather than by means of self-identification. In effect, B.Slim constructed a target group that had no say in its construction and, as I will show in the next section, that not recognized itself as such.

4.2 Making an area of problems

In the previous section, I have demonstrated how the infrastructural networks of B-Slim entailed that what started as a community approach ended up as a project that focused on specific top-down determined risk groups. In this section, I show how national categories made this target group into a geographically located area, categorized it as inherently problematic regions. I show how this problematization coloured B.Slim's view on their target group, up to a point where all its socio-economic characteristics where considered as problematic and the potential existence of capabilities or assets was not considered anymore.

From the onset, B.Slim adopted the administrative category 'priority neighbourhoods' [prioriteitswijken] (A, p. 2). This term was coined in 2003 by the then Minister of Housing as classification

of the 56 Dutch neighbourhoods ranked highest on an index for 'cumulated liveability problems', such as a lower incomes, small and old housing, nuisance and vandalism, noise pollution and a low housing satisfaction (VROM, 2003; Vogelaar, 2007). The goal of this policy was to improve the quality of live in these neighbourhoods through social policy and restructuring of the public space (Leidelmeijer et al., 2010). In the town Amersfoort, too, various blocks were designated as priority neighbourhoods: Kruiskamp, Koppel, Randenbroek and Schuilenburg (Monitor Leefbaarheid en Veiligheid, 2019, p. 5).

At the time of B.Slim initiation, Amersfoort was part of the Dutch Grotestedenbeleid ['large cities policy'] – a partnership between ten government departments and the 31 biggest Dutch cities. with the aim to improve urban liveability. Every five year, state subsidy was then provided to each city, which could be spend at their own discretion (Vogelaar, 2018). In 2005, the reduction health inequalities was one of the priority areas of the partnership, and it was agreed that the grand received had to be spend to keep the percentage of overweight amongst children from 0-19 stable during the funding period, from 2005-2009 (Klink et al., 2009). The municipality of Amersfoort asked the regional GGD [Dutch acronym for Municipal Health Services] to design an action plan to fulfil this goal. The GDD then, advised the municipality to start the project in one of its priority neighbourhoods, since 'these neighbourhoods are characterised by families with a low socioeconomic status and a large number of immigrants, populations amongst whom overweight common' (A, p. 2).

Over the years, B.Slim expanded its program to the other blocks in the municipality that were categorized as priority neighbourhoods. Interestingly, B.Slim included these blocks and referred to them as 'priority neighbourhoods' long after this term disappeared from Dutch policy practice. In 2007, a new minister of Housing replaced the concept 'priority neighbourhoods' by that of 'Krachtwijken' [potency districts] (Stuiveling, 2008). From then, Amersfoort had only one neighbourhood categorized as such, Kruiskamp (Heckman et al., 2007). In 2012, Kruiskamp was removed from the list of Krachtwijken, due to improved liveability in the area. While these changes in categorization gained national attention (e.g. De Vries, 2012), nothing changed for B.Slim, and it remained referring to its target group as residents of 'priority neighbourhoods' in its newest documents (e.g. V, p. 5; X, p. 3).

The adaptation of the category 'priority neighbourhoods' is consequential for how B.Slim constructed its target group. First, by adopting the policy category 'priority neighbourhoods', B.Slim also embraced the negative connation that comes with this term. In the Netherlands, priority neighbourhoods

are 'known' as areas in which all kinds of problems concentrate, and often priority neighbourhoods are referred to as 'probleemwijken' [problem areas] or 'achterstandswijken' [deprived neighbourhoods] (e.g. Leidelmeijer et al., 2010). Frequently, B.Slim does the same: it assumes all kinds of problems in its priority neighbourhoods on the basis of its classification as such. For instance, in 2014, the authors stated (slightly confusingly formulated) that 'the expectation was that external factors and barriers would stand in the way of positive behavioural intentions among families in the Kruiskamp/Koppel district [one of the priority neighbourhoods], *because* barriers and external factors play a major role in this district, given the LSES and/or immigrant origin of its residents' (I, p. 22, emphasis added). Here, the authors say that *because* the neighbourhood is inhabited by LSES and immigrant families, problems are to be expected.

Fuelled by the use of the category priority neighbourhoods, problems, rather than strengths and abilities, became B.Slim's focus. This becomes particularly visible in how B.Slim informed itself about the neighbourhoods where its target group was geographically identified and where the interventions should be implemented. For instance, in 2011, the organization wanted to get 'a first impression' of het Soesterkwartier, a priority neighbourhood newly added to B.Slims target population. To that purpose, B.Slim asked its intermediaries[6] the following questions (F, p. 26):

1. Do you recognize the problem of overweight amongst children (0-19) in this neighbourhood?
2. What do you think is the main cause of the increasing obesity rates among children in this neighbourhood? What are the specific problems in this neighbourhood?
3. What do you think are barriers for parents to eat healthy and to make their children physically exercise? And what are the chances?
4. What wishes and needs do you think parents have when it comes to healthy food and physical exercise for children?

Hence, consistent with the negative image of priority neighbourhoods, B.Slim's 'first impression' of its target group is informed by questions that solely focus on problems and needs, not on assets, capabilities and resources. The only exception is the question on 'chances' for healthy behaviour. The answer to this

[6] Professionals working in the neighbourhood, such as the district manager and the community worker (F, p. 26).

question, however, only referred to external chances – the availability of playgrounds, soccer fields, a swimming pool and sports activities – rather than to chances and capabilities of parents.

At one occasion, B.Slim seemed to be aware of the negative connotation that clings to 'priority neighbourhoods', when they wrote that: 'Socially vulnerable target groups are often seen as people with a negative identity. It is argued that people who belong to a socially vulnerable target group are ignorant, can't do anything and are not open to change' (I, p. 23). However, in the next sentence, the authors, rather than questioning the generalization and adequacy of this negative image, stated that the neighbourhoods' inhabitants don't want to be associated with it, not that the generalization may be unjustified: 'This seems to be the reason that people do not want to admit that they have benefited from the project, because then the outside world would conclude that they are vulnerable or that they had done something wrong. Therefore, it is questionable whether parents really understand what the target group of B.Slim is' (I, p. 23).

Second, by adopting the category 'priority neighbourhood', B.Slim's target *group* became a target *area* with geographic boundaries defined by zip-codes , rather than a social community made out of real live interactions. While one may want to belong to a self-defined community of social relations, many people do not recognize themselves in nor feel attached to predetermined, administrative target areas. A short paragraph in one of the B.Slim documents, a study of students in Educational Sciences amongst parents in the B.Slim neighbourhoods, indicates that this is also the case in the B.Slim project. The authors wrote that:

> About 20% of all parents stated 'we are not the target group of B.Slim.' One parent, for instance, said: 'Maybe it's useful for immigrants. But I don't need it.' Another parent said: 'Maybe migrants hear more about the project, I don't know. Or maybe it's related to income. But I don't hear much about it.' This shows that there exists a perception amongst parents that the B.Slim project is only for immigrants, and it shows that people do not want to belong to this target group (I, p. 9).

Hence, the definition of a 'target group' defined as 'priority neighbourhood' resulted in the withdrawal of people who were, apparently, administratively included in this area, but who did not consider themselves as part of it.

The geographical identification of target population was strengthened by changing national policies and funding opportunities. From 2015, B.Slim was financed by the so called 'GIDS-gelden' [GIDS-fundings, GIDS is the Dutch abbreviation for Healthy In The City]. This money, made available by the Dutch Ministry of Health, was mend to reduce health inequalities at the neighbourhood level and had to be spend on interventions that fitted the Dutch 'Healthy District Approach' [Gezonde Wijk Aanpak] (Van Rijn, 2014). This approach aimed at strengthening the health and wellbeing of residents in a particular district, neighbourhood or village while involving community members in the design, implementation and/or evaluation (van der Lans, 2014; RIVM, 2018). With this funding, B.Slim's 'community approach' became conflated with the Dutch 'Health District Approach', and B.Slims conceptualization of community as neighbourhood became solidified. Indeed, the same principles as B.Slim earlier presented as the 'Guiding principles of the community approach' (2005-2006, p. 2) was listed in exact similar wording under 'District-oriented approach' in 2015 (2015-2017, p. 6). This didn't mean that the term 'community' disappeared. Rather, from 2015 onwards, 'community' and 'neigbourhood' or 'district' were used interchangeably. For instance, in 2018 B.Slim introduced itself as 'an integral and neighbourhood-oriented lifestyle program aimed at more exercise and a healthy diet' and stated that '[in order to reach the target group], a neighbourhood-oriented approach was chosen.' (Q, p. 1, 8, emphasis added. See also A, p. 6; R, p. 8). Thus, with the advent of the GIDS-funding and its Healthy District Approach, 'community' was truly made into 'neighbourhood', as there was no distinction between the two concepts anymore.

