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Just one more cookie: An ethnographic study of subversion in weight-related health promotion in a Dutch fishing community

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1. Introduction

Dad, can I have a cookie?'.

'No, darling, you just had your breakfast'.

'But Daddy … just one, one very small cookie?'

'No, Suzy, you know the rules. No snacks after breakfast.'

'But Dad, Daddy, I am still hungry. Please! Daddy! Pretty please?

On a Tuesday evening, common childrearing dilemmas such as this filled the stage of the community center. A handful of parents had gathered to watch the interactive educational play '*Voor je het weet zijn ze groot*' ('They grow up before you know it'), a public health initiative targeting childhood obesity in Katwijk, a former fishing town on the west coast of the Netherlands. Just as little Suzy is about to continue nagging for another cookie, the actors stop the scene: "*What could dad do, in this situation?*" Silence. Murmuring. Mothers joking among each other. Until Clive (pseudonym), a father, shouts from the back of the room, "For goodness' sake, *just give that child another cookie!*"

Despite efforts to reduce obesity among youth worldwide, there is no sign that its prevalence is declining (Ahrens et al., 2014, 2021; World Health Organization, 2019). Even when interventions for childhood obesity are available, these are not always taken up by families (Anderson et al., 2019; Hoeeg et al., 2020; Kelleher et al., 2017; Mead et al., 2017; Teevale et al., 2015; van der Kleij, 2017). Rather, as shown in Clive's response to the cookie scene above, weight-related health promotion (WRHP) is often contested/protested. A powerful case of protest against WRHP was found in Katwijk, where obesity (BMI >25) is highly prevalent across generations. In 2020, the prevalence of obesity was 50% among adults aged 18–64 years and 18% among 2- to 14-year-olds. Among youth, obesity is particularly highly prevalent among 10- to 11-year-olds and 12- to 14-year-olds, reported as 25% and 21%, respectively (Community Health Service Hollands Midden, 2020). Due to concerns over rising obesity rates among 2- to 14-year-olds (14% in 2012, 18% in 2020), the municipality of Katwijk invested in an intersectoral community program called JOGG (*Jongeren op Gezond Gewicht*, or Young People at a Healthy Weight), targeting childhood obesity. Contrary to expectations, the program's preventive activities were not well attended. To improve the uptake of preventive interventions, it is essential to find out *why* particular groups hold off or contest interventions (Heggenhougen & Clements, 1990). The current study builds on the notion of 'subversion' to examine commonplace protests against WRHP from a sociohistorical perspective.

Several explanations have been suggested for the phenomenon of the low uptake of WRHP, despite ample availability. First, the uptake of WRHP can be compromised by the fear of stigma (Noordam & Halberstadt, 2016; Palad et al., 2019). Second, lifestyle recommendations may not be compatible with families' needs (Kelleher et al., 2017; Palad et al., 2019; Skelton & Beech, 2011; Teevale et al., 2015) and sociocultural contexts (Hoeeg et al., 2020). One relatively unexplored explanation for the low uptake of WRHP is resistance to governmental and, by extension, health institutes. Resistance fueled by mistrust of public institutions (Peeters et al., 2020) has been widely documented in communities with a history of adverse social conditions, including poverty and political exclusion (Perry, 2021). In the recent COVID-19 pandemic, for example, scholars showed that vaccine hesitancy among African American communities (Bogart et al., 2021) and Latin American farmworkers (Gehlbach et al., 2021) in the US was fueled by legacies of mistreatment by institutes. Similarly, a study among a historically disadvantaged Bedouin community described how a cycle of distrust affected the uptake of interventions targeting *brucellosis*, an endemic infectious zoonotic disease known as a 'disease of the poor' (Hermesh et al., 2020). Another study among mothers in Puerto Rico during the Zika epidemic linked widespread resistance to Zika-related public health messaging to women's collective memories of coerced sterilization and clinical trials in the colonial past (Horan, 2020). Stories of these painful experiences were passed down from mother to daughter, leading to continued deep institutional mistrust.

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1.1. Protest against health promotion

To the author's best knowledge, only a single study has focused on resistance as an explanation for the low uptake of WRHP. In the Netherlands, sociologist Van Meurs and colleagues (2022) observed a trend of 'negative' online comments to health promotion-related news posts. In the former study, for example, one person commented, "*Everyone should decide what to eat him- or herself. [People in] government jobs should be dealing with other things*! (2022, p.4)". The authors' preliminary analysis of these online comments showed that health-promotion messages were seen as unsolicited attempts by outsiders to interfere with freedom of choice (2022: p.4). A follow-up survey study showed that institutional distrust and anti-paternalism, two aspects of anti-institutionalism, largely explained the lower uptake of nutritional information among less educated individuals. Lifestyle recommendations were likely to be associated with the elite, their untrustworthy institutes, and their sense of moral superiority. Coupled with feelings of misrecognition, aversion against these dominant elitist institutes inspired resistance toward nutrition advice (van Meurs et al., 2022).

