Article

Science, Technology, & Human Values
2020, Vol. 45(1) 138-163

DOI: 10.1177/0162243919841694
journals.sagepub.com/home/sth


Challenging Diversity: Steering Effects of Buzzwords in Projectified Health Care

Michael Penkler[1,2], Kay Felder[1,2] and Ulrike Felt[1]

Abstract

This article discusses the effects of two trends in contemporary biomedicine that have so far been largely addressed separately: the steering of fields through programmatic "buzzwords" and the projectified nature of contemporary health research, care, and promotion. Drawing on a case study of an Austrian diversity-sensitive health promotion project related to obesity prevention, we show how the articulation of these trends—governance by buzzwords and projectification—often leads to not unproblematic and often paradoxical outcomes. Buzzwords such as "diversity" become especially important in an innovation-driven environment encouraging a promissory rhetoric. At the same time, the project form shapes and restricts how buzzwords (as typically vague terms that need to be fleshed out) are articulated and translated into a specific project design. In our case study of an obesity prevention program, the need to translate diversity into a "doable" project encouraged the identification of seemingly clearly delineated target groups and thus promoted a rather narrow

[1]Department of Science and Technology Studies, University of Vienna, Vienna, Austria
[2]Munich Center for Technology in Society, Technical University of Munich, Munich, Germany

Corresponding Author:
Ulrike Felt, Department of Science and Technology Studies, University of Vienna, Universitätsstraße 7/II/6, 1010 Vienna, Austria.
Email: ulrike.felt@univie.ac.at

understanding of diversity, which stands in tension with much more fluid and context-sensitive ways of performing "diversity." We show how actors grapple with these paradoxes. This restricts the full power a buzzword such as diversity could achieve in terms of social justice.

Keywords
diversity, health promotion, projectification of health care, governance by buzzwords, obesity

Introduction

"Diversity" has become the focus of policies and practices in a wide variety of institutional contexts ranging from private businesses and state agencies to universities, research institutions, and health-care providers (Vertovec 2012). Originating from managerial and organizational discourses, the notion of diversity has come to signify a revaluation of the importance of addressing human differences. Diversity touches upon central, albeit contested values in contemporary societies and implies positive connotations of differences, suggesting that they are valuable and enriching (Blackmore 2006). While diversity within such framings appears as a self-evident good, its meaning in practice is often ambiguous (Vertovec 2012). Diversity shares the characteristics of what Bensaude Vincent (2014) has termed "buzzwords" and what Bos et al. (2014) have called "big words": terms that are widely used by policy makers, managers, scientists, journalists, and others to convey a shared sense of importance, but which are at the same time vague enough so that they can be linked to different agendas and concerns.

Such terms are "encompassing concepts that are uncontested themselves, but that allow for multiple interpretations and specifications" (Bos et al. 2014, 151). Reminiscent of Star and Griesemer's (1989) concept of "boundary object," they allow "actors from different social worlds . . . to coordinate with each other in spite of their differing points of view" (Trompette and Vinck 2009, 5). Such notions play an important role in steering policy fields toward broad and generic goals and have concrete consequences as actors reorient their practices and relate to these terms. However, to become effective and fully deploy their steering capacity in a specific context, "big words" need to be "articulated" (Bos et al. 2014, 152); their meaning needs to be fleshed out, and they need to gain legitimacy within a specific situated context.

In this article, we discuss how the steering of fields through programmatic buzzwords intertwines with another trend: the increasing organization of contemporary health research, care, and promotion work in the form of externally funded and time-limited projects. We empirically investigate how "diversity" as one buzzword has been negotiated, specified, and thus turned into a "doable problem" (Fujimura 1987) in an obesity-related health promotion project in a Viennese health center, which explicitly positions itself to be "diversity-sensitive." Taking obesity prevention as a case study seems particularly interesting, as body weight often gets linked to cultural differences in ways of living and eating and has become the focus of numerous public health interventions. Our goal is to contribute to the emerging literature on the tangible governance effects of buzzwords by exploring the challenges unfolding within the projectified context of contemporary health promotion. What occurs when large encompassing goals such as being "diversity-sensitive," which are tied to central social values and aim at long-term cultural change, have to be addressed within small-scale and temporally limited projects with all their concomitant restrictions and limitations?

This article shows how the articulation of big words is not simply a process in which the broader meanings of such guiding terms are narrowed down. Rather, the vagueness of buzzwords allows the simultaneous presence of multiple realizations of situated meanings of "diversity" and potentially conflicting normative commitments to it. Concurrently, the requirements, possibilities, and limitations of the project form, as organizing principles, create tensions with the normative commitments tied to the notion of "diversity." To successfully translate buzzwords into specifically situated practices, actors therefore must reconcile different discursive and institutional requirements and address the subsequent tensions and constraints.

Diversity in Health Care

Biomedicine and health care are areas where the buzz around diversity has been particularly pronounced in recent decades, with policies developed specifically to promote and institutionalize forms of "diversity care" that ensure the "special needs" of different population groups are addressed (Green et al. 2014; Saha, Beach, and Cooper 2008). One health-care domain in which diversity discourses have gained particular prominence is public health. Public health as a scientific and policy field is concerned with assessing, surveying, and promoting the health of "the public." As such, public health has been central to what Foucault (1978) and others (e.g.,

Rabinow and Rose 2006) have termed biopolitics, that is, governmental strategies that target the "vital" characteristics (such as fertility, mortality, and morbidity rates) of the population as a whole. Scholars have noted that historically, public health has assumed a prominent role in delineating "normal" from "deviant" behaviors (Bunton, Nettleton, and Burrows 1995; Race 2009) in a given context, which is "founded on a series of normative assumptions about the character, preferences, motivations and behavior of subjects held to comprise a given social totality" (Duff and Moore 2015, 54).