In this section, I showed how funding schemes demanded B.Slim to adopt the nationally used category 'priority neighbourhoods'. Also when funding structures changed and when, at the national level, the category 'priority neighbourhoods' was not used anymore, B.Slim stuck to this category. In effect, B.Slim's target *group* became a target *area.* While B.Slim acknowledged that inhabitants of this area might not want to be associated with the negative connotation that surrounds 'priority neighbourhoods', they did not question the origin or use of this category. Moreover, with the adoption of this administrative category, the negative image that accompanies it also travelled into B.Slim, problematizing the whole area.

4.3 Making a deviant target group

In the previous section, I showed how B.Slim's adoption of a political-administrative category – priority neighbourhoods – made its target group into a geographically defined and problematized target area. I showed the category coloured B.Slim's view on its target group in such a way that it became a population with no assets or capabilities, only with socio-economic problems. In this section, I focus on two tools adopted by B.Slim from its academic landscape - BMI and the Wheel of Five – to analyse how B.Slim's target group was made inherently problematic and deviant with respect to their weight and dietary pattern.

As highlighted in the previous section, B.Slim came into being with the financial aid of the GSB-iii subsidy of 2005. By means of this subsidy, overweight came to be the central issue for B.Slim: the funding came with the condition that it had to be spend on the stabilisation and/or reduction of overweight amongst children (Klink et al., 2009). To measure the weight of their target group and, hence, to determine the intervention's effect, B.Slim regularly evaluated participants' Body Mass Index (BMI):

> The BMI measures weight in relation to height and provides an estimate of the health risk at a certain body weight. Children up to 12 years of age can be considered overweight with a BMI between 17.34 and 26.67. With a BMI is above 26.67, there is obesity (K, p. 3).

> In order to evaluate the main goal of B.Slim, the weight and height of children in grade 2 and grade 7 of primary education and the second grade of secondary education are registered annually by the Youth Health Care. This allows the BMI to be determined so that the degree of overweight among young people can be monitored at the neighbourhood level (P, p. 20).

B.Slim adopted the BMI not as 'just' a measure of weight, but referred to it as objective instrument, that would neutrally determine the target group's health status and, hence, its compliance to B.Slim's messages. In an evaluation report of 2009 (D, p. 12), the authors wrote:

> It should be taken into account that participants may have provided socially desirable answers to the questions related to lifestyle. However, BMI and waist circumference[7] are objective measurements…

In addition to BMI as objective measure for health professionals, it was also deployed as tool to make the target group aware of their ill-health: in 2005 (A, p. 17) B.Slim handed out BMI-measurement tools in the priority neighbourhoods, and in 2009 women were taught how they could calculate their BMI in order to 'adjust their incorrect image of a healthy weight' (D, p. 5).

Using BMI as objective measure for health is a common practice in biomedical and other health related sciences. In these fields, as well as in popular discourse and the media, BMI is seen as *the* criterion to distinguish 'healthy' from 'unhealthy' weight (Saguy & Almening, 2008). In the Netherlands, the department Youth Healthcare (JGZ) of the Municipal Health Services (GGD) is responsible for the regular monitoring of the length and weight of children, and thus of the identification of overweight amongst children. Annually, regional JGZ sections measure the length and weight of school-age children. These results, then, are used to determine their BMI and form the basis for weight-related policy making (Kist-van Holthe et al, 2012). As the JGZ publishes its data on overweight and obesity at neighbourhood level (GGD, n.d.) it is not surprising that B.Slim used this data to determine the BMI of children in priority neighbourhoods (e.g. L, p. 3; O, p. 17; U, p. 9) and put this data in graphs to provide insight into overweight trends (fig. 1). Also in the epidemiological studies that B.Slim referred to (e.g. Kroon, 2011), BMI is used as convenient metric for identifying and monitoring the prevalence of obesity and overweight. Indeed, from a mathematical perspective, BMI is simply a ration of two facts of an individual – height and weight. However, it also defines a weight norm for boys and girls at each age[8] that allows to label them 'normal', 'overweight' or 'obese'.[9] These labels are informed by a normative model of health, premised on the existence of an 'ideal range' of good health and weight that should be attained (Gutin, 2018). Hence, B.Slim's reliance upon the BMI as objective diagnostic instrument of overweight facilitates an expectations

[7] In addition to BMI, B.Slim sometimes also used waist circumstance as a measure for healthy weight. However, since this happened less regularly, and since time and space do not allow to detail every aspect of the B.Slim intervention, I decided to leave waist circumstance aside in this analysis.
[8] In contrast to adults, who are considered 'overweight' when their BMI is >25, the definition of overweight amongst children is determined by age- and gender-specific cut-off points (Coole et al., 2000).
[9] While underweight is considered as 'abnormal' as overweight, B.Slim did not pay attention to underweight.

about normal and deviant weight and is a way to determine 'normality' and 'abnormality' (Jutel, 2009). As the children in B.Slims' target group were selected based on the average elevated high BMI in their neigbhourhood (Q, p.6), this 'unhealthy' and 'deviant' status was stuck on all neighbourhood children at once, regardless of their individual weight.

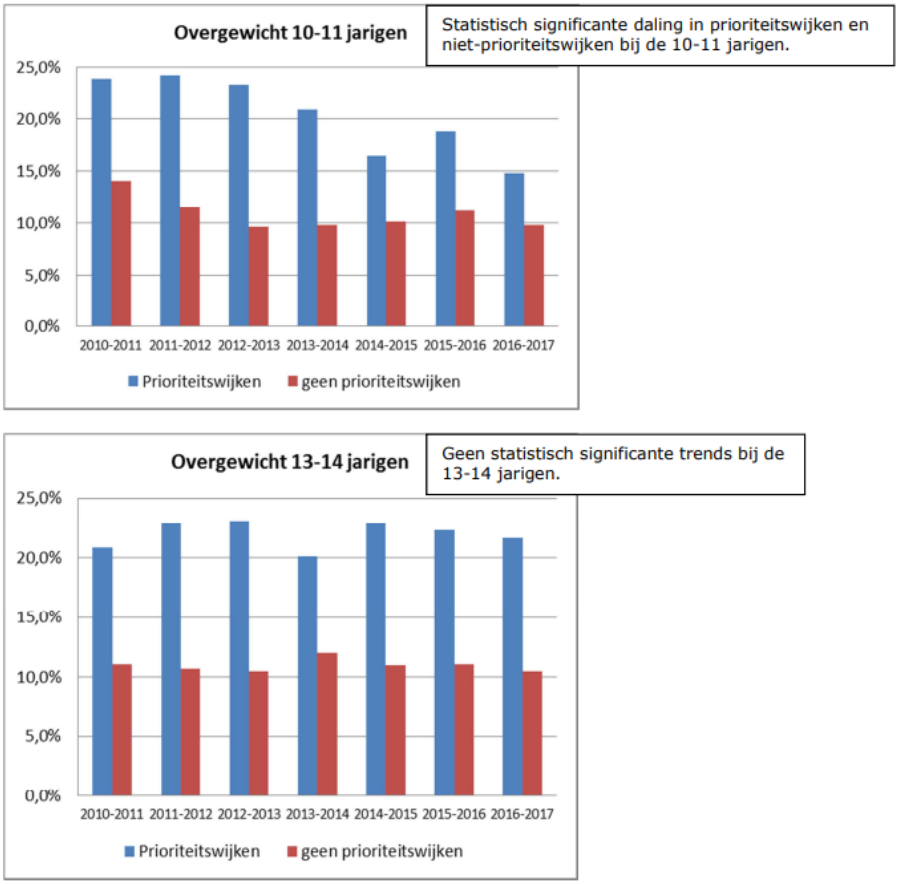

Figure 1.
Overweight amongst 10-11 year olds and 13-14 year olds in priority neighbourhoods (blue) and non-priority neighbourhoods (red) (A, p. 4)

A second tool that worked to make B.Slim's target population deviant is the so called 'Schijf van Vijf' [Wheel of Five]. Since 1953, the Dutch Nutrition Centre [Voedingscentrum] published various variants of this nutritional educational model. It depicts food items that should help people to divide their food into five nutrient categories.[10] The Wheel suggests, and the additional rules and explanations (Stichting Voedingscentrum Nederland, 2020) stipulate, that people should include all five categories in

[10] Currently these are: (1) grains and grain products; (2) fruit and vegetables; (3) meat, fish, tofu and milk; (4) oil and butter; (5) water and tea (Stichting Voedingscentrum Nederland, 2020)

their daily diets. In the Netherlands, the Wheel is considered a scientifically proven model for a health-improving diet (Stichting Voedingscentrum Nederland, 2020; Verried, 2021). Many generations are being raised with the model, and it is still widely known among the Dutch public (Vossen & Hoeymans, 2016). The Wheel, however, is not a neutral education model: it based on food norms as determined by the Dutch Health Council [Gezondheidsraad] which are defined as 'the average target values to consume enough of all nutrients' (Stichting Voedingscentrum Nederland, 2020, p. 77). In addition, the wheel entails the message that a diet should be varied and used as means to a 'healthy weight' (Mol, 2013; Vogel, 2018) and comes with the (implicit) norm that a 'good eater' is a rational eater: it is up to individuals to make the right – that is: varied, healthy – choices that fit the Wheel (Mol, 2013; Verried, 2021).