To date, explanations of resistance to WRHP programs have largely focused on individual rather than community processes. Current scholarship lacks a framework in which local history, including historical power relations, is central to the analysis of everyday resistance against health promotion. For example, Van Meurs' study provides invaluable insights into anti-institutionalism among less educated individuals but does not address the extent to which historical power relations between the general population and institutes steer anti-institutionalism. In light of the local sociohistorical context, historical power relations are important to address, as they can act as catalysts to resistance (Scott, 1985). Dahl defined power as: "*A has power over B to the extent that he can get B to do something that B would otherwise not do* (1957, p.202)". The latter aspect has been extensively discussed in the medical anthropologist literature but is scarcely researched on a day-to-day basis at the micro-level of interactions in health care.

1.2. Subversion in weight-related health promotion: how and why?

Recently, population-wide responses in the COVID-19 pandemic have underscored the need to refine analytical tools to understand the low uptake of public health interventions in specific populations (Zixuan et al., 2021). Therefore, this study adds subversion as an analytic tool to conceptually capture resistance to WRHP in communities with a history of endemic social conditions. The Latin root for subversion, *subvertere,* means 'to turn from below'/'to overthrow' and refers to the process of opposing or undermining power (Vocabulary, 2022). In his publication *Weapons of the Weak*, anthropologist James Scott (1985) was one of the first to study how people exercise their agency when open acts of resistance might be dangerous, for example, in interactions with landowners, employers, or government. He was especially interested in everyday forms of resistance "that do not make headlines" (Scott, 1985, p.XVII). He argued that people who might be seen as relatively powerless have hidden ways of critiquing and resisting the powers that be, challenging that *A* can *always* get *B* to do something that *B* otherwise would not. Commonplace and relatively subtle ways of overthrowing power are gossip, rumors, jokes and "foot dragging, false compliance, feigned ignorance, arson, sabotage slander" (Scott, 1985, p. 29). By studying these everyday and somewhat hidden ways of undermining power within their sociohistorical context, Scott attended to larger issues that give rise to resistance (Scott, 1985, p. 29).

Following up on Scott's work, Barnes and Prior (2009) attended to the ways in which professionals and citizens undermine government intentions in the policy context. In the volume 'Subversive Citizens,' Barnes shows three commonplace strategies of subverting government intentions: revision, resistance, and refusal. Although distrust toward government has been widely documented in communities with a history of power inequality, including fishermen communities in the Global North (Jentoft, 2007; Zundel, 2019), to date, little is known about subversion in health care. The first research question in this article, therefore, is 'What are the commonplace expressions of subversion in WRHP in Katwijk'?

Further, the analysis of such expressions is extended with a psychological anthropological approach. Similar to Barnes and Prior and Scott, subversive responses are not approached from a moral position, whereby subversion is considered good, bad, or even heroic. Rather, the study sets out to understand how and why people, individually and collectively, protest against WRHP in this context. For a contextualized analysis of institutional distrust and anti-paternalism, I recur to the work of medical anthropologist Arthur Kleinman and colleagues (Kleinman et al., 1997, p.ix), who studied health phenomena in communities with a shared history of 'social suffering'. Social suffering refers to human problems that result from "what institutional, political and economic power does to people, and reciprocally, how these forms of power themselves influence responses to social problems" (Kleinman et al., 1997, p.ix). Through their work, ranging from rural China to metropolitan New York, Kleinman and his colleagues showed that the local community functions as the foundation of social life, and that daily life deeply matters (Kleinman et al., 1997; Yang et al., 2007). Therefore, Kleinman and his colleagues urged the study of population-wide responses to health care by asking what people, individually and collectively—as deeply engaged stakeholders—stand to lose, to gain, and to preserve when engaging in health care interventions. For example, studies of low uptake of mental health interventions showed that engagement with these interventions, each heavily stigmatized, threatened the accumulation of financial resources among Chinese-American migrants (Yang et al., 2014) and family prestige among families in urban India (Slagboom et al., 2021). In this article, Kleinman's approach is extended to protesting responses in weight-related interactions, leading to the second research question: From a local perspective, whom and what is protested against when weight health promotion is contested?

2. Research context

In the 17th century, the small town of Katwijk had one of the largest fishing fleets of the Netherlands. The town was ruled by vessel owners and other wealthy, highly educated people who held powerful positions in the church (Deursen, 2011; Society Old Katwijk, 1974). The life of fishermen was uncertain, and often harsh. A family's income depended on the catch, working conditions on the ship were poor, and the fishing occupation came with dangers such as drowning (Deursen, 2011; Leydse Courant, 1867). Historically, the maritime community of Katwijk was known for its close-knit families and Orthodox Protestant Christianity (Deursen, 2011). Families were strongly organized in a positional way (Bernstein, 2003), meaning that roles and responsibilities were allocated by position: older, younger, male, or female. Grandparents carried a lot of weight. There were women's and men's jobs. Men, who worked offshore for weeks or months, were the breadwinners and head of the family. Women took care of the (large) family and were in charge while the men were away (Beelen & Hing, 2009; Deursen, 2011).