Public health has often been ambivalent about what the "public" is that it addresses and needs to address. On the one hand, it has often operated with rather undifferentiated notions of "the public," viewing it as the entirety of a given state's population (Duff and Moore 2015; Bunton 2008). On the other hand, public health has a long history of addressing groups that are perceived as deviant or simply different, for example, drug users, homosexuals, or ethnic and migrant minorities, thereby assuming a prominent role in the policing of these groups (Conrad 2007; Race 2009; Douglas 1995). Douglas (1995) argued that public health measures that target migrant and ethnic minorities have often assumed a "culturalist" perspective, "attempt(ing) to explain the health status, health experiences and health behavior of . . . minority ethnic communities . . . purely in terms of culture, often comparing (them) to white majority cultures in a detrimental way such that the beliefs and values of minority cultures were undervalued" (p. 70). Such approaches, often framed as a "deficit model of health education," tend to "'blame the victim' or their culture for poor health, and (do) not address the social economic factors contributing to (their) health status" (Douglas 1995, 71). Hall and Lamont (2009) have argued that there is an urgent need to widen the lens through which we view public health problems and investigate socioeconomic factors and "the role played by institutional practices and cultural frameworks in the determination of population health" (p. 7).

The emergence of diversity discourses during the past two decades must be situated against this background because it has led to a shift in the rhetoric used for public health measures targeting minority groups. In these discourses, diversity has been reestablished as a positive value and resource, giving rise to "diversity-sensitive," "intercultural," or "transcultural" public health programs that aim to "activate" or "empower" minority groups. While discussions within public health often laud this development as an important step for addressing the health needs of what is perceived as unprivileged segments of the population (Wolf, Endler, and Wimmer-

Puchinger 2010), social science scholars have often been quite critical. They have argued that such interventions still "build upon an understanding of intervention and culture that has evolved from colonial initiatives of correction" (Schneeweis 2011, 297). In this context, Krieger (1996) delivered a powerful critique of notions such as "diversity," "heterogeneity," and "disadvantaged" that are often used in public health, denouncing such vocabulary as euphemisms for sidestepping questions of social justice. Such terms obscure the inequalities in health that are deeply rooted in social structures and hierarchies rather than mere expressions of "differences." Words such as "disadvantaged" or "special populations" "catch almost exactly that combination of sympathy for the victims of a social order with the conviction or unnoticed assumption that such an order will or must continue to exist," thereby barring discussions of socioeconomic inequalities, power relations, and health (Williams 1983, 324, cited in Krieger 1996, 135). A language of "diversity" might thus tend to obscure how medical and health-care issues are deeply related to social justice issues (Fishman, Mamo, and Grzanka 2017).

Contemporary public health interventions that aim to be "diversity-sensitive" or "intercultural" occur in spaces that are not only characterized by a vagueness of what "diversity" or "culture-sensitivity" actually mean but that are also highly contentious. Obesity—a prominent example of contemporary public health debates—is arguably an excellent case for studying how issues of human diversity are imagined and acted upon. Research, policy, and public debates have persistently linked obesity to "cultural" factors such as lifestyle and eating behavior (Boero 2007; Penkler, Felder, and Felt 2015; Felt, Felder, and Penkler 2017; Gard and Wright 2005), and the bellicose imagery of the "war on obesity" can be easily transformed into a vilification of the norms, values, and identities of minority groups, as their "culture" is often blamed for higher than average body mass indexes (Herndon 2005). In this context, targeting minority groups with specially designed health promotion projects—as this is the case in our study—treads in a particularly uneasy terrain of stigma, moralization, and reifying assumptions about "others" and their cultures.

Projectification of Health Care and Health Promotion

Traditionally, the universal Austrian health-care system, which covers virtually the full population living in Austria, was strongly oriented toward a curative approach, and the first legislative initiatives for health promotion were not established until the 1990s (Noack 2011; Hofmarcher and Rack

2006). The most important legislation was the federal Health Promotion Act of 1998 that delegated the implementation of health promotion measures to the publicly funded nonprofit *Healthy Austria Fund*. The fund's main purpose is to finance health promotion measures through short-term projects; they do not receive funding for long-term programs. From the beginning, Austrian health promotion has thus taken a highly projectified form (Noack 2011).

There have been a number of studies on the effects of projectification in broader scientific research contexts (see Felt 2009; Vermeulen 2015; Torka 2006; Abrahamsson and Agevall 2010). However, given the centrality and prominence of work in the form of projects in biomedicine and health care, surprisingly, there have been few studies on their effects on the production and application of biomedical knowledge. The increasing allocation of research and health-care funds for projects is tied to the administrative doctrine of new public management (NPM), which has been increasingly propagated since the 1980s (Abrahamsson and Agevall 2010; Fred 2015). The creation of marketplaces where different organizations compete for resources is one of the core ideas of NPM approaches. The use of temporal projects to steer activities and allocate public resources is tied to the promise that this will make health care and research activities more efficient, flexible, and easier to shape and will increase the cost-effectiveness and accountability of those who receive public funds.

While the use of projects has often been lauded as an organizational response to the "challenges of managing in a world of growing complexity," scholars from science, technology, and society and related fields have also noted how "the world of projects is inhabited by dilemmas and contradictory logics" (Vermeulen 2015, 31-32). Projectified modes of working introduce novel "modes of ordering" (Law 1994) into academic research and, as in our case study, also in the provision of health care. They bring along "project related principles, rules, techniques and procedures, aspiring to form a 'new iron cage of project rationality'" (Maylor et al. 2006, 664), which reorients practices and aspirations to align with the logics and constraints of temporally well-delimited projects. In the context of research, this means that the open and unpredictable process of conducting research is at least partly subordinated to the logic of administrative control and accountability (Felt 2009), formalized through contracts (Vermeulen 2015), and driven by the idea of an optimal knowledge/time relation. Embracing such a logic of accountability means that attention must be shifted to countable outputs per time when a project is acquired (Felt

2017b, 53), which conflicts with the character of knowledge generation because it is generally an unexpected and open-ended process (Felt 2009).

Abrahamsson and Agevall (2010) described comparable dynamics and paradoxes in their study of two health-care projects designed for immigrants in the Swedish context: the projectification of health care increases the administrative workload, reducing the actual provision of health care. In addition, compartmentalizing health care into projects and predefining project goals are detrimental to developing a more holistic perspective that remains sensitive to a more comprehensive concept of health and to possibly unforeseen health-care needs. Projects are often "short-term solutions to long-term problems" (Abrahamsson and Agevall 2010, 201); at best, they may be ineffective and at worst counterproductive, as clients continue to have persistent unsatisfied needs after the termination of projects (Abrahamsson and Agevall 2010).