B.Slim adopted the Wheel as its model for a healthy diet (e.g. I, p. 4) and placed it at the centre of all its food-related activities: children were taught the Wheel's categories by doing games (e.g. A, p. 9; F, p. 6, 10); mothers were taught the food rules that accompany the Wheel (e.g. 2008, p. 6); after the workshop 'making healthy snacks' participants got a picture of the Wheel to take home (D, p. 13); and the Wheel was used to determine which foods should be available in a healthy school canteen (U, p. 11; also J, p. 58). Also, B.Slim often used the Wheel as evaluative tool to measure the effect of B.Slim activities on participants' knowledge: by means of a 'knowledge-quiz' on aspects of the Wheel, B.Slim tested how effective a certain activity had been (Box 5).

Box 5
Knowledge-quiz results (D, p. 24. Translated by ID).

1) 6 out of 8 participants knew what it means to have a varied diet;
2) Everyone knows that fibers make the intestines function properly
3) Everyone could identify which products contain unsaturated fats;
4) 7 participants know that you need toe at 4 serving spoons of vegetables each day;
5) 5 participants could list the components of a healthy diet;
6) 7 participants could name 1-3 rules of the Wheel of Five;
7) Everyone knew that there is a link between an unhealthy diet and obesity;
8) Everyone knew that food labels indicate whether a food is healthy or not.

The Wheel, thus, shaped B.Slim's activities and messages to a large extend and also informed the criteria for success of the B.Slim intervention: activities are regarded 'successful' if participants either lower their BMI and/or know the rules and components of the Wheel and behave according to them (2009, p. 24).

With the Wheel as only model for a 'good diet', B.Slim brought the Wheel's dietary norms and standards into the project. This was particularly visible with regard to the eating patterns of 'non-western' participants. Their eating habits were a recurring cause of concern, in particular their consumption rates of sugar and milk:

> [After the meeting] the women stated that they intended to use less sugar in Moroccan tea. One mother said that she intended to buy a maximum of 5 kilos of sugar a week, instead of the 10 kilos she purchases now! (2007, p. 3)

> Parents indicate that they find it difficult to reduce the consumption of milk. Many 3-year-old toddlers still drink a warm bottle of milk! (2011, p. 12)

> Many parents give their child much more milk than the recommended 300 ml. They think that milk is good/healthy: the more the better. The nurse has made the parents aware that too much milk isn't healthy either (2011, p. 12),

These phrases show that participants were expected to adopt the Wheel's ideal. They also indicate that discussion about other food habits or eating for other reasons than health – such convenience, or tradition – were not considered. In effect, migrant participants are made 'deviant', not only with regard to their weight, but also with regard to their dietary behaviours. Combining the Wheel's norms for healthy eating with socio-epidemiological findings about overweight amongst migrants, B.Slim made a 'deviant' non-western culture the cause of their unhealthy behaviour. That is, B.Slim repeatedly referred to the non-western food culture as the cause of their overweight (Q, p. 15):

> For the non-Western target group, cultural differences in dietary habits, lifestyles and ideas about health risks, play, among other things, an important role in the development of overweight or

> obesity. In the Turkish, Moroccan and Antillean culture, for example, being overweight is a sign of prosperity and they often have a different diet (Cornelisse, Maassen van den Brink, 2002; Yilmaz, 2016).

Even though it was stated that there are also 'other things' that cause overweight and obesity, the 'cultural differences in dietary habits, lifestyles and ideas about health risks' became the main focus of B.Slim to explain the unhealthy state of migrants, and references to these factors repeatedly occurred in the B.Slim documents. In effect, the Wheel's norm for a healthy diet overflew in the construction of a deviant 'non-western culture'.

Only twice, 'migrant foods' and the 'non-western food culture' were referred to in a positive sense, both in the same document. The first time was when a social worker recalled that one women and her daughter prepared a 'delicious meal of couscous' for the rest of the group (F, p. 16). The second notable exception is the evaluation of an activity in which participants cooked a healthy meal together. Here, the authors cheerfully write that it was 'by means of the cultural diversity', that the activity became a 'true culinary feast' (F, p. 20). Such positive statements about the 'non-western migrant (food) culture', however, were scarce, and were never made in relation to health. Also, at the initiative of three residents, a cookbook was published in one of the priority neighbourhood with recipes 'from various cultures,' supplied by female neighbourhood residents. However, the submitted recipes were assessed by B.Slim: only those that were considered healthy by these professionals were included in the book (B, p. 10).

In the case of LSES, it was not an (assumed) culture that was understood as cause of unhealthy behaviour, but low educational degree and lack of knowledge about healthy food. Referencing socio-epidemiological findings, B.Slim stated that: 'The lower the level of education, the unhealthier the lifestyle and dietary habits. the lower the level of education, the unhealthier the lifestyle and dietary habits. The level of education, knowledge and skills about one's own health play an important role here' (Q, p. 15). Given the fact that 'parental educational level' is used as indicator for SES (Q, p. 15) the expectation amongst B.Slim professionals was that '[parents'] knowledge about health behaviour would be insufficient and that they would pass this on to their children' (J, p. 19; also R, p. 15). Interestingly, a lack of knowledge about healthy behaviour is also ascribed to non-western migrants, but without any reference to their educational level is made: 'These [non-western migrants] lack Dutch language skills and have very little

knowledge about healthy food. Therefore, passing our message on to them is too ambitious' (A, p. 6; also Q, p. 15). Here, by stating that passing on their message is 'too ambitious', B.Slim made it almost impossible for its target group to comply to their norms for a healthy diet: they wouldn't understand, even if they are told how to eat.

By using BMI and the Wheel of Five, B.Slim medicalized and standardized health and health behaviour. Rather than considering the possibility that there are other forms of knowledge than that proposed by the Wheel, and rather than considering the fact that people might want to make food choices for other reasons than health - such as convenience, pleasure, religion or tradition - B.Slim, informed by the BMI, socio-epidemiological studies and the Wheel, made its target group inherently deviant with regard to weight, health, diet, culture and knowledge.

4.4 Making unmotivated consumers

As shown in the previous section, B.Slim adoption of BMI and the Wheel of Five in combination with references to socio-epidemiological studies made its target group into one with a deviant health status. I showed how the LSES lack of knowledge and the deviant migrant culture were made the cause of overweight. In this section, I analyse how an entanglement of tools made this target group into consumers, unmotivated to 'purchase' a healthy lifestyle and a healthy weight. Three kind of tools paid a particular large role in the making of an unmotivated target group, all related to B.Slim's mission to 'reach' the target audience with their message and to 'make them involved' with the program (I, p. 23): the FCB-grid, gadgets and fun activities, as well as mild pressure and control.

Community participation is important aspects of CBHP. Also B.Slim wrote that it was their guiding principle to 'let the target group participate closely and make activities match with their wishes and needs' (A, p. 2). The program used various tools to involve its target group, to which I return later. First, it is important to note that for B.Slim, the involvement of their target group was not self-evident: as people with LSES and/or migration background 'tend to have a low degree of involvement' (Q, p. 18). Unfortunately, no reference or further explanation for this statement is provided, but in in several sociology and socio-epidemiological studies to ascribe a lower involvement to LSES communities in all kinds of settings, as compared to their HSES counterparts (e.g. Humbert et al., 2006; Muijs et al., 2009; Walpole, 2003). Interesting, however, is how B.Slim responded to this 'low degree of involvement.' In 2018

(Q, p. 18), the authors explained that they used a psychological model, the FCB-grid, to better align with their target group's needs. Their (assumed) 'low degree of involvement' places the B.Slim target group in the FCB's "do-feel-learn" quadrant which, according to the model, means that their decision making process is driven by emotions: they do before they think. B.Slim used this tool to shapes its method to involve the target group:

> By approaching the target group in this way: first doing a healthy activity (do), then experiencing (feel) what it is like to behave healthy. By doing and experiencing they would learn (learn) and change their behaviour. Therefore, many B.Slim activities are designed to make the target group experience that behaving healthy is fun (…) (Q, p. 17).