Public health reports (1840–1940) show that fishermen families in Katwijk were vulnerable to poor health outcomes. Figures for adverse health outcomes were often strikingly higher than elsewhere in the region. School physicians worried about children's low vaccination rates, tuberculosis, malnourishment, poor oral health, and poor eyesight (NTVG, 1934). Infectious diseases, such as typhoid, tuberculosis, and cholera, were endemic in the town, causing high mortality rates (Geneeskundige Courant, 1849; Municipality Katwijk, 1981). During the cholera epidemic in 1849, Büchner, a physician, described how living circumstances in the fishermen quarter—poverty, proximity to fish waste, large families in small houses, and no means to quarantine—heightened the risk for infection, and death (Geneeskundige Courant, 1849). During such epidemics, preventive measures known to mitigate the risk of adverse health outcomes were only available to

wealthy families (Geneeskundige Courant, 1849).

For many fishermen families, life continued to be harsh throughout the 20th century. During World War I (1914–1918), 26 ships from the Katwijk fleet were blown up by mines, leading to the drowning of 103 men (Deursen, 2011). Given that families worked together on one ship, such accidents often led to the loss of three generations of men (Deursen, 2011; Society Old Katwijk, 1974). According to Van Deursen (2011), during World War II, a large part of the fleet was confiscated, and many men were sent to work in Germany. To build a defense wall along the coastline, 600 houses were demolished, leading to the forced migration of women and children to other parts of the country. In 1945, after returning to the town after the war, the fishing fleet had lost many ships, and there was a severe housing shortage.

In the early 20th century, the fishing fleet consisted of 130 ships (Museum of Katwijk, 2022). Due to fishing bans, fishing quotas, and globalization, from the 1970s onwards, the fishing industry declined rapidly, turning Katwijk into a fishermen town without ships (Reformatorisch Dagblad, 1971). Vessel owners sold their fishing rights for a large sum. For fishermen families, the deterioration of the fishing industry has led to mass unemployment and a rapid change in livelihood (Beelen & Hing, 2009; Deursen, 2011). Over the years, the community had multiple disputes with local and national governments over building a local port, fishing bans, and fishing quotas (Reformatorisch Dagblad, 1976). The current fishing fleet consists of 10 ships. Recently, Dutch fishermen have been in conflict with the European Union over a ban on using electric pulse fishing (NOS, 2021), giving rise to the sense of being robbed of the North Sea (Verschoor, 2022).

Although fishing is no longer the main occupation of families in Katwijk, many aspects of daily life remain unchanged. Men continue to work long hours and largely remain providers and heads of family. Women are increasingly entering the formal labor market, but the greater emphasis is on their responsibility of running the household.

3. Materials and methods

This study was embedded in a four-year applied study "Levensloopaanpak", an interdisciplinary, mixed methods focusing on understanding and addressing population wide patterns of intergenerational poor health.

The town of Katwijk (43000 inhabitants) was selected as a study area because of a pattern of poor health outcomes across generations (Slagboom et al., 2020; 2021). Fieldwork for the Levensloopaanpak study was conducted in a neighborhood with some of the poorest health outcomes in Katwijk (13510 inhabitants).

Between 2015 and 2019, a methodology of focused ethnography (Knoblauch, 2005) was combined with multigenerational life course interviews, and participatory action research (PAR) with children, families and professionals (Minkler, 2005). For the multigenerational life course study, the author conducted oral history interviews with seven key informants, and interviewed children, parents, and (when possible) grandparents from 16 families (Slagboom et al., 2020). In addition, she observed interactions occurred during activities that children and families regularly visited, such as schools, churches, community centers, care facilities, and local events. The interview topics, recruitment, and sampling for the interview study are detailed in Appendix 1.

Following the above-mentioned multigenerational life course study, researchers, families, and professionals from the social, medical, and policy domains worked together in four PAR projects (Appendix 1). Each of the PAR projects aimed to organize health promotion activities to improve the physical activity, healthy nutrition, and wellbeing of children aged 10–14 years and their families in the study area (Crone et al., 2021). A list of health promotion activities that resulted from the PAR projects, as well as information on who and what was targeted with the activities, is provided in Appendix 2. Over the course of 3.5 years, the author and her research team observed interactions and conducted (informal) interviews during the preparation, implementation, and evaluation of these health promotion activities.

The PAR projects were co-designed with families (from the study area) and health professionals working in the study area (both from the locality and from outside the locality). Health professionals included community social workers, nurse practitioners focusing on mental health problems in a general practitioner's office, youth workers providing tailored sports advice, behavioral scientists and child health professionals working with families at Child and Family Service, dietitians, and remedial teachers from schools.

In every first interaction, in newsletters and in interviews in the local paper, the author made herself known as a researcher interested in health and wellbeing of families. In informal interviews, the author repeated her research interest and regularly asked permission to take notes. In a community that often distrusts professionals from governmental institutes, including research institutes, the author's longitudinal, everyday engagement laid a foundation for trust, which enabled her to connect with children, (grand)parents, and professionals. Acceptance and sensitization of the author were further facilitated by her professional experience as drama therapist in working with families, and her personal experiences of growing up as a chubby child in a Dutch Orthodox Protestant community.

With a special interest in protesting responses in WRHP, interviews and notes were analyzed for themes and patterns, following the four steps outlined below.