In both health care and research, projectification leads to "structural uncertainty" (Abrahamsson and Agevall 2010, 202) with which the actors are left to cope (see Sigl 2016). This often leads to a situation in which actors only pursue research or care approaches that are "doable" (Fujimura 1987) within the temporal and spatial confines of a project, leading to the exclusion of approaches that may not fit the project form (Sigl 2016; Torka 2006). In this context, it is not mainly substantial and content-related considerations that guide project applications but often pragmatic considerations of what is deemed fundable.

In the following, we analyze how the buzzword diversity currently plays an important role in steering project-funded Austrian health promotion activities in the area of obesity prevention.

Method

We conducted a case study of a diversity-sensitive public health promotion project for obese clients at a Viennese health center specializing in women's health. The project, taking place in the early 2010s, focused on what the center described as "disadvantaged" population groups and had a project duration of roughly two years.[1] The center conducting the project is primarily operated by psychologists and social workers. It has a noticeable focus on behavior-related health interventions and its projects center on topics such as nutrition, exercise, and body weight. The women's health center cooperated with an affiliated men's health center but took a clear lead in conducting the health promotion project.

The health promotion project primarily consisted of diet groups for obese clients in addition to lobbying for public health policy on obesity and raising health awareness. Groups were separated according to gender, and the project was conducted in several languages (German, Turkish, and Bosnian-Croatian-Serbian [BCS]). For a period of eight months, each of the diet groups met once a week for two hours. While the main part of the weekly meetings was dedicated to psychological group work, there were dedicated time slots for nutritional advice and group exercise under the supervision of dieticians and exercise trainers. Groups were led by gender-matched psychologists or psychotherapists, with the exception of the Turkish male and female groups, which were coled by a male medical doctor.

In 2012, we conducted in-depth, open-ended interviews with the director of the health center (who was also the project leader) and other health professionals involved in designing and conducting the health promotion project. Among these individuals were two psychologists who led the German-language women's groups, a psychotherapist who led the German-language men's group, and a psychologist who led the Turkish-language women's group.[2] We were not able to conduct interviews with the psychologists who led the Turkish-language men's group and the (by then defunct) BCS group nor with the medical doctor who coled the Turkish-language groups.

We documented the activities of the health professionals and the public events held between 2012 and 2014; in addition, we attended talks, conferences, and network meetings that the health professionals organized. Further, we analyzed the public health center's reports, documents, and publications. We also interviewed four public health stakeholders to gain better insights into the broader context of Viennese public health promotion. Furthermore, we conducted six in-depth, open-ended interviews with attendees of the male German-speaking diet groups to gain a more nuanced picture of the groups and their dynamics. We obtained informed consent from the participants for the interviews, which were tape-recorded and fully transcribed. We regard the interviews not as representations of an underlying reality but as situated performances and as occasions to engage in reflexive sensemaking and articulation practices (Holstein and Gubrium 1995; Gubrium and Holstein 2003). Unfortunately, we did not obtain access to the actual group sessions due to concerns that our participation might invade clients' privacy and disturb therapeutic progress nor did we get the opportunity to interview participants in the female diet groups. We coded and analyzed all data employing grounded theory coding procedures (Charmaz 2006).

Findings

Searching for "Hot Topics"

Since the implementation of health promotion as a policy field in Austria in the 1990s, the definitions of priorities and goals set for activities are largely tied to project funding (Noack 2011; Hofmarcher and Rack 2006). The women's health center, similar to other public health actors in the Austrian context, has only limited stable funding that ensures their ability to offer basic health counseling hours. Offering additional health promotion activities and launching new initiatives are almost entirely dependent on receiving third-party funding. Major sources of project funding include the federal *Healthy Austria Fund*, the communal *Wiener Gesundheitsförderung* (Viennese Health Promotion), and the Austrian social security carriers.

In this context, the procurement of funding is a major concern for the health center, leading to interventions being mainly organized around topics that may attract funding. Innovativeness is a major criterion for the funding of projects in the Austrian health promotion context; therefore, the health center must constantly search for new "hot topics," as stated by health professionals. Buzzwords such as "diversity" play a crucial role in this search and foster an entrepreneurial atmosphere among the team members of the health center.

The health promotion project we observed was actually based on a combination of two hot topics: obesity and diversity. Since the early 2000s, obesity has become increasingly framed as a major public health concern in the Austrian context (Felt et al. 2014; Penkler, Felder, and Felt 2015). Indeed, in the past few years, the health center has been able to attract project funds to address obesity, including several health promotion projects aimed at obesity prevention or weight loss. One health professional told us that the director of the health center had pushed to focus on this topic despite the fact that other members initially showed little interest:

> I cannot say why, but (the director) wouldn't stop talking about this topic. I guess she had realized that it is a politically popular topic and there will be money in it.

For many on the team, and at that point in time, obesity was not an obvious matter of concern, which illustrates how in projectified contexts, health professionals need to develop the skills to anticipate which topics will be regarded as having enough future potential and which will not.

The second hot topic around which the health promotion project was organized was "diversity," a buzzword that has gained popularity in the Austrian context in the 2000s, and which was largely imported from the US context (Felt, Felder, and Penkler 2017). As indicated by the interviews we conducted, being "diversity-sensitive" is often considered "best practice" in public health, and it also plays a central role in the self-presentation of the health center, which had begun to explicitly engage with this notion during the design of the project. The project team, whose members come from different migrant backgrounds and pride themselves on their ability to speak multiple languages (thus "living diversity," as stressed by several team members during the interviews), was clearly drawn to this new positive framing of human differences.

The health center began to consider the term "diversity" against a background in which concerns about health differences have always played a central role. The women's health center was founded in 1999 specifically to cater to what was perceived as the "socially disadvantaged" segments of the population. Its foundation was a response to the growing realization that existing public health services mostly focused on more "privileged" groups. As explained by the director of the health center, "Anyways, health promotion used to be—frankly—a middle and upper-class program, wasn't it?"

The director and other members stated that the original work of the health center was strongly motivated by a social justice framework in which differences in health access and needs were framed as the consequences of well-entrenched socioeconomic disadvantages. Therefore, due to the original framing, differences among population groups were considered to be something negative that would ideally be overcome at some point. The health professionals embraced more recent discourses on "diversity," partly in response to concerns about the stigmatizing effects of framing disadvantaged groups by using deficit terminology and partly because of the opportunity to ground their work in a more positive understanding of human differences. At the same time, they remained concerned that a purely positive framing of "diversity" might obscure how it is linked to and might lead to inequalities due to structures of discrimination.