B.Slim's choice of the FCB grid as tool to shape its 'involvement strategy' is an interesting one, since the tool is originally mend – and most often used – to explain consumer choices and to develop marketing advertisements. 'Involvement' in this model describes how important a certain product is for a consumer, and a low involvement means that a consumer finds the product doesn't care much about a certain product (Vaughn, 1980). By using the FCB-grid, for B.Slim made the neighbourhood inhabitants 'consumers' with a (too) 'low involvement' in the 'product' health. In this line of reasoning, the target group has to become more involved with health and to reach that, B.Slim has to 'market' health in an attractive way: 'It is important to present the activities in a festive manner, and to add a competitive element. That will motivate the local residents to participate' (F, p. 27). Hence, through the use of the FCB-grid, a 'participatory community' comes to be defined as a group of people involved in the B.Slim activities and, by means of the activities, in healthy behaviour.

Throughout the documents, many tools appeared by which B.Slim aimed to 'market' its activities and health. The amount of 'stuff' handed out by B.Slim is striking. Over the years, B.Slim handed out shopping cart coins, notebooks, fruit boxes, water bottles, magnets, books, bookmarks, bags, pedometers, frisbees, table tennis rackets, footballs, beachballs, juggling balls aprons, DVD's – and more, most with the B.Slim logo. In addition, B.Slim used 'fun-tools' to make both its activities and health attractive: there were a great number of food-parties, kickoff parties, closing parties, many activities were made more attractive by the use of garlands and balloons, B.Slim's mascot 'Slimpie' appeared at many occasions (fig.

4), B.Slim hero's – young local professional sporters – are employed to make physical activities more attractive, participants receive or learn to cook foods that are not only healthy but also tasty and many activities had a competitive element.

Both the gadgets and the fun activities served two functions: first, they had to improve the brand awareness for B.Slim amongst the target group (e.g. B, p. 20; E, p. 29; M, p. 10). At the same time, they had to motivate the target group to participate with both the B.Slim activities and with their own health. The fruit boxes (fig. 2), for example, were mend to give parents to their children fruit to school, instead of sweets (D, p. 22; E, p. 25); 'exercise gadgets' such as balls and skipping ropes were mend make children move more (E, p. 25); and the shopping cart coins together with the groceries note blocks (fig. 3) where mend to 'nudge' parents to buy healthy food (F, p. 47):

> B.Slim shopping cart tokens and B.Slim groceries note block are purchased to use for nudging. They remind parents subtly of the B.Slim message. Unconsciously, the pictures of fruit and vegetables will make people more inclined to buy these products.

Figure 2.
B.Slim fruit box (D, p. 37)

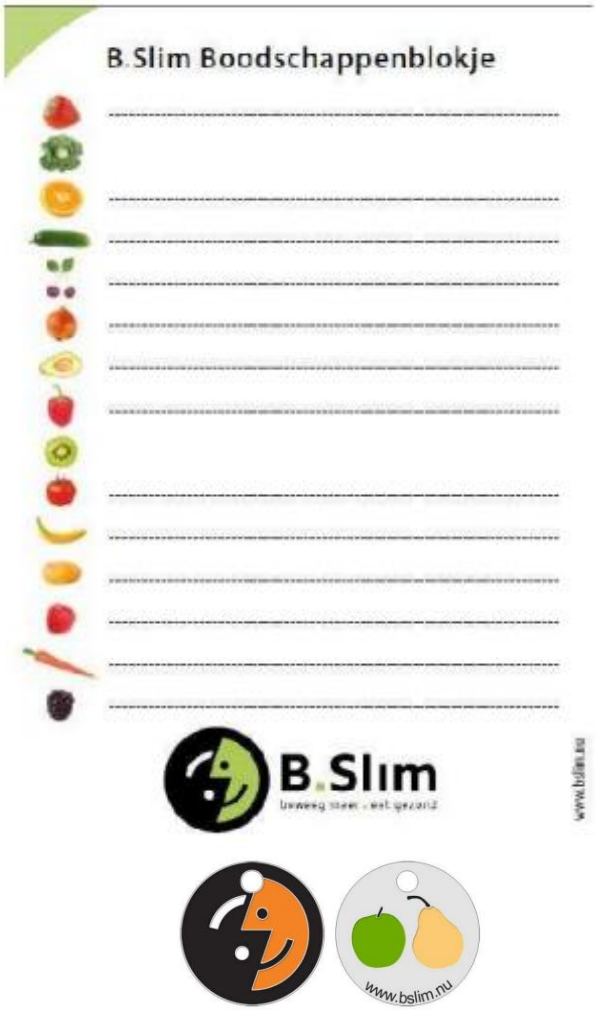

Figure 3.
B.Slim groceries note block and shopping card token (E, p. 47)

Figure 4.
B.Slim's mascot: Slimpie (V, p. 2)

B.Slim put a lot of effort to make their intervention fit the FCB-grid's logic: make people *do* healthy and make them *feel* it's nice, then they would *learn* and behave healthy – in other words, to make them participate with and involved in B.Slim activities and in health. This wide variety of fun activities and nicely designed gadgets demonstrate B.Slim's commitment and creativity to market health amongst its target group as something fun and attractive. At the same time, however, the activities and gadgets performed disappointment when the target group didn't seem want to participate. More than once, B.Slim's surprise and frustration about the lack of the target group's participation in both activities and health behaviour seeps through the texts. With regard to lack of involvement and participation in the B.Slim activities, the attendance rates that were a great source of disappointment:

- A lot of effort has to be made to enure that the parents attend the meeting. (A, p. 15)
- Many appointments are forgotten by parents, people often don't show up. (C, p. 14)
- (…) after the Ramadan, the participants struggled to get involved again. (D, p. 29)
- The child worker has to make a lot of effort to encourage the (immigrant) parents to join the exercises: they often just sit together [while the children exercise]. The activity ended with singing and dancing. Only then parents participate. (E, p. 12)

And the list goes on (e.g. B, p. 14; C, p. 15). In such cases, the low turn-out initially effected in more efforts at the side of B.Slim to make the target group participate, this time by contacting them personally (see also B, p. 16; C, p. 24; E, p. 10)

> Many efforts have been made to reach the parents: orally, by letter and they have been called by phone. Nevertheless, the turnout was disappointing. (B, p. 23)
>
> [the activity organizers] have called the parents on every meeting day in or to remind them of the meetings. A contract has also been drawn up with the parents. Nevertheless, the turnout gradually decreased. (B, p. 25).
>
> The dietician and social worker called the parents very often and tried to motivate them, which turned out to be only partly successful. (D, p. 31)
>
> Unfortunately, we were unable to reach the parents. This despite the fact that members of the residents' committee personally went to their houses in person. (D, p. 10)

When the additional efforts at the side of B.Slim didn't have to result hoped for, B.Slim deployed its ultimate tool: mild pressure and control. For instance, it becomes forbidden to take cookies and sweet drinks to public meeting areas (e.g. Q, p. 26), and when 'many women dropped out' of the mothers' fitness group, the gym's registration system is used to map the number of sporting women and the frequency of their visits to the gym (B, p. 4). Also, when the involvement of parents of children who participate in the fit-today-kids program is 'too low', parental meetings are mandated: 'parental meetings are a condition for a child to come and play sports' (B, p. 26). In this particular case, the use of compulsion as tool was particularly striking, since it is noted that 'According to the implementers, the main reason why parents did not come were: not being able to find a babysitter, work shifts, and unexpected visits, for instance from grandpa and grandma'. Hence, while parents might have had organizational reasons to not join the meetings, their absence is made into unwillingness that could have been solved through compulsion.

Taken together, the documents give a clear picture of the tools used to make the target group participate. Based on the FCB-grids' logic, B.Slim tried to make its target group participate in its activities 1) by marketing them in an attractive and fun way, and by handing out lots of free materials; 2) by making extra efforts to make participants not forget to show up and 3) by putting in place tools of mild pressure and control to show up. These efforts and tools resulted in a situation in which participants made into non-engaged consumers: the 'known' 'low degree of involvement' of the target group remained. This, according to B.Slim, made their overweight a 'persistent problem' (G, p. 51).

