Community involvement at what cost?—local appraisal of a pan-European nutrition promotion programme in low-income neighbourhoods

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SUMMARY
In the UK, government has committed itself to improving health and reducing inequalities in health. For the first time, issues such as food poverty will be addressed by tackling the causes of poverty and wider determinants of ill health. The time has never been better, therefore, for health and local authorities to work collaboratively to promote and improve health. Community involvement is also paramount to sustainable programmes. However, such a dramatic shift in policy and greater emphasis on public health requires health professionals themselves to adopt a different approach. The World Health Organization (WHO) recommends a health promotion approach as a framework for action. But despite the existence of this framework there is little evidence that a wider understanding of health promotion and the necessary practical experience has been achieved. This has weakened the potential impact of health promotion and has possibly encouraged inappropriate use of health promotion principles in practice. The European Food and Shopping Research Project (SUPER project) was established under the WHO European network of Healthy Cities to help local projects implement the principles of health promotion (WHO, 1986). This paper describes the SUPER project and its implementation in Liverpool (1989–1997), where levels of unemployment, deprivation and ill health are amongst the highest in the UK. Participation in SUPER is appraised to identify the various benefits and obstacles involved and to identify links with progress at the local level. This appraisal is discussed and the use, and potential misuse, of participatory appraisal techniques to elicit information and mobilize communities is examined.

Key words: community involvement; dietary change; low-income neighbourhoods; rapid participatory appraisal

INTRODUCTION
In the last decade, the strategy for promoting dietary change in the UK has largely focused on providing nutrition education. The emphasis was clearly placed on individual responsibility, relying on dissemination of healthy eating advice as the main vehicle for change. Although dietary trends suggest improvements have been made, this is far from universal, with increasing health and nutritional inequalities between socio-economic groups (James et al., 1997; Acheson, 1998).

Research consistently demonstrates that low-income households find it difficult to adopt healthy eating guidelines. Contrary to popular belief, this is due to economic and circumstantial barriers such as lack of income, access to shops, or inadequate storage and cooking facilities, not lack of nutrition knowledge [Dobson et al., 1994; Department of Health (LIPT), 1996].

More recent attempts involve tailoring nutrition education to the socio-cultural needs of poorer groups and the development of local food initiatives such as ‘cook and taste’. Here, participants are shown how to implement guidelines under difficult financial circumstances. However, critics argue this fails to address the real issue of food poverty: lack of money. Moreover, previous work demonstrates that this type of approach is labour
intensive and is unable to reach a sufficiently large proportion of those in need to be cost effective (Kennedy et al., 1998). More recent work suggests that although worthy, most projects reach a small population and are rarely sustained beyond initial funding (McGlone et al., 1999).

Policy and organizational support are recognized as prerequisites for health promotion. In relation to food and health, policy developments aimed at the broader economic and structural barriers to change have been limited. This is illustrated by the recent emergence and popularity of the term ‘food deserts’, characterized as: …those areas of inner cities, where cheap nutritious food is virtually unobtainable. Car-less residents unable to reach out of town supermarkets depend on the corner shop where prices are high, products are processed and fresh fruit and vegetables poor or non-existent (Jeremy Laurence, *The Independent*, 11 June 1997).

The present government has drawn up