As a buzzword, "diversity" exemplifies the fuzzy nature of wide-sweeping concepts that are often used to programmatically steer fields in particular directions. As we will show in the upcoming sections, this multivalence and ambiguity regarding how to evaluate "diversity" proved to be a source of constant struggles and negotiations during the implementation of a "diversity-sensitive" health promotion project. The tensions apparent in the health professionals' work were further increased because of the

time-limited nature of the project. The professionals were required to identify and delineate "public health problems" that could fit within these temporal confines. This emphasis encouraged narrow definitions of target groups and the attribution of clearly defined needs to these groups, which may be at odds with a more comprehensive understanding of "diversity."

Designing and Assembling a Doable Project

To translate "diversity" into concrete public health interventions, the health professionals had to articulate the buzzword in a way that fit the project format. Working in a "diversity-sensitive" way was operationalized as designing interventions that cater to target groups meant to represent clearly distinct segments of the population. Based on prior experiences, the project team chose to adopt a commonly recognizable and easily relatable understanding of diversity in the form of categorical differences between groups. They decided to focus on the combination of two rather robust large-scale categories for grouping the Austrian population: gender and native language; therefore, they planned and conducted gender-separated diet group interventions in German, Turkish, and BCS.

The need to legitimize a "diversity-sensitive" approach created a strong incentive to conceptualize the different diet groups as having clearly distinguishable ways of living and therefore different needs for addressing issues related to body weight. On the one hand, the center argued that gender-separated diet groups were necessary, as women and men relate to specific gender roles and attach different meanings to their bodies, have gender-specific ways of expressing their concerns, and experience differently the highly emotionalized topic of body weight.

On the other hand, the reason for conducting interventions in Turkish and BCS as well as in German was to reach population groups that were perceived as somehow disadvantaged compared to others in the Austrian health-care system. Based on their prior experiences, the health professionals started by forming the hypothesis that migrant communities struggle not only with language problems but also with access barriers due to specific blends of cultural, educational, and socioeconomic factors related to health literacy. Language was thus used as a proxy for addressing "cultural" differences, that is, differences in the social and cultural contexts of their clients and differences in their biographical situations as well as their assumed values.

These assumptions about these different needs led the center to develop different strategies for enrolling the participants into the diet groups. For

example, the health professionals scheduled the Turkish women's groups for specific times of the day:

> We have, for example, planned the Turkish courses before noon because in our experience, the housewives or women who are not working full-time prefer to come to us at this time, don't they? Because they often have to go home at noon in order to pick up the kids from kindergarten or school . . . .

In contrast, the BCS groups were planned during the evening because the psychologists assumed that women who had migrated from former Yugoslavia would—in contrast to Turkish migrants—work full time and thus would only have time in the evening.

Similarly, the health professionals employed very different strategies for contacting the potential participants based on prior assumptions. Below are comments from another psychologist involved in designing the project:

> The Turkish-speaking psychologists went where the women could be found, which was primarily at the mosques and cultural clubs. And every woman had to be individually approached there. It wasn't enough to go speak to a group or so, you really had to talk with every single woman. The German-speakers were naturally a bit easier to approach. I remember when we put an insert in the *Kronenzeitung* [Austria's largest tabloid], and the telephone wouldn't stop ringing.

The effort that the health professionals put into reaching the Turkish clientele illustrates how their predefined target groups were not simply "out there" waiting to be enrolled. Rather, developing the diet groups described in the project proposal required much extra work for the health professionals in terms of assembling the respective groups. This effort indicates that the composition of the diet group did not simply represent preexisting population groups. The specific form of the health center's recruitment work homogenized what was regarded as typical for the Turkish- and German-speaking women in general; it also excluded potential clients that did not conform to these constructions, such as German-speaking women with low health literacy or those who did not respond to the advertisement in the newspaper. We regard this as an example of what Busch (2011) calls "standardized differentiation" (p. 152), that is, the use of standards to establish differences between categories. The participants were positioned both as members of a specific group and as different from all others outside of the group.

The requirement to construct a doable diversity-sensitive health promotion program thus led the health professionals to conceptualize target groups with different needs and, subsequently, to engage in assembling actual diet groups that corresponded to their initial definition of "diversity." However, the process of assembling the groups was not always successful because it also depended on the availability of actors that would fit to the prescribed groups. This was particularly evident for the BCS groups, which proved not to be doable, as explained by the director:

> We dropped [the BCS groups] again. We held one course, but we saw that holding another one was not necessary. The women are simply linguistically more advanced; it is clearly possible that women who come from former Yugoslavia take German-language courses. There are not so many . . . of these classical cultural differences.

The center's difficulties in recruiting participants for the BCS group led to the conclusion that the needs of BCS women had become close to those of German-speaking women. The BCS group had an advanced understanding of the German language, which was considered to be a proxy for having similar health-related needs. In contrast, difficulties in recruiting participants for the Turkish-speaking groups triggered an even stronger effort to reach women who met the requirements for inclusion in the target group.

Coproduction of Diet Groups and Problem-Solution Packages

The definitions of the different target groups, how the health professionals perceived their respective problems, and the solutions to those problems were all mutually constitutive. In observing the health promotion project, we could thus witness coproduction in the making (Jasanoff 2004), that is, how the actors know and represent the world around them is inseparable from the ways they live and intervene in it. The actual composition of the diet groups not only changed what was discussed during the two hours of the weekly meetings but also shaped the understanding of the participants' bodies and of the health issues that needed to be addressed.

The health professionals identified the factors motivating German-speaking and Turkish-speaking clients to participate in the health promotion project as differing markedly. The director of the health center told us:

> Women without a migration background have enormous [amounts of] psychological stress; they have tried umpteen diets . . . . They also already

> know quite a lot regarding nutrition; [they] are better nutritionists and dieticians than our trainers . . . . This is not at all the case for women of Turkish origin . . . they have only very little nutritional knowledge but also less psychological stress: I now have to lose weight . . . and part of that is simply that they don't have to worry about a certain societal beauty ideal, isn't it?