4.5 Making a muted target group

In the previous section, I showed how tools that were mend to make B.Slim's target group participate – both in B.Slim's activities and in healthy behaviour – turned out to have the opposite effect: it made its target group unmotivated and non-participating. In this final section, I focus on how the target's group voice is performed in the design, implementation and evaluation of B.Slim. By analyzing the tools that B.Slim used to grand its target group voice, I show that actually the opposite happened: B.Slim made target group with muted voices

Community voice and representation are central aspect in CBHP to empower communities. Also B.Slim aimed to work 'in consultation with the target group' (Q, p. 17). Over the years, various tools were deployed to 'consult' the group. In most occasions, it was chosen to let the target group be represented

by health professionals. That is: the B.Slim were informed about the target group by the professionals that were considered to represent target group. This happened in both the design, the implementation and the evaluation of B.Slim at large and in its particular activities.

B.Slim was designed by professionals from the start. As outlined earlier, the request to develop a prevention program for children with overweight, made possible by means of the GSB-funding, came from the municipality of Amersfoort – not from citizens. The municipality then asked the Municipal Health Services to 'make an action plan' (A, p. 2). The Municipal Health Services, at their turn, gathered a group of health professionals, referred to as 'chain partners' [ketenpartners]. All these partners were professionals in the field of health and social care organizations, amongst which the regional General Practitioners' Association, the local hospital, and mental health care organizations. Then, the coordination committee [regiegroep] 'Prevention of overweight amongst children' was appointed:

> In February 2005, the B.Slim steering group 'prevention of overweight amongst children' has been established. Since then, the steering group met six times. (…) In addition to the steering group, various working groups started to work on further elaboration of the project. (A. p. 19)

This document did not further specify the members of the committee, but the evaluation document of 2009 shows that it consisted of organizations located in various neighbourhoods in Amersfoort:

> The members of the steering group are very satisfied with the collaboration between the various organizations. Every organization realizes that the problem of overweight cannot be tackled by one organization on its own, but that we really need each other. By means of our collaboration in the steering group, we jointly look with a helicopter view at the problem twice a year, which is very important. (D, p. 34)

The same happened in the B.Slim's activities: they were initiated and designed by (health) professionals. The earlier mentioned pilot for 'obese pregnant women' is a good example: when a health professional, a gynaecologist in this case, suggested that obesity interventions should include pregnant women, B.Slim instantly decided to design an intervention aimed at these women (D, p. 32). The task

force 'obese pregnant women was created the next year, with as its job to 'develop a plan that focuses on healthy eating and staying physically active during pregnancy' (E, p. 21). Further, the task force sought support amongst midwifes in the B.Slim neighbourhoods, and determined pilot goals, such as the goal to 'support 20 pregnant obese women by a lifestyle advisor, by means of personalized care plans (aimed at food, exercise and behaviour). The goal is that 80% of the pregnant women complies with the care plan' (E, p. 21). Striking in the setup of the pilot is the fact that obese pregnant women were included in the pilot design as the ones who need to be 'motivated to go to the lifestyle coach', and to 'comply with the personalized care plan' (F, p. 44; G, p. 43; H, p. 45). Over the years, it was the task force that kept track of the pilot's state of affairs: 'In order to judge whether the pilot has achieved good results, the task group has developed a number of evaluation forms with the help of the epidemiologist of the GGD (E, p. 44; see also F, p. 43).

Another example is the mothers' meeting group 'talking about your baby'. This group was initiated by district nurses – as far as we can understand from the documents without consultation of the mothers for whom this meeting group was designed. In 2005, the authors noted that the meeting group had not been started yet: 'There were many mothers interested, but the fact that the course consists several meetings probably discouraged them to register (threshold too high)' (A, p. 12). Based on the assumption that it was the duration of the course that kept mothers from signing up, B.Slim decided to shorten the course to only two meetings. In 2007 however, again no single mother subscribed. In reaction, B.Slim decided for another approach, namely individual consults at the dispensary:

> 'Moms with babies are offered three extra consultations in which they discuss the usefulness of breastfeeding during the first 6 months after birth, supplemental feeding only from 6 months onwards, parenting questions such as dealing with crying babies and the importance of physical exercise.' (B, p. 10)

While some women participated, the attendance rate remained disappointing:

> With a lot of effort from our side, a total of ten children and parents appeared at the three dispensaries [that offered the extra consultations]. The district nurses have invested a lot in the

> recruitment of parents, but apparently there is no urge amongst the parents to join. It seems like they can ask all their questions in the regular dispensary visits. (B, p. 10)

In the end, B.Slim concluded:

> We could only provide ten parents with advice and guidance related to nutrition and physical exercise. Therefore, we decided to not continue with this activity. There is not enough support amongst the target group. (B, p. 10)

Interesting in the process of development, implementation and evaluation of these meetings is that B.Slim based all its decisions on assumptions on the motives and considerations of its targets group, rather than that they talked with them and asked for their wishes, needs, and suggestions. They made them stay away and constructed lack of support and interest.

The examples described above are no exceptional events. The B.Slim intervention is laced with professionals talking about, making decisions for, developing programs for, and evaluating the status of its target group. In addition to the coordination committee and the 'obese pregnant women'-task force, there are more of such groups, amongst which the task force 'primary neighbourhood based prevention' (H, p. 45; F. p. 44), the task force 'programmatic intervention' (F, p. 44), a management group headed by the alderman (M, p. 18; Q, p. 21; S, p. 12). Characteristic for all these groups is that they consist of nurses, general practitioners, physiotherapists, dieticians, midwives, paediatricians, sports' coaches, youth health care workers, and more – in short, all B.Slim's decision making groups consisted of health care professionals. Also at the various symposia that were organized throughout the years, only (health care related) professionals were invited as both speakers and as audience (e.g. E, p. 21; H, p. 43).

Sometimes, B.Slim referred to 'partners in the neighbourhoods' [wijkpartners] with whom activities were designed and implemented (e.g. M, p. 21; U, p. 2). However, these 'partners' were no neighbourhood inhabitants, but neighbourhood-located companies, such as day care institutions (e.g. M, p. 6, 8), organizations for environmental education (S, p. 1), supermarkets (R, p. 8) and the local zoo (R, p. 8). The same goes for the so called 'key figures' [sleutelfiguren]. Repeatedly, key figures were mentioned

as B.Slim's consultants on neighbourhoods' needs: at some points, the activity plans were made based on their input:

> By means of key figures, who work closely with the target group, residents' participation is increased. They are granted the opportunity to contribute ideas within the themes such as healthy eating, and offer input for the direction and concrete form of activities, as well as their wishes (Q, p. 6, see also B, p. 11; C, p. 1; F, p. 46; G, p. 12).

While these key figures were no health care professionals, they were no neighbourhood inhabitants either: the group consisted of community workers, sports coaches, youth workers (F, p. 35) and the professionals of the earlier mentioned 'networkpartners, the neigbourhood-located companies and organizations (T, p. 5). Also, these key figures are designated by – again – health care professionals, not by neighbourhood inhabitants (E, p. 26; fig. 5).

Figure 5.

The health care professionals who appointed the key figures (F, p. 26)

From 2012 till 2017, B.Slim had public-private partnership with the largest dairy company of the Netherlands, FrieslandCampina (G, p. 44; N, p. 20; fig. 6). Through this partnership, FrieslandCampina's message that milk and other dairy product fit in a healthy diet, permeated B.Slim's activities. For instance, on World Milk Day, FrieslandCampina organized a 'milktour' for primary school children (G, p. 12), the company provided (chocolate) milk for primary school breakfasts (2013, p. 24) and during B.Slim activities (H, p. 29) and handed out their leaflet 'Milk is good for your body' at various B.Slim activities (G, p. 31). This emphasis on milk as part of a healthy diet is striking: in the year before the public-private partnership B. Slim had stated that 'milk is not necessary [in a healhty diet].' This this comment was made after a discussion with parents about the amount of milk their children should drink. According to B.Slim:

> 'Many parents give their child much more milk than the recommended 300 ml. They think that milk is good/healthy: the more the better. The nurse has made the parents aware that too much milk isn't healthy either. Together, we concluded that milk is actually not necessary (F, p. 12)

B.Slim's target group thus had the same opinion on milk as the dairy company: milk is part of a healthy food pattern. However, when this opinion was expressed by the target group, B.Slim dismissed it, and when it was put forward by the sponsoring food industry, it was accepted and became part of B.Slims activities. In effect, B.Slim's partnership with FrieslandCampina reproduced existing power relations in which the interests, strategies and ideas of the food industry are rather dominant.