1) Open coding of weight-related interactions
2) Thematic coding of tense weight-related interactions
3) Comparison of expressions of protesting responses in WRHP
4) Comparison of themes and patterns across cases of protesting responses in WRHP

Following the above four steps, building on an arts-informed research approach (Cole & Knowles, 2008), in health research (Rosenbaum et al., 2005; Rossiter et al., 2008), cases of protesting responses in WRHP were scripted into theatre dialogues. The abovementioned theatre dialogues were then analyzed for social dynamics and dramatic conflicts by coding the theatre dialogues for roles, role reversals, emotions, and expressions. NVivo 11 was used as a tool for analysis.

Over the course of four years, interviews, observations of interactions, and theatre dialogues were discussed in bi-weekly reflective meetings with the two supervisors of the ‘ … ’ study. In addition, as part of the participatory action research cycle, observations of interactions were regularly discussed with stakeholders, such as mothers and professionals involved in health promotion.

To protect the identity of the participants, identifying information was omitted from transcripts, pseudonyms were used, and occasionally, the characteristics of participants were altered or combined to maximize anonymization. Research permissions were granted by the Medical Ethical Committee of Leiden University Medical Centre, which gave the studies a statement of no objection.

4. Findings

In a sports hall, local stakeholders gathered for a presentation of the research project ‘Levensloopaanpak’. During the presentation, the research team expressed their interest in family health, and how health outcomes in families might be shaped by the town's historical context. Following the presentation, a community leader was the first to rise from his chair for a question. Looking around the room, he immediately brought up the issue of weight by saying:

> I think … that you are merely interested in the fatties of Katwijk.(…) I have the strong suspicion that one of you just wants to write an essay or so about this.

This micro scene was the first of many times that ‘weight’ and ‘power’

were immediately readily brought together in a conversation about health, followed by a cynical joking response that ended with a strong sentiment of 'keep out'. In fact, virtually every subsequent interaction with the research team of the ' … ' study contained clues of the strained relationship between community members and powerful institutes. The following paragraph first outlines three common responses in weight-related interactions. 'Weight-related interactions' refer to interactions in which food traditions or body posture were addressed explicitly, but also to more subtle, everyday actions that can be associated with health promotion goals. Next, the paper describes subversion against the sociohistorical background of Katwijk in order to understand whom and what is protested against when health promotion is contested.

4.1. Commonplace expressions of subversion

4.1.1. Anger and agitation

Health promotion professionals regularly spoke about their struggles in engaging families in activities, such as water drinking or fruit eating campaigns. Such activities were met with angry, agitated responses that reflected negative sentiments. For example, when the municipality tried to introduce a 'healthy foods policy' in the local soccer club cafeteria, this was immediately met with protest by mothers. An article in the local paper that quoted two mothers read:

> It is condescending. Do you really think children will spend their buck on a healthy sandwich? Just leave them alone.

In another example, a 72-year-old grandmother angrily objected to a water drinking campaign at a school. During a conversation with a teacher, she took a candy bar out of her bag, summoned her six-year grandchild over, and asked her to unwrap and eat the bar, saying, "*I get to decide what she eats.*" Through this agitated response, the grandmother indirectly critiqued institutional interference in their everyday lives; her response implied that 'nobody tells me how to raise my grandchild'. Similarly, a mother protested against school breakfast, a JOGG health promotion activity that she described as 'forced upon children'. Like many others, she said, "*School is school, home is home.*" When her children asked for 'new' types of breakfast foods, she taught her children that school habits would not apply in her home. She said:

> All of a sudden, my kids wanted to eat things like cottage cheese and so on. I don't think so, I told them, you will eat bread with chocolate sprinkles, as we always do.

Objection toward health promotion also came in the shape of a protest against state power. For example, a father commonly voiced 'negative comments' on local health promotion social media accounts. When he was invited to talk about his comments, he said, "*You are trying to control the population; you don't realize how much power you have.*"

4.1.2. Joking and mocking

As illustrated in the Dad-and-Cookies scene in the introduction of this article, joking and mocking were other commonplace ways of pointing back at institutes and protesting paternalism. Such responses were particularly observed in everyday interactions that contained clues about WRHP goals. Someone choosing water over a fizzy drink, arriving at a meeting by bike instead of car, passing the sugar for coffee, or declining an offer for a cookie: such everyday actions were immediately met with a mocking "*Trying to be healthy, are we*?"

Over the years, I have found that the protest response occurred not only in weight-related interactions with families but also often in conversations with local care professionals. For example, I unpacked carrots as an afternoon snack, a local health professional, laughed out loud, poked her neighbor, and called out for her colleagues to come and see: "*Look! Carrots. Oh my, if you join her project, you will become a rabbit too!*"

4.1.3. Polite-yes-but-no responses

Less explicit, but no less common, were the subversive yet polite 'yes-but-no' responses in WRHP. In such instances, families would seemingly respond positively to invitations to health promotion, or health promotion advice. However, as evidenced by a generally high no-show rate, an initial positive agreement often did not result in action. Tom, a dietician for children, reported that up to 25 percent missed consultations daily. Fearing that families would not come back at all, he did not dare to charge for these no-shows. Health promotion professionals often spoke about suddenly not being able to reach parents anymore. One professional, for example, said:

> Often, I can't reach them afterwards, not by phone or by mail. People don't pick up the phone, or hang up once they realize it's me.