According to the health professionals, in the context of these two groups, obesity was constructed as a quite different problem. For German-speaking women, they described the weight problem as being largely psychological: prevalent body images would pose a lot of emotional stress on women to comply with hegemonic beauty ideals, which in turn leads to self-deprecation and unhealthy dieting habits. Psychological work addressing the emotional aspects of food and body weight and aiming at transforming the women's self-perceptions was thus put in the focus of the German-speaking diet groups.

In contrast, the health professionals characterized the Turkish-speaking women as being less concerned with their body image and as more motivated by genuine health concerns such as back pain. Allegedly, beauty ideals were of less importance for this target group due to traditional Turkish gender roles. The main problem of this target group was described by a psychologist as "having a very strong deficit in regard to healthy nutrition." Accordingly, the Turkish-speaking diet groups were designed with a focus on providing nutritional knowledge and increasing health literacy. The project team, therefore, decided to include a male Turkish-speaking medical doctor as a coleader in both the male and female groups. They had collaborated with the doctor in previous projects and argued that he was well received by this target group that attributes a lot of authority to medical expertise. This was somewhat at odds with the design of the German-speaking groups, which were led by gender-matched psychologists, as gender parity between clients and supporting health professionals was deemed as psychologically advantageous. Knowledge orders and social orders thus got closely entangled.

Catering to the Turkish-speaking clientele also had consequences for how the Turkish-speaking diet groups developed in practice. From the beginning, it proved difficult to develop an obesity-focused project that was attractive to Turkish-speaking migrants; in the advertisements, the health professionals reframed it in strategic ways, as noted by one of the psychologists:

> What is always well received is healthy nutrition—isn't it?—healthy cooking for the family . . . if we came and said: we have a wonderful slimming program here—that would be totally unattractive.

Thus, while the project was financed and legitimatized as a weight-loss intervention, adapting to the perceived needs of the target group led to a marked reduction of the focus on body weight in the Turkish-speaking groups. This became even more of an issue when the groups were actually held. A Turkish-speaking psychologist shared the following:

> They not only ask questions about nutrition or losing weight, but, as there is a Turkish-speaking doctor here, they come with all their clinical reports and want to discuss all kinds of things with the doctor . . . for example, what are the side effects of this or that drug? Or they ask questions about other diseases, for example, thyroid diseases. You can tell that the women cannot usually discuss these things with their doctors because of their limited ability to speak German.

The method used to define the Turkish-speaking groups thus led to shifting the focus away from weight loss, and the health issues discussed in the group went far beyond issues related to weight and food. The Turkish women utilized the diet groups as an otherwise missing occasion to discuss health problems with a medical doctor in their native tongue. The health professionals in turn were happy to provide this service to a target group that was seen as disadvantaged and as having difficulties to access comprehensive primary health care. Accepting that the official goal of losing weight shifted to the background, they also perceived the Turkish-speaking dieting groups as an opportunity to bring together women who are often isolated to discuss topics of physical and emotional health.

In the Turkish-speaking diet groups, the shift away from a focus on issues related to weight loss was a consequence of the project design; to ensure that the health promotion intervention was diversity-sensitive, the health professionals had to "identify" diet groups with clearly distinguishable needs. The project's success thus rested on the capacity to shape doable problems that are both adapted to the funding logic and appropriate for the respective groups the project should speak to (Abrahamsson and Agevall 2010). Thus, our case shows how the attempt to develop a project that relates to two hot topics—"obesity" as a growing health concern and the buzzword of "diversity"—can create challenges and tensions for a health promotion practice that tries to attend to both. We witnessed a shift in how

the very health problem that needed to be addressed was reconfigured on the frontstage and concerns over body weight were moved to the backstage.

The methods used to define the groups and their needs performed "substantial difference," which then shaped how the health professionals represented their clients. In the interviews, project reports, and conference talks, the perceptions of Turkish-speaking clients reiterated arguments that attributed their otherness to culture.[3] Their weight problems were depicted as rooted in their poor health literacy and cultural norms; thus, the center engendered public health concepts that define the poorer health status of particular groups in terms of a deficit with regard to the majority population (Schneeweis 2011; Douglas 1995). Turkish-speaking women were characterized as being less affected by beauty ideals because their lifestyle and mode of dressing were perceived as more traditional and less westernized. These differences were partly an artifact of the recruiting process tied to the project design: the "German-speaking" group was self-recruited and included clients who were already concerned about their body weight. Individuals for Turkish-speaking groups were explicitly searched for while concurrently excluding Turkish-speaking women who worked.

The descriptions used for each group fall inconveniently in line with widespread stereotypes about Muslims in Austria (Hametner 2014). However, the psychologists were not ignorant of these potential consequences and were very conscious of the dangers of othering their Turkish-speaking clients. We will highlight their struggles to address these tensions in the next section.

Struggling with Tensions in Diversity-sensitive Project Work

As previously discussed, designing the health promotion project for diet groups separated based on gender and language coproduced representations of the clients that tended to inconveniently fall along the line of prevalent cultural stereotypes (Hametner 2014). Such representations not only tend to influence how people perceive themselves (Hacking 1986) but also affect how they are perceived in a wider public sphere through the health center's publications and conference presentations. This posed a challenge for the health professionals who were deeply concerned about the social disadvantages of their clients and potential stigmatization and who, as one psychologist puts it, were "of course" aware that "differences are produced."

Despite being conscious of the risks embedded in such an approach, the health professionals fully stood behind it. This is well described in the following reflection provided by a psychologist:

> Out of our experiences at the health center: yes, there are real differences. And it doesn't matter if they are a specific nationality or where they come from because there are groups that are disadvantaged and really need special support, aren't there? . . . . And it is also good that we offer gender-specific programs because it is a necessity and it does make sense.

To counterbalance the potential problems linked to explicitly calling people "migrants" or labeling them as "disadvantaged," the health professionals highlighted the importance of explicitly acknowledging existing social injustice: they strongly called for acknowledging that there are structural disadvantages that need to be identified and addressed, even at the danger of homogenizing groups and fostering certain stereotypes.

The professionals deeply cared about and struggled with such questions, which became evident in the interviews we conducted with them but did not find expressions in their official statements. On the one hand, the project team presented the utility of a diversity-sensitive approach as self-evident in their official reports and at conference presentations and did not further problematize it. They described their approach as an unequivocal success in addressing a clear need for diversity-sensitive health promotion. For example, the final project report states: "The results have shown that this approach accommodates very well to the needs of the different target groups," adding that there is a continuous "high demand" for such measures.