Figure 6.
Signing the contract between B.Slim and FrieslandCampina, April 2012 (G, p. 44)

A very few exceptions occurred in which the target group was consulted (more or less) directly. The first were the kick-off meetings in the several priority neighbourhoods (see also C, p. 16; T, p. 16):

> The first activity took place on November 8, 2005: a neighbourhood breakfast for parents in the Kruiskamp/Koppel district. (…) In order to meet the wishes and needs of parents, this group was asked to provide ideas and tips for follow-up activities. This information is also included in the consultation of key figures. (A, p. 3)

However, already at these kick-off events, originally mend to consult the neigbourhood inhabitants, B.Slim professionals started to provide advices on food and physical exercise:

> After the breakfast, advisors spoke in their own language with those present, taling about, among other things, the importance of having breakfast every day and playing outside. (A, p. 3)

> After the breakfast, a Turkish healthcare consultant and a Moroccan healthcare consultant talked to the parents and talked about, among other things. the importance of breakfast and the implementation of B.Slim in their neighbourhood. (B, p. 12)

Also, at one point, B.Slim mentioned to start a task force 'with people from the target group itself, who will play a collaborating role' (A, p. 6). This intention was formulated after it turned out that no one from the target group showed up to join B.Slim's promo-team:

> It was the intention that the promotion team would consist of people from the target group itself, also to give shape to the participation of the target group during the project. (…) Several people had been approached for the promotion team and had expressed their willingness to join, but only one father showed up. The following factors may have contributed to people dropping out:
> • When the fathers/mothers were approached, it was not specifically stated what the exact idea was. Instead, they were approached with a fairly general question: if they wanted to participate in the B.Slim project.
> • Subsequently, people were send a letter about what was expected from them. Maybe this scared them off. [11]

In 2007, the B.Slim promoteam included neigbhourhood inhabitants, so called 'guiding women' [wegwijsvrouwen], women who lived in the priority neighbourhoods and were trained by municipal agencies to help other women integrate in the Dutch society. These women could approach people in their own language' (B, p. 16), while distributing B.Slim goodie-bags to passer-by's. In 2012, these women took part in a food information meeting as translator and to share their own experiences with the participants women (G, p. 20). In these instances, however, these women were made into 'semi-professionals', sending B.Slims messages about healthy food to other neighbourhood inhabitants, not into a speakers talking with B.Slim professionals about neighbourhood experiences, concerns or insights. They

[11] Note, again, the many interpretations of the target group's behaviour.

talked, for instance, with passerby's about the high amounts of sugar in soda's (G, p. 20) and to explain the messages of dieticians (B, p. 20).

Second, B.Slim included parents' and childrens' assessments of activities in its yearly evaluation reports. Most often, this happened in the form of a 10-point grading system (see also C, p. 5, 6, 17: D, p. 13):

> The activity was rated with a 7½ (A, p. 11)
>
> The women rated this activity with an 8 (B, p. 18)
>
> On average, the tour was rated by the participants with an 8 (C, p. 9)
>
> It was a very successful meeting that the women rated with a 9 (D, p. 7)

Such ratings give the target group a voice, but one that is standardized. Also, the sentences in which the grades are mentioned commonly appeared with additional texts from the professionals that led the activities. These texts are about the target group's experiences, but seen through the eyes of the professionals and formulated in their terms:

> The meetings themselves went very well. Parents have many questions and are actively participating. (A, p. 15)

> What was particularly striking was the great enthusiasm of the children and the positive reaction of this immigrant target group to new sports such as rugby and korfball. (K, p. 8)

> The dietitian said [about the cooking workshop]: "It was a nice, sunny afternoon where salads were made and vegetables were stir-fried. The attendees participated enthusiastically. Herbs were even taken from home. After cooking we had dinner together, also with a few male residents! 1 young resident collected a large watermelon at home to hand out for dessert. Very nice. (K, p. 9)

> At the end of the morning it looked like all the ladies did their best during sports and exercise. They received a goodie bag with all sports options for women in Amersfoort. And now, let's get to work! (V, p. 2)

Such quotes outline the professionals' involvement with and commitment to B.Slim. However, with regard to the voice of the target group, two things happen here.

First, as said before, the opinion of the target group is performed as legitimate representation of the target group. In effect, B.Slim is not constructing a target group that speaks for itself or that is able to speak back. Second, in many of these quotes, professionals perform themselves in a hierarchical position: they position themselves in a position in which they are allowed to judge about the target group as 'participating well' or 'being actively involved'. At a very few occasions participants were allowed to speak for themselves about the activities they attended:

> After the gardening lessons, the children were asked what they thought of the vegetable garden project. Below are a few comments:
> • "I really enjoyed it. At first there was nothing at all. But later when we started sowing, all kinds of things had come out of the ground! Such as lettuce, red cabbage and white cabbage.
> • "We have learned a lot in the vegetable garden."
> • "I think the vegetable garden is really cool."
> • "I really enjoyed gardening. You could also make tasty things from the vegetables at home and the soup was delicious!!!" (E, p. 19)

> The quotes below give a good idea of what parents thought of the [dance] course:
> • "I thought the course was very successful. It is great that it is not only for the children, but really for parents and children together".
> • "We really liked the course. It's fun to watch the kids dance and grow." (E, p. 33)

> The evening [about cheap healthy food] was concluded with enthusiastic reactions: "I have gained inspiration", "I now look differently when I go shopping", "I have learned that I can also eat healthy with less money." (I, p. 34)

These direct quotes, that only appeared in 2011 and 2014, were not about a target group that 'needs to get started', nor about their attitude, knowledge or healthy behaviour. Rather, when given voice, participants talked about their (positive) feelings and experiences. These voices offer a very different picture of B.Slim's target group than those of the professionals.

The tools outlined in this section – the various kind of meetings and collaborations between health professionals and the dairy industry, the use of 'key figures' and 'guiding women', the kick-off events, the evaluations of activities by professionals, the interpretation of the target group's behaviour, and the ten-point grading system – were mend to grand B.Slim's target group voice, and/or to listen to their wishes and needs. However, these tools had exactly the opposite effect: they made the voice of neighbourhood inhabitants inaudible, and constructed inhabitants as a muted target group.

5. Discussion

In this thesis, I examined how the tools, practices and infrastructural network of CBHP perform CBHP interventions. To do so, I focused on how one particular health promotion intervention in the Netherlands, B.Slim, performed CBHP. In this section, I first will present a summary of my findings on how B.Slim performed its CBHP-approach, and with which effect. Next I will discuss the strengths and limitations of this study. Subsequently, I return to the STS literature that informed my study. Then, I will relate my findings to relevant discussions in the field of CBHP. Finally, I will draw my conclusion on how B.Slim performed CBHP, and what this means for the broader field of CBHP.

5.1 Summary of findings: performing B.Slim

Through careful and in-depth analysis of B.Slim's documents, I traced hybrid entanglements of tools and networks that were operative in the making of B.Slim's CBHP-approach. The epidemiological concept 'target group'; the category 'priority neighbourhood'; funding policies; requirements of funding and recognition bodies; the educational model of the Wheel of Five; BMI as measurement tool; epidemiological facts on the health of LSES and migrant populations; the psychological model of the FCB-grid; promotion materials such as garlands and shopping card tokens; attendance registrations forms, the public-private partnership with FrieslandCampina, and many other tools together made B.Slim's CBHP-approach. Through these tools the community was made into a geographically located group of consumers, with the same (assumed) problems, namely a deviant weight and dietary pattern, unmotivated to be involved with B.Slim and equally unmotivated to change their lifestyles. As B.Slim's tools also worked to make professionals' voices louder and to mute participants' voices, their CBHP-approach did not grant participants the ability to make themselves, their wishes, needs and constraints known and to participate in the project on their own terms. I showed how these tools did not appear out of nowhere, but entered B.Slim from the scientific, administrative, industrial and political infrastructural networks that the project is embedded in and to which it relates itself.