In direct interactions with health promotion professionals or researchers, families respond enthusiastically to invitations to health promotion or health promotion advice. Once the professionals were out of sight, the advice or suggested program would be mocked. As an illustration, a mother, Lily, accepted an extra invitation from the school nurse to discuss her son's overweight. During the overweight consultation hour, she nodded agreeingly to the nurse's suggestions and politely took leaflets of the prevention program. When asked about her child's food intake, Lily cited the 'golden rules' of health promotion, such as giving her children a maximum of two treats per day and water instead of sugary drinks. She added that her children only ate sweets on special occasions and that she sent them to play outside every day. Prior to the visit, however, she told the interviewer:

> He is a big, sturdy boy, and that's what he has always been. You know, he is just a spitting image of his father, who is a sturdy, big man. That is what he is going to be too (…) I might as well go (to the obesity screening, red.), but I don't feel like making a great effort. If the nurse says he should lose a few kilos, well … I don't think so. I won't adhere to that.

4.2. Whom and what is protested against?

Weight-related messages were associated with unwarranted institutional interference—in other words, "meddling from above," which triggered a protesting response. This finding resonates with observations from an earlier study indicating that anti-institutionalism is likely to drive widespread resistance against public health messaging (van Meurs et al., 2022). In this section of the article, which attends to the second research question, the commonplace expressions of subversion in WRHP are studied in light of the sociohistorical context of Katwijk. Following Kleinman, I analyzed *whom and what* is protested against, and what people stand to gain or lose when engaging in health promotion. To this end, the following paragraph describes the legacies and current contemporary experiences with institutes that are likely to underpin subversive responses.

4.2.1. Protest against institutional indifference toward local concerns

Historically, mistrust among fishermen in the Netherlands was related to limited support from the 'elite' in the face of harsh working and living conditions, and the deterioration of the fishing industry. In low-income neighborhoods in Katwijk, poor social conditions are not merely stories from the past. Ten percent of the population continues to live in poverty (Odekerken et al., 2021). Cumulative stress related to poor housing, poor working conditions, and financial stress continues to drive vulnerability to poor health (Slagboom et al., 2020). Health promotion programs, then, seemed to trigger a protest against institutional indifference to pressing matters. This critique resonated in a conversation with Dave, a 33-year-old father, who mockingly expressed his doubts about our research program conducted in his neighborhood:

> Madam researcher, you might as well stop what you are doing [research on health across generations in Katwijk, red.]. I can tell you the outcome right now. The aches and the burnouts. It is the pressure for a good house, a nice car, a beautiful woman. Making ends meet, unemployment, money … those worries. Stress is the biggest thing here.

Dave described the relationship between adverse socioeconomic circumstances and poor health, and protested against what Popay et al. (2010) described as "lifestyle drift", the tendency of institutes to focus on individual lifestyle factors rather than taking action to address structural factors. Worries over income or housing often hampered efforts to implement health promotion activities, such as cooking or sports classes. Tina, for example, could not focus on the sports activity that she had signed up for in the community center. She was one of many mothers who worried about having to leave her old apartment block, which would soon be replaced by new apartments, which she would not be able to afford. On this particular morning, she could not focus because she had been up half the night due to the noise caused by her drug-addicted neighbors. Scared by the yelling and screaming sounds from next door, her children could not get to sleep. A month prior, there had been a fire in the apartment, one of the many incidents in the poorly maintained apartment block. In short, conversations with Dave, Tina, and others testified of people who feel that the government does little or not enough in the face of their everyday worries and challenges.

4.2.2. Protecting the family against the power of health institutes

Institutional distrust was also triggered in interactions with health care professionals and medical researchers, who were readily associated with the state. A deep mistrust manifested strongly during the recruitment of the elderly from the town for three-generation life course interviews. As soon as the first author disclosed that she worked at the academic hospital on the border of Katwijk, these elderly, mostly fishermen's families, politely declined to be interviewed.

Interlocutors from younger generations explained their (grand)parents' general mistrust of health institutes as a heritage from the past, a time in which fishermen families belonged to the poor low class's and doctors to the powerful elite. For example, 60-year-old Steve described that for his mother's generation, who grew up poor, visiting a doctor continues to be an extremely frightening situation. After Steve introduced me to his 80-year-old mother, she explained that her fear of doctors started in her early childhood when she lost her mother. Like many other poor families, she was raised with the thought of avoiding doctors as "*one only pays the doctor for him to tell you that you will die, so why would you*?" This fear continued throughout her adult life as a fishermen's wife. At the age of 19, she lost her husband to pneumonia, leaving her without an income and pushing her young family into extreme poverty. Being pregnant a few years later during her second marriage to a fisherman, Gertrude feared for her life when her labor started on a Sunday evening. As Sunday was a church day—the Sabbath—she did not dare to ask for help. Out of fear of the repercussions of breaking church rules and wanting to protect herself and her baby, she struggled through the night by herself. Seventy-five years later, the pain and fear she experienced that night continued to haunt her in nightmares.