In contrast to these public presentations, the health professionals explicitly told us that they welcomed the opportunity to reflect on this "difficult topic" in the more informal setting of the interviews and to engage us as "diversity experts." They asked us, the social scientists, about our own opinions of what the definition of diversity is or should be. This allowed us to gain insights into how they addressed a perceived tension between the need to acknowledge differences and the danger of stereotyping. We observed two main strategies to handle these tensions at work. One technique of resisting such culturalizations was to collectively remind each other in team meetings of the fragility of concepts such as culture and to scrutinize their own evaluations of the communities they worked with. For example, the director of the health center shared the following:

> We discuss this topic a lot, that we ourselves do not say: the "migrants" and the "non-migrants." Okay? Like in the example of the farmwomen. We tend to think: Oh, of course, women of Turkish descent are like that. But if we look at the countryside here [in Austria], there actually is no difference, is there?

> This is something you can apply to other topics as well, such as the issue of headscarves . . . my grandmother never left the house without a headscarf. Yes, there are these differences, but they are sometimes not as massive. But of course, there are specificities.

The psychologists stressed that the differences perceived as "cultural" were often rather a matter of education, socialization, or class. The professionals occasionally policed themselves in our interviews when they realized their arguments might paint a stereotypical picture about Turkish-speaking Viennese.

Another strategy that the psychologists applied was to stress the individuality of each participant. By doing so, they observed that their view aligned with recent trends in discourses on diversity:

> It goes ever more into the direction of paying attention to individual needs. Not to build rough categories, but to pay attention: what makes this individual person different. To look at all the small parts. I do think that this is a good approach. Because, as I said, the social milieu, the migration background, or sexual orientation do not really mean much, do they?

To address the tensions that emerged in their work, the psychologists stressed the importance of taking an individual approach and reminding themselves that "everyone is different." However, they also called for caution and stated that they should not lose sight of the systematic oppression and discrimination of specific groups by simply focusing on each client individually, which highlights the danger of obscuring structural factors.

The complexity of the health professionals' engagements with the notion of diversity shows how diversity is a vague and ambiguous buzzword that can encompass different articulations of the relevant differences between human beings. However, the way in which the project was set up was mainly focusing on one articulation of diversity—caring for diversity as attending to group differences—and subsequently it also reproduced this understanding, leaving in practice little room to actually engage with the unique needs of individual clients. The health professionals wished they had more time and money to integrate a more individualized understanding of human differences into their work. They found that good health care required both a focus on the individual and a consideration of the specific vulnerabilities of different groups; however, the limits of projectified health promotion severely impeded this task.

The short-term nature of project work was thus seen as a constant impediment and challenge. The health professionals told us that working meaningfully in a diversity-sensitive way would require more stable arrangements, and they worried about the sustainability of their health promotion interventions: they felt that any success they made with their clients was threatened by the imminent discontinuation of their work when a one-year diet group was over. The director told us:

> It [a health promotion program] is well accepted, it is going nicely, there is demand, and then the project ends. And that is an absolutely frustrating experience that we have again and again.

The project team worried about how to continue rendering their services to their clients on a more long-term basis and worked hard to find solutions. The health center funded a small amount of diet groups out of their basic budget after the official end of the project, and the team strived to find new funds for a more large-scale continuation of the project but was unsuccessful at the time when we concluded our fieldwork. In our interviews, they voiced a sense of frustration between policy makers' claims about the importance of "diversity" as a buzzword and the lack of resources devoted to it in a project-driven world. This sense is palpable in the following quote by the director: "Diversity is fashionable, and you often hear how important it is, but it's mostly a fig leave. Lived diversity is rare." According to her, what is really needed is a more open approach toward diversity that allows addressing more long-term and partly unforeseeable needs and that gives enough space for meaningful developments: something that is difficult to accommodate for in short-term and necessarily time-limited projects.

Discussion

This article identifies the effects of two trends in contemporary biomedicine that have thus far been largely addressed separately in the literature: the steering of fields through programmatic "buzzwords" and the projectified nature of contemporary health research and health care. Our case study of a diversity-sensitive health promotion project shows how these two trends are intimately intertwined in contemporary Austrian public health programs: the "structural uncertainty" (Abrahamsson and Agevall 2010, 202) inherent in an organizational form based on (always insecure) short-term funding leads to a situation in which actors strategically articulate new projects based on currently fashionable funding trends—a dynamic that is

strengthened by an insistence on "innovative" approaches in NPM. In this context, terms that are popular, highly value-laden, and quite vague play a crucial role in guiding the design of projects. The promissory logic inherent in the world of projects (see Borup et al. 2006) leads to a situation in which actors feel compelled to make sweeping promises about solutions to societal challenges as epitomized in buzzwords such as "diversity" combined with the promise of obesity prevention.

At the same time, the organizational form of the project often undermines the realization of these wide-sweeping claims and ambitions. Our case study exemplifies that well: while the buzzword of diversity often stands for a positive revaluation of human differences tied to imaginaries of long-term cultural change, the institutional logic used to develop projects caused health professionals to articulate and specify it in a much more restricted way. One reason for this is that the design of projects requires the identification of clear-cut problems and goals that can be addressed within the spatial, infrastructural, and temporal constraints of a single project. In the context of public health's biopolitical concern with the health of subpopulations, the need to develop "doable" projects encourages health professionals to identify clearly specified (large enough) target groups and their needs. The logic used for projectified health promotion thus promotes a practice of addressing diversity that may appear as being crude and potentially stereotyping and thus be at odds with efforts to increasingly fine-tune the categorizations applied (see Felt, Felder, and Penkler 2017). Notions such as "superdiversity" (Vertovec 2007) highlight how entrenched categories of diversity are increasingly regarded as problematic and as inadequately representing the complexity of contemporary societies and the proliferation of social stratifications and identity categories. While the health professionals expressed enthusiasm for such notions of diversity in our conversations, they also felt compelled to design their project in line with and reinforcing more rigid understandings of diversity in terms of entrenched social categories. The need to define "doable" health interventions upfront thus means that a more open and flexible form of diversity that is responsive to unforeseen needs, intersectionality, and, perhaps, newly emergent forms of difference easily appears to be too risky and complex.