This analysis of B.Slim's approach shows that these tools were often an obligatory passage point in the infrastructural landscape of B-Slim. For instance, in order to qualify for national grands, B.Slim had to use the category 'priority neighbourhood'; to be registered as certified health intervention, B.Slim had

to describe its community as a 'target group'; and by inviting students in Educational Sciences to evaluate the project, B.Slim brought psychological models such as the FCB-grid into its practices. Moreover, these tools brought histories, norms and values with them that B.Slim took for granted: it accepted priority neighbourhoods as problematic areas; epidemiological quantitative outcomes as evidence about health; the Wheel of Five as the only norm for a healthy diet; a BMI below certain cut-off scores as the norm for health and good weight, and more.

While B.Slim's tools were used to build its community-approach, they had the opposite effect: they predefined norms for health, knowledge and practices and, as such, kept the meaning of these concepts out of discussion and conversation with the community. Also, the tools did not work to empower the community but, on the contrary, reified existing power differentials between (health) professionals and the target group, and reproduced the dominance of the food industry in health practices. It is not clear from the documents that B.Slim explored manoeuvring space and actually checked the obligatory character of these tools. In effect, the tools came to function as black boxes that performed B.Slim's CBHP-approach in a way that mirrors the individual lifestyle-approach that CBHP aims to counter. That is, B-Slim became a CBHP-approach with predetermined ideas on what the target group is like, instead of the opportunity for self-identification; a target group that was worked *upon*, instead of a community that was worked *with*; with a clearly defined idea of what health and health behaviour 'is', instead of openness to various definitions of health and a diversity of health behaviours; and with risks and problems as its focus instead of strengths and capabilities. In effect, the imported black boxed tools unintendedly made, what started as a community approach, into a health promotion intervention that is at odds with the values and principles of CBHP.

5.2 Strengths and limitations

First, my data set consisted of most of the documents that B.Slim has published, from the onset of the program up to the year of my study. There were, however, a few documents that I could not retrieve. These included the interview- and evaluation forms used at the start of the intervention in each B.Slim neighbourhood, as well as the program descriptions from before 2018. However, given the consistency in the large number of documents that I could analyse, I expect that inclusion of these documents would not have led to other outcomes. Second, my research methods did not include field visits or interviews with B.Slim professionals or with B.Slim participants. At many occasions, the documents brought on my curiosity, and I would have liked to observe health professionals' tinkering with the CBHP-approach and to ask further questions to them and the participants about their use of the various tools that I came across. This type of data could have provided more insights on how the performative effects of B.Slim's documents shape real life experiences with CBHP, both for involved health professionals as well as for participants. Third, time and space did not allow to elaborate on all the tools and networks that are available in the B.Slim documents. A large amount of theories, concepts and measures were used throughout the project, I only focussed on a number of them. However, I found no tools or networks that directed B.Slim's performative effect into another direction as the ones I described. Fourth, following tools and their performative effects over various sites is an aspect of document analysis that I did not consider. It would have been interesting to follow how the performative effect of B.Slim on CBHP travels by means of other document sites, such as newspaper articles, into the Dutch society. Such an analysis would be a valuable next step in examining the performative effects of tools and networks on CBHP and the people these intervention are concerned with.[12] Time and space, however, did not allow for such comprehensive analysis.

Despite these limitations, the thesis can be considered as an in-depth and relevant case study of CBHP-practices in the Netherlands: with its 16 years of existence, B.Slim is one of the few long-lasting Dutch CBHP-interventions. It gained significant publicity in both regional and national newspapers, and

[12] A first glance at newspaper articles on B.Slim suggests that such an analysis would be worth wile, as it seems that B.Slims construction of its target group as 'unhealthy', 'problematic' and 'deviant' is taken up in the media, in newspaper articles titled 'Leave fatteners, just eat normal' (Tomassen & Hoving, 2008), 'Allochthonous inhabitants of the problematic neighbourhood Kruiskamp go on a trip to the supermarket' (Mat, 2008a), and 'Dietician and sports coach teach fat inhabitants to lose weight' (Mat, 2008b)

serves as example for the development of other CBHP-interventions in the country. Today, B.Slim is not only carried out in Amersfoort, but also in the municipalities Baarn, Zeist and Soest (GGDRU, 2020), which indicates that the project is indeed used as format for new intervention programs, and has a considerable impact on the Dutch health promotion landscape.

5.3 STS: understanding the performative effect of B.Slim

In this thesis, I used insights of Science and Technology studies to study how B.Slim performs CBHP. This academic field offers the theories and methods to analyse how tools, embedded in infrastructural networks, have a performative effect on practices and, in turn, create social reality. In this section, I return to this body of literature, and employ three STS concepts to elucidate the performative effect of B.Slim's infrastructural network on its CBHP-approach: black boxes, obligatory passage points and contexting.

As outlined in the introduction, black boxes function to imagine as scientific facts as stable and uncontested, hiding their histories of contest and controversy (Latour, 1999). Yates-Doerr (2012) employed the black box-metaphor to explore the consolidation of dietary practices as facts. She showed how seemingly objective nutritional facts – for instance, 'fats and sugars are bad' and 'nutrients are good' – are black-boxed through a logic that does not care about context or the knowledge that individuals possess. Removing the context from mealtime experiences, nutritional black-boxes reduce meals and food stuffs to absolutes: they are either good or bad. In nutritional black boxes, foods take on absolute identities, Yates-Doerr concludes, like the universal and generalizable properties associated with numbers. As additional effect, the valuation of food as either 'good' or 'bad' assigns individuals to personal responsibility of following these 'self-evident' rules. While professionals have sought to establish these rules to simplify and expand the delivery of healthcare services, these attempts result in denigration of other perspectives on health.

Many of B.Slim's tools can be conceptualized in terms of the adoption of black boxes. That is: B.Slim relied on the 'factual' and taken-for-granted tools in its infrastructure to develop its ideas on health and healthy behaviour. This does not only count for its nutritional model, the Wheel of Five, but also for tools such as the funding schemes, policy concepts, RIVM forms, BMI, the FCB-grid, nudging strategies and epidemiological facts on the causes of obesity amongst LSES and migrant populations: in the academic fields from which these tools originate, they are treated as irrefutable theories, rules, facts,

methods and concepts. By adopting these black boxed tools, B.Slim also adopted their assumed factual and generalizable nature, leaving their complex and contestable nature untouched. In effect, standardized notions of health and health behaviour permeated the project's design and activities, leaving no space for discussion and conversation on the meaning of these concepts. As such, these black boxed tools proofed to be particularly ill-suited to perform a participatory approach.

Scholars in STS demonstrated how black boxes, infused with authority and legitimacy, easily turn into obligatory passage points that scientists must pass through in order to further their claims and establish accountability. By taking up black boxes, infrastructural networks set rules for addressing certain topics (Asdal, 2015; Latour, 1988; Latour & Woolgar, 1986). In this way, networks come to contain obligatory passage points that cannot be avoided (Callon, 1986). Such obligatory passage points are, for instance, the use of techniques, instruments and findings from epidemiology in public health practices (Shim, 2002). Adhering to these passage points, however, is not without consequences. Horstman (2020) showed how technologies of accountability functioned as performative obligatory passage points for health promotion. She described how a Dutch participatory health promotion project, in order to be eligible for funding, had to be registered as 'practice-based intervention'. To be registered, the project needed to provide a clear description of the evidence and techniques for behaviour change and of the effective elements of its intervention. In this way, Horstman holds, what had started as an intervention that provided a 'playground for new behavioural repertoires and celebrat[ed] a philosophy of ownership' (p. 597) turned into a method of standardized elements, disconnected from its local context. This example show how obligatory passage points in the infrastructural networks of health promotion interventions shape their design and practices in ways that the values of evidence-based medicine are met, rather than the principles CBHP. In this way, the ideals of evidence-based medicine and the public accountability culture permeate CBHP-interventions.

My analysis points in the same direction: many of the tools that made B.Slim drift away from its initial CBHP-approach were obligatory passage points in infrastructural networks that celebrated the quantitative epistemic culture of accountability. For instance, to be registered in the RIVM database, B.Slim had to describe it's 'target group', rather than its community. Also, the form obliged B.Slim to provide an overview of its 'effective elements' – it was here that many of the psychological tools, such as the FCB-grid and nudging, entered the intervention. Thus, the elements of evidence-based accountability

in their infrastructural networks are obligatory passage points for CBHP-interventions to be registered, acknowledged and funded. In effect, the principles of CBHP become overruled by the values of evidence-based medicine and what started as participatory intervention ends as individualistic lifestyle approach.