Although grandparents like Gertrude often kept silent about their painful past experiences, lessons about protecting oneself from powerful institutes seemed to be passed on to subsequent generations through their storytelling. In life history interviews, stories of the elderly were often filled with funny (family) anecdotes of pranking powerful figures and Houdini-like escapes during fearful situations. For example, May, a grandmother who looked back on a harsh life from her early childhood onwards, laughingly told stories about dodging social workers and youth services to protect herself and her family.

Despite the growing availability of health care, the lesson of distrusting health care seemed to be passed on from one generation to the other. For example, 50-year-old Sarah avoided consulting a doctor for her mother, who had become forgetful and increasingly experienced problems with judgment and planning. Instead of consulting a medical professional, the family preferred to solve everyday concerns among themselves, which she explained by saying, "*In our family, we generally distrust health care.*" Slowly closing her palms together, Sarah illustrated her families' mechanism of silently dealing with their worries: "*If we don't talk about it, it isn't there.*"

The lessons about protecting oneself from powerful institutes seemed to have extended across three generations, as manifested in interactions with parents of school-aged children. For example, during the recruitment phase of a survey study of parents and their school-aged children, mothers commonly feared the negative consequences of participating.

> What will happen to us if our answers are communicated to other health or governmental institutions?

The immediate institutional mistrust was particularly instigated by questions on everyday food choices. As an illustration, during a fieldwork visit, a mother took the author aside behind closed doors, lowered her voice, and explained that her survey questions were risky. The survey contained a question on parents' and children's' daily uptake of vegetables. To decide whether she and her family would participate, she asked, "*Who will be reading these answers?*" Another mother feared that her answers to the abovementioned survey would endanger the social benefits related to her husband's illness. Lowering her voice, she explained that she could not serve her family vegetables on a daily basis: "*Nienke, I know I should. I really do. We all do. Sometimes, it's just too expensive.*"

A few years later, on one of the author's last days of fieldwork, two mothers confided that they, like many mothers in the neighborhood, had been hesitant to participate in the survey study. As the questionnaire contained questions about weight, food intake and encouraging exercise, the mothers had feared the repercussion of child services, who had the authority to take the children from their homes: "*It would not be the first time, you know.*"

4.3. Preserving the family unit: feeding practices, food rituals, and childrearing duties

Four years of ethnographic work enabled the examination of weight-related interactions through a kaleidoscopic lens (Siddique, 2012)— new and different insights constantly materialize from familiar scenes and interactions. During home, school, and church visits, and in the corridors, while gradually building trust, the author chatted with countless mothers, children, and their families. From these conversations, an insider's perspective on protecting the family against the power of health institutes emerged. WRHP measures triggered a sense of interference of institutes within the private sphere, particularly interference with family feeding practices and social relations. Therefore, these measures also triggered immediate protests *within* the community and *within* families. The following paragraph describes how protesting *against* health promotion, which implicitly encouraged changes in family feeding practices, family roles, and childrearing duties, meant choosing *to* preserve the family unit.

Respondents often spoke about food rituals, feeding practices, and eating patterns that are characteristic of Katwijk. Historically, there has been a strong tradition of sharing evening meals with the wider family, a food ritual passed on from one generation to another. For example, families meet at Grandma's for Sunday Coffee after church. Other food rituals include daily coffees, Saturday Fries, and the traditional Fish Friday. Throughout the years of fieldwork, many (grand)children spoke warmly of the cakes, cookies, and treats for which their grandmas were renowned. A preference for these food groups was described as a hallmark of belonging to the population of Katwijk: "*We have a sweet tooth.*" In a focus group, one family described the piles of goodies that were typically served at Grandma's Sunday Coffee after church:

> Marly: After church, we begin with coffee …

Stella: With something yummy

Marly: Apple pie, cake or butter cake. When that is over, then there is cheese and sausages

Stella: And chips!

Marly: Then there are the chips, heaps and heaps of chips. Well, then, if it's summer, they [the children, red.] also get an extra ice cream

Stella: And when they go home, a nice marshmallow …

Marly: A candybar ….

Interviewer: This is still at Grandpa's and Grandma's?

Marly: Yes Grandpa's and Grandma's. You have to understand; this is how it has always been.

Anthropologists have emphasized that people form their eating patterns in relation to others. Mothers explained that at these recurring family gatherings—contrary to health promotion advice of portion control—being able to eat a large amount of food was highly valued. Families explained the appreciation of the ability to eat a lot (load up) as a legacy from a time in which fishermen's life was physically strenuous and food was often scarce. Joining in the abovementioned food rituals and feeding practices affirmed belonging to the group. By contrast, declining foods offered resulted in immediate protest. One mother, for example, explained how turning down Grandma's treats was perceived as a grave insult. Passing on a piece of butter cake during Sunday Coffee would attract comments such as, *"Have you gone mad?"* from her grandmother and the rest of the family. Deviating from recurrent feeding practices and changing the course of food rituals seemed to be discouraged through public mockery and joking. Mothers' efforts to implement health behavioral change—replacing chips with nuts or tomatoes, restricting the portions of snacks, or sticking to the plan of eating greens—put them at risk of being labeled disloyal. Occasionally, mothers spoke about being caught between conflicting norms of being a good mother. Monica, for example, spoke about the difficulties she experienced when she implemented behavioral changes as advised:

By now, I have a bad reputation; they will say: "Oh, not her again," "For goodness sake, get off the child's back."