Additionally, the temporalization of project work hampers and complicates attempts to implement more structural changes in the provision of health care—something clearly needed if the visions of structural and cultural change tied to notions of "diversity" are taken seriously. There is an inherent tension in trying to reach long-term goals through projects, as what they can contribute is necessarily and by definition limited by time and

resources. Projects tend to offer temporary and singular "fixes" for long-term structural problems (Abrahamsson and Agevall 2010; Felt 2017a). As a result, actors constantly worry about how to maintain sustainable work arrangements despite these limitations, asking questions like: how can they get the next project funded? Is a specific topic going to continue to be "hot" and thus to attract funding? How can they ensure continuity between and across projects in order to be able to cater to health-care needs and problems that require long-term approaches?

The pressure to align with certain buzzwords thus adds to the "dilemmas and contradictory logics" of the "world of projects" (Vermeulen 2015, 32) in specific ways. The "new iron cage of project rationality" (Maylor et al. 2006, 664) tends to change how these buzzwords are specified and articulated in ways that may create considerable tensions with what actors would actually regard as the most appropriate way to engage with notions such as diversity. As a result, actors face the challenge of having to navigate and reconcile conflicting institutional, substantial, and conceptual demands, as the logic of the project form guides their work in directions that are far removed from what they were initially inspired to do.

Our analysis identifies the limitations of addressing diversity-related health issues through projectified work. There is an inherent tension between the short-term nature of projects and the long-term aspirations tied to establishing diversity-sensitive approaches. While the projectification of health care is often advanced with the argument that it allows predefined goals to be reached more efficiently, in reality, the logic and framework of projectified work considerably change how diversity in health care can be approached as a problem and how solutions are developed. Temporalized project work does not allow organizations the time they need to develop novel approaches to diversity in specific contexts nor does it allow for the work that is needed to address the complexities of multiple coexisting differences. Instead, short-term projects tend to focus on classical forms of "standardized differentiation" (Busch 2011, 152). For professionals to imbed meaningful definitions of human differences that address the complex web of life concerns and structural factors in the design and outreach of their projects, they need a work environment that allows for reflection and for considering broader problems that might not be solved during the short life span of a single project.

Acknowledgments

The authors would like to thank the participants who gave us their time and shared their ideas with us. Finally, the authors want to express their appreciation to the reviewers and the editors for their comments and guidance to improve the article.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was conducted at the Department for Science and Technology Studies as part of the project "From Lab to Intervention and Back. Doing and Undoing Diversity in Obesity Research, Treatment and Prevention" (PI: Ulrike Felt), which was funded by the Vienna Science and Technology Fund.

ORCID iD


Ulrike Felt https://orcid.org/0000-0001-7506-4234

Notes

1. We have anonymized references to the health center, the project, and project members for confidentiality reasons.
2. All interviews were conducted in German. Quotes were translated by the authors.
3. Thus, we might say that their otherness was "culturalized."

References

Abrahamsson, Agneta, and Lena Agevall. 2010. "Immigrants Caught in the Crossfire of Projectification of the Swedish Public Sector: Short-term Solutions to Long-term Problems." *Diversity in Health and Care* 7 (3): 201-9.

Bensaude Vincent, Bernadette. 2014. "The Politics of Buzzwords at the Interface of Technoscience, Market and Society: The Case of 'Public Engagement in Science'." *Public Understanding of Science* 23 (3): 238-53.

Blackmore, Jill. 2006. "Deconstructing Diversity Discourses in the Field of Educational Management and Leadership." *Educational Management Administration & Leadership* 34 (2): 181-99.

Boero, Natalie. 2007. "All the News that's Fat to Print: The American 'Obesity Epidemic' and the Media." *Qualitative Sociology* 30 (1): 41-60.

Borup, Mads, Nik Brown, Kornelia Konrad, and Harro Van Lente. 2006. "The Sociology of Expectations in Science and Technology." *Technology Analysis & Strategic Management* 18 (3/4): 285-98.

Bos, Colette, Bart Walhout, Alexander Peine, and Harro van Lente. 2014. "Steering with Big Words: Articulating Ideographs in Research Programs." *Journal of Responsible Innovation* 1 (2): 151-70.

Bunton, Robin. 2008. "Public Health and Public Involvement." *Critical Public Health* 18 (2): 131-34.

Bunton, Robin, Sarah Nettleton, and Roger Burrows. 1995. *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle, and Risk*. London, UK: Routledge.

Busch, Lawrence. 2011. *Standards: Recipes for Reality, Infrastructures Series*. Cambridge, MA: MIT Press.

Charmaz, Kathy. 2006. *Constructing Grounded Theory. A Practical Guide through Qualitative Analysis*. London, UK: Sage.

Conrad, Peter. 2007. *The Medicalization of Society. On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, MD: Johns Hopkins University Press.

Douglas, Jenny. 1995. "Developing Anti-racist Health Promotion Strategies." In *The Sociology of Health Promotion. Critical Analyses of Consumption, Lifestyle and Risk*, edited by Robin Bunton, Sarah Nettleton, and Roger Burrows, 69-75. London, UK: Routledge.

Duff, Cameron, and David Moore. 2015. "Counterpublic Health and the Design of Drug Services for Methamphetamine Consumers in Melbourne." *Health* 19 (1): 51-66.

Felt, Ulrike, ed. 2009. *Knowing and Living in Academic Research. Convergence and Heterogeneity in Research Cultures in the European Context*. Prague: Academy of Sciences of the Czech Republic.

Felt, Ulrike. 2017a. "Of Timescapes and Knowledgescapes: Re-timing Research and Higher Education." In *New Landscapes and Languages of Higher Education*, edited by P. Scott, J. Gallacher, and G. Parry, 129-48. Cambridge, MA: Cambridge University Press.

Felt, Ulrike. 2017b. "Under the Shadow of Time: Where Indicators and Academic Values Meet." *Engaging Science, Technology, and Society* 3:53-63.

Felt, Ulrike, Kay Felder, Theresa Oehler, and Michael Penkler. 2014. "Timescapes of Obesity: Coming to Terms with a Complex Socio-medical Phenomenon." *Health* 18 (6): 646-64.

Felt, Ulrike, Kay Felder, and Michael Penkler. 2017. "How Differences Matter: Tracing Diversity Practices in Obesity Treatment and Health Promotion." *Sociology of Health and Illness* 39 (1): 127-42.