The third relevant STS-concept is that of 'contexting'. This verb was coined by Asdal and Moser (2012) to suggest that documents are actively taking part in the shaping their own context. They hold that 'contexts are made and performed' and that contexting 'takes part in enacting versions of reality, of worlds in progress, and of making some possibilities more real and others less so' (p. 303). My analysis confirms but also extends the observations of Asdal and Moser. The documents of B.Slim indeed actively take part in the construction of their own context: it is through references in the documents that B.Slim places itself in the infrastructural network of epidemiology, psychology, as well as Dutch policy and the Dutch food industry. Similarly, it is by means of quotes and pictures in documents that (health) professionals' voices drown out those of participants. My study highlights that contexting not only happens in and through documents. B.Slim's acts of contexting also take place in and through all its activities, meetings and materials. For instance, the FCB-grid placed B.Slim in the context of marketing psychology on paper, but physical tools such as the shopping card tokens and grocery note blocks did the same in the every day life of its target group. Hence, contexting is done both inside and outside documents, in the everyday reality of health promotion.

5.3 CBHP: understanding 'failed' community-interventions

B.Slim promoted itself as community-approach, but interestingly no relation was made in any of the documents between B.Slim and the academic field of CBHP, nor with the discussions in this field. The academic field of CBHP, in other words, was not part of B.Slims infrastructure. In this section, I bring B.Slim back to the context of CBHP by relating my findings on B.Slim to those of CBHP-scholars. It is not my aim to bring about norms for 'good health promotion' for B.Slim, but, rather, to show how discussions about CBHP help to understand B.Slim's performative effect on CBHP.

I am not the first to conclude that a particular CBHP-intervention does not bring the values of community-approach into practice. Various scholars in the field of CBHP have observed the same trend, and discussed the factors that draw CBHP-interventions away from CBHP-values and -principles. Most of them have focused on practical factors, such as the use of methods 'inadequate' for CBHP (e.g. Merzel &

D'Affliti, 2003;) and to 'insufficient' theories of community change (e.g. Merzel & D'Affliti, 2003; Tremblay et al., 2017). There are also CBHP-related scholars who looked at contexts to explain the struggle of CBHP-interventions to adhere to CBHP-values and to generate considerable effect in terms of social and health equality. Given my remarks in the previous section on B.Slim's acts of contexting, these observations are particularly relevant for this thesis.

Carter (2015) states that the existing neoliberal context in western countries form a dominant ideology that underly and shape CBHP-interventions. He argues that this political context turns community members into individual consumers, promotes individual responsibility for health and, hence, draws community-based strategies away from their principle of empowerment and equal participation between community members and professionals. According to Herens et al. (2016), local governance contexts are often not supportive for CBHP-interventions: their organizational dynamics, policy changes, staff turnover, lack of continuity, as well as their financial mechanisms, restrain community-based interventions. Gombert et al. (2017a, 2017b), analysed the meagre effects of a Scottish intervention to improve the nutritional state of formerly homeless young people. They found that elements in the socioeconomic context of these youngsters, such as poverty and peer pressure, restricted their ability to make (healthy) choices. The authors conclude that meagre attention in the intervention program to such social and economic contexts made it drift away from CBHP-values such as empowerment and equal participation. Seidell and Haberstadt (2014, 2020, 2021, see also Grootens-Wiegers et al., 2020; Wilderink, 2020) repeatedly emphasized that community-based obesity prevention should take into the 'contextual complexity' of overweight and obesity. For them, this means that not only the individual-level context (such as family histories) and the socio-economic contexts in which people live should be intervened upon, but also that food production systems (agriculture, horticulture and farming); natural contexts (biodiversity, climate and pollution), political contexts (taxes, regulation, legislation and subsidies); social contexts (education, social cohesion and social services), and the healht care system (wellbeing, prevention, food safety and food security) should not be ignored. In their perspective, CBHP aimed at obesity-reduction should intervene upon all these contexts simultaneously.

My study do not oppose the conclusions of these scholars - their observations might point at possible explanations for B.Slim's struggles to generate considerable effect in terms of social and health equality and to meet the principles of CBHP – but sheds new light on their findings. Namely, these

scholars take context as something that exists prior to the introduction of an intervention, and as outside of its control. Contexts are treated as givens with which CBHP has to deal. My analysis shows that the contexts in which CBHP is shaped are not just existing realities, but that CBHP-intervention actively context themselves and, hence, relate themselves to existing contexts and co-shaping these contexts. Also, in contrast to these CBHP-scholars who point at the broader ideological of social climate in which CBHP-interventions are implemented, my study highlights the role of material infrastructural tools as obligatory passage points – such as evaluation forms, gadgets, grand applications and partnerships – in how CBHP is performed. By adopting the tools from the scientific, political and administrative infrastructures in which they are developed, CBHP actively takes part in the construction of its own context.

My analysis illuminates that the CBHP-intervention B.Slim 'contexted' itself in the infrastructural network of epidemiology, psychology, as well as Dutch policy and the Dutch food industry. The tools used to shape the intervention all derived from these fields. The fact that B.Slim, as community-based intervention, did not context itself in the infrastructural network of CBHP is not as surprising as it might seem at first sight. Although the approach of CBHP has developed over the last three decades, it did not develop a material symbolic infrastructure. The conventional, evidence-based and individualist strand of health promotion is immersed in and build out of an infrastructural network of protocols, policies, technologies, standards, definitions, informatics, databases, reporting requirements and research designs, and it is embedded in a long academic tradition of biomedical, epidemiological and psychological research (Bolt, 2015). CBHP, in contrast, is characterized by an intentional lack of standardization: scholars in this field consistently stress that CBHP is an open process made to be adapted to social contexts and local needs, rather than a standardized formula (Brown & Stalker, 2018; Butterfoss, 2006; Peterson & Gubrium, 2011; Wallerstein, 2006). Some scholars have argued that CBHP should become more standardized in order to meet the requirements of 'conventional' evaluation measures (e.g. Faridi et al, 2007; Huse, 2020). Placed in the light of the STS literature, my findings suggest that this might not be helpful. Meeting the requirements of established infrastructures of accountability will create obstacles to aligning CBHP-practices with the values and principles that distinguishes this form of health promotion from its conventional evidence-based counterpart. At this moment, CBHP-interventions appear to have no choice other than to conform with the dominant structures, methods and rules of conventional epidemiologically-informed and evidence-based health promotion and a quantitative accountability

culture. The crucial issue, then, is how CBHP can do justice to its principles of self-definition, equality, complexity and community empowerment in practice? How can CBHP create a context in which she can deliver her promises? Another question is whether contexting in this sense is truly necessary for CBHP. As Horstman (2020) showed, there are examples of CBHP-interventions that deliberately ignore most epidemiological, evidence-based and political contexts. Rather than aiming to be nationally recognized examples of 'good interventions', they focus on local contexts of knowledge production and funding and, in this way, are able to adhere to CBHP-principles and values. However, it is the question whether staying 'local' could make CBHP a solid alternative to individualist lifestyle-approaches in health promotion.

5.4 Conclusion: contexting CBHP

In this thesis, I used concepts and theories from Science and Technology Studies to analyse how B.Slim performed CBHP. My analysis illustrates how B.Slim's context, with its black boxed tools as obligatory passage points, made the intervention drift away from its CBHP-starting point and made it into an intervention that at many points opposes CBHP-values and -principles. This, however, is only one part of the conclusion. Namely, the contexts of CBHP are not givens; CBHP-interventions take actively part in the process of contexting and as such, they produce and reproduce realities and power relations. My study also shows how CBHP-interventions actively construct their context by adopting the tools from the infrastructural networks to which they relate and in which they embed themselves. I showed how, in the case of B.Slim, this practice of 'contexting' moved the intervention away from its CBHP-values and -principles.

Contexting matters. Contexting takes part in the construction of version of realities, of making some possibilities more and others less so (Asdal and Moser 2012). Latour (1983) once argued that laboratories modifies society by moving key actors from the laboratory into the 'field', summarized in his famous saying: 'Give me a lab, and I will raise the world'. This study turns this idea on its head by demonstrating how existing 'worlds' (infrastructural contexts with their black boxed tools) shaped the B.Slim intervention, the 'lab' in this case. Thus understood, the 'outside world' performs the CBHP-approach of CBHP-interventions, instead of vice versa. In order to make its values and principles a reality, CBHP should enrich its discussions and research into the development of CBHP-tools with the development of CBHP-supportive contexts. As long as CBHP relies on and works with the material tools

of existing political, scientific and bureaucratic contexts CBHP-interventions might well be reproducing what they sought to counter: individualistic health promotion interventions in which participants remain unheard, uninvolved, unresponsive and unhealthy.

6. References

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