WRHP messages were not only protested against because of perceived interference with food rituals that hold families together but also because of perceived intrusion with childrearing, a domain of the family rather than the state. At a fundamental level, WRHP messages carried clues of 'untrustworthy' institutes interfering with social relations.

As illustrated earlier in this article, when parents or grandparents protested against WRHP, their agitated, mocking, joking, and polite responses often implied that "nobody tells me how to raise my child". These protests against (health) institutional interference in everyday life reflected critical public health studies arguing that health promotion messages are inherently paternalistic, as they promote certain ways of eating that people otherwise would not choose and mingle with decisions that are deemed deeply social. In the literature, health promotion measures represent nannying by the state (Calman, 2009; Steele et al., 2021) or "broccoli paternalism" (S Jongers, 2022). While this critique of paternalism is well documented, a protest against health institutional interference in the private sphere took particular shape in Katwijk. In this historically Orthodox Protestant community with more or less fixed family roles and child-rearing duties, institutional interference clashed with the biblical duties of grandparents and parents to raise and educate children as they see fit. Warnings against paternalism by the state, for example, were conveyed in the Gezinsgids, a well-known monthly magazine for Orthodox Protestant families. Observing the growing influence of the government on family life, one article addresses how to deal with the state trying to 'get behind the front door' (Roelof, 2016). In another article, a political leader from an Orthodox Protestant Party stated:

We must be weary of anything that reeks state pedagogy. […] First and foremost, the upbringing lays in the hands of the parents. It is their biblical duty.

In articles and sermons on Sunday, the message conveyed that how children navigate the world needs to be 'fed from behind the front door' (Roelof, 2016, p. 16). To live by God's ground rules, families need to work hard to fulfil their childrearing duties and make radical choices against the governmental tendency to strive for individual freedom and thereby mingle with fixed family roles. For example, after linking institutional distrust to institutional failures, a scholar in education emphasized the importance of preserving religious values—values that represent an inherently different worldview than those imposed by the government. In an interview in Gezinsgids, he said, "*State pedagogics form a threat […] The best way to deal with threats is to resist them* (Leeuw, 2021, p.52)."

Although many families no longer lived by the 'strict' rules of Orthodox Christianity, it seemed that family members continued to line up in protest when child rearing duties were threatened. In a society where group conformity, social cohesion, and continuity are held in high esteem, measures steering toward individualism and self-determination were immediately protested against. As illustrated above, a mechanism to protect and preserve the family unit was not only triggered in interaction with state representatives—the outsiders—the protests extended to insiders trying to implement health promotion measures in the family environment, most notably mothers. The strong mechanism of protecting and preserving social cohesion and continuity occasionally brought about a fatalistic sentiment among mothers and local care professionals alike that 'nothing can be done'. These intended change agents struggled with the gridlock that immediately emerged when they followed, or provided, health promotion advice. Mary, a local health professional, well familiar with the sweet battles within families, wondered whether health promotion could ever work in the context of Katwijk. She said:

You can't win this one. As much as I believe change is needed, it is just too strong.

Similarly, another mother described how she often felt stuck in her family:

It is really difficult for parents. Because you have to grow up in a family. They are what you've got—the family—or it won't work. But together, you won't get anywhere.

In the introduction of this article, Clive made a comment that opposed the suggestions of weight-related health promotion. He overthrew the suggestion to give up his role as indulger and restrict his child from having another cookie. Jokingly, he protested against meddling by external institutions and emphasized his right to raise his child as he saw fit. In this instance, mothers in the audience immediately recognized the gridlock triggered whenever health promotional measures implied changing traditions or family roles. One mother said, "*This, this is exactly what always happens*." Another mother shouted, "*Clive, that's how it will never change*."

5. Discussion

This study examined commonplace protests against WRHP in Katwijk, a former fishingtown on the West Coast of the Netherlands. The findings indicate that joking, mocking, anger, agitation, and politeness are likely underpinned by a protest against institutional indifference to local worries and the desire to protect the family unit against the power of health institutions.

Through a close investigation of everyday interactions, this study provides insights into the stakes in an area that has been demonstrated to be controversial: childhood adiposity. Overall, the findings of this study add to the literature describing the complexities that health professionals

face when addressing children's overweight (Alegria Drury & Louis, 2002; Mikhailovich & Morrison, 2007; Puhl & Brownell, 2003; Schalkwijk et al., 2016). As the majority of studies of tense interactions in weight-related care focus on individual processes, with this paper, I highlight the need to examine population-wide interaction patterns, as these can reveal what people, individually and collectively, stand to lose when engaging in obesity care or health promotion.