Fishman, Jennifer R., Laura Mamo, and Patrick R. Grzanka. 2017. "Sex, Gender, and Sexuality in Biomedicine." In *Handbook of Science and Technology Studies*, edited by Ulrike Felt, Rayvon Fouché, Clark A. Miller, and Laurel Smith-Doerr, 379-405. Cambridge, MA: MIT Press.

Foucault, Michel. 1978. *The History of Sexuality. Volume 1: An Introduction*. New York: Pantheon.

Fred, Mats. 2015. "Projectification in Swedish Municipalities. A Case of Porous Organizations." *Scandinavian Journal of Public Administration* 19 (2): 49-68.

Fujimura, Joan H. 1987. "Constructing 'Do-able' Problems in Cancer Research: Articulating Alignment." *Social Studies of Science* 17 (2): 257-93.

Gard, Michael, and Jan Wright. 2005. *The Obesity Epidemic. Science, Morality and Ideology*. New York: Routledge.

Green, Gill, Charlie Davison, Hannah Bradby, Kristine Krause, Felipe Morente Mejías, and Gabriele Alex. 2014. "Pathways to Care: How Superdiversity Shapes the Need for Navigational Assistance." *Sociology of Health & Illness* 36 (8): 1205-19.

Gubrium, Jaber F., and James A. Holstein. 2003. "From the Individual Interview to the Interview Society." In *Postmodern Interviewing*, edited by Jaber F. Gubrium and James A. Holstein, 21-49. Thousand Oaks, CA: Sage.

Hacking, Ian. 1986. "Making Up People." In *Reconstructing Individualism. Autonomy, Individuality, and the Self in Western Thought*, edited by Thomas C. Heller, Morton Sosna, and David E. Wellbery, 222-36. Stanford, CA: Stanford University Press.

Hall, Peter A., and Michèle Lamont. 2009. *Successful Societies: How Institutions and Culture Affect Health*. New York: Cambridge University Press.

Hametner, Katharina. 2014. "From Retreating to Resisting: How Austrian-Turkish Women Deal with Experiences of Racism." *Migration Letters* 11 (3): 288-99.

Herndon, April Michelle. 2005. "Collateral Damage from Friendly Fire? Race, Nation, Class and the 'War against Obesity'." *Social Semiotics* 15 (2): 127-41.

Hofmarcher, Maria, and Herta Rack. 2006. "Austria: Health System Review." *Health Systems in Transition* 8 (3): 1-247.

Holstein, James A., and Jaber F. Gubrium. 1995. *The Active Interview (Qualitative Research Methods)*. Thousand Oaks, CA: Sage.

Jasanoff, Sheila, ed. 2004. *States of Knowledge: The Co-production of Science and Social Order*. London, UK: Routledge.

Krieger, Nancy. 1996. "Inequality, Diversity, and Health: Thoughts on 'Race/Ethnicity' and 'Gender'." *Journal of the American Medical Women's Association* 51 (4): 133-36.

Law, John. 1994. *Organizing Modernity*. Cambridge, MA: Cambridge University Press.

Maylor, Harvey, Tim Brady, Terry Cooke-Davies, and Damian Hodgson. 2006. "From Projectification to Programmification." *International Journal of Project Management* 24 (8): 663-74.

Noack, Horst. 2011. "Governance and Capacity Building in German and Austrian Public Health Since the 1950s." *Public Health Reviews* 33 (1): 264-76.

Penkler, Michael, Kay Felder, and Ulrike Felt. 2015. "Diagnostic Narratives: Creating Visions of Austrian Society in Print Media Accounts of Obesity." *Science Communication* 37 (3): 314-39.

Rabinow, Paul, and Nikolas Rose. 2006. "Biopower Today." *BioSocieties* 1 (2): 195-217.

Race, Kane. 2009. *Pleasure Consuming Medicine. The Queer Politics of Drugs*. Durham, NC: Duke University Press.

Saha, Somnath, Mary Catherine Beach, and Lisa Cooper. 2008. "Patient Centeredness, Cultural Competence and Healthcare Quality." *Journal of the National Medical Association* 100 (11): 1275-85.

Schneeweis, Adina. 2011. "Constructing the Roma Audience: Public Health Communication and Intervention in Contemporary Romania." *Critical Public Health* 21 (3): 297-312.

Sigl, Lisa. 2016. "On the Tacit Governance of Research by Uncertainty: How Early Stage Researchers Contribute to the Governance of Life Science Research." *Science, Technology, & Human Values* 41 (3): 347-74.

Star, Susan Leigh, and James R. Griesemer. 1989. "Institutional Ecology, 'Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology." *Social Studies of Science* 19 (3): 387-420.

Torka, Marc. 2006. "Die Projektförmigkeit der Forschung." *die hochschule* 15 (1): 63-83.

Trompette, Pascale, and Dominique Vinck. 2009. "Revisiting the Notion of Boundary Object." *Revue d'anthropologie des connaissances* 3 (1): 3-25.

Vermeulen, Niki. 2015. "From Virus to Vaccine: Projectification of Science in the VIRGO Consortium." In *Collaboration across Health Research and Medical Care: Healthy Collaboration*, edited by Bart Penders, Niki Vermeulen, and John Parker, 31-58. Surrey, UK: Ashgate.

Vertovec, Steven. 2007. "Super-diversity and Its Implications." *Ethnic and Racial Studies* 30 (6): 1024-54.

Vertovec, Steven. 2012. "'Diversity' and the Social Imaginary." *European Journal of Sociology* 53 (3): 287-312.

Williams, Raymond. 1983. *Keywords: A Vocabulary of Culture and Society*. London, UK: Fontana.

Wolf, Hilde, Margit Endler, and Beate Wimmer-Puchinger. 2010. *Frauen, Gesundheit, soziale Lage*. Vienna, Austria: Facultas.

Author Biographies

Michael Penkler is a lecturer (Akademischer Rat) in science and technology studies. His research focuses on knowledge cultures and practices in the (postgemonic) life sciences and biomedicine.

Kay Felder is a research associate and lecturer in the field of science and technology studies. Her research interests include temporalities, public understanding of science and medicine. In her current research, she focuses on valuation practices and changes in knowledge cultures.

Ulrike Felt is a professor of science and technology studies and currently president of the European Association for the Study of Science and Technology. Her research focuses on public engagement and governance of technosciences, changing knowledge politics, and research cultures.