In a review of complexities in obesity interventions, Skelton argued that it is often a mystery to clinicians why 'simple, high-impact behavioral change can be difficult to implement' (2012, p. 892). Findings from this study confirm that because weight is associated state health control ambitions, health promotion can trigger historical institutional distrust (van Meurs et al., 2022) as well as system and surveillance critique (Bunton et al., 2003), thereby providing explanations for why health promotion measures and messages are contested. While the above-mentioned studies often focused on battles with the state—outsiders—this study also draws attention to battles that are set off within the family. This study addresses the idea that WRHP measures can also be heavily contested because of a perceived threat to social structure. In the context of the family, health promotion measures seemed to threaten prevailing feeding practices and food rituals, as well as fixed family roles and child-rearing duties. Thus, at a fundamental level, a worldview represented in health promotion interventions—valuing individualism and self-determination—clashed with the worldview of a society that holds social cohesion, continuity, and group conformity at its core. In everyday life, therefore, a choice *for* behavioral change, as promoted by health promotion professionals, could become a choice *against* the social structure. In line with studies that have emphasized food and eating as a social practice (Delormier et al., 2009; Visser, 2016), I therefore, point to the limitations of behavioral change models that focus on individual behavior theories in addressing a phenomenon that is deeply social: food intake.

The observation that social and economic problems hindered families' capabilities to eat differently, or to be more physically active, resonates with other critiques of tackling obesity through measures focused on individual behavioral change (Popay et al., 2010; Rutter et al., 2017). A recent Cochrane review concluded that despite current understandings of the complex etiology of obesity, interventions persist to be skewed toward downstream, individualistic determinants (Nobles et al., 2021). The protesting responses in this study, one might say, confirmed the influence of the food environment on overweight (Osei-Assibey et al., 2012) and called attention to the struggles of child rearing in an obesogenic environment. Therefore, the joking, anger, mocking, and polite responses in WRHP might also be translated as a form of system critique, as a way of pointing back at broader, upstream factors that shape food intake and physical activity.

A weariness of health promotion measures and messaging is not unique to Katwijk. The protective mechanisms triggered by a perceived threat to the social structure might go a long way in explaining the low uptake of preventive public health measures in communities with similar social characteristics. In the Netherlands, for example, measures meant to contain COVID-19 were met with angry and mocking responses in Orthodox Protestant communities, groups that reported higher infection and mortality rates at the height of the pandemic (Engels, 2020; Oskam et al., 2021). Rather than implying that protest against preventive public health measures are related to the sociodemographic characteristics of Orthodox Protestant religion, a recent study indicates that the findings of this study are likely a reflection of communities of close-knit families with a strained relationship with the government (Zixuan et al., 2021).

This study was not without limitations. First, because studies examining subversion in weight-related care for children are scarce, limiting the comparability of outcomes, the exploratory nature of this study needs to be emphasized. Second, this study was carried out after observing a recurring pattern of tense interactions in WRHP, which means that the data collection for the specific research questions was not planned in advance. Rather, the author relied on the triangulation of qualitative data collected throughout a four-year participative action research project aimed at improving interventions. Relatedly, the data used in this study included observations from interactions in thePAR studies, which the author coordinated for over three years. The multi-positionality of the author might have biased the analysis. Although combining research roles and working data from applied studies has its limitations (Vernooij, 2017), it is doubtful whether insights into the phenomenon under investigation would have been fully understood if the author had not been involved in tailoring health promotion activities. Being present in a wide range of weight-related interactions allowed for an in-depth, thoroughly contextualized exploration of protesting responses that are otherwise hard to grasp.

Future qualitative studies seeking to understand the low uptake of interventions are recommended to triangulate traditional methods such as interviews, which predominantly measure stakeholders' perceptions, with methods that attend to interactions in clinical encounters and everyday life. If families sufficiently trust a researcher to record their encounters with care professionals and their families, future studies could integrate conversation or discourse analysis into their design. Following the identification of common themes in a qualitative study, a survey study might be used to validate these themes in populations with similar sociodemographic characteristics. To address feelings of disloyalty that may arise when participants are directly asked to reflect on family or community processes, arts-based and arts-informed methods with components of projective techniques are recommended. The observation that fathers resisted the changes that mothers tried to introduce underscores the need for more research into the role of paternal support and gender in obesity research and interventions. While public involvement was at the core of the health promotion interventions observed for this study, fathers were not sufficiently represented. The findings of this study underscore that *everybody* who has a seat at the table needs to be included in future applied studies focused on strengthening health of families.

This study confirmed the importance of knowing a community's history and legacies with health institutes. This is not only true for health professionals working with families but also for researchers who intend to design and deliver health interventions using public involvement. Due to researchers' affiliation with universities or health institutes, their work can also be associated with state interference, which can trigger immediate distrust. Budgeting extended time for community building is therefore recommended. The findings from this study also highlighted the relevance of training health professionals and researchers to be sensitive to the many faces of fear and protection, which might include anger, joking, mocking, and polite nodding. In addition, the knowledge, attitude, and skills required to attend to children's food intake (what's literally on their plate) as well as families' living circumstances (what's figuratively on their plate) need to be integrated into the curriculum for professionals working in health promotion for children.

6. Conclusion

This contextualized analysis of subversive responses in health promotion sheds new light on behaviors often framed as low adherence, noncompliance, and avoidance. In communities with strained sociohistorical relations between the general population and government institutes, lessons of protection passed down the generations need to be considered when introducing public health interventions. Such an analysis can provide the necessary information to sensitize and tailor public health programs targeting childhood obesity.

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Ethical statement

The study protocols were reviewed by the Medical Ethical Committee

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Declaration of interest

None.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2022.100206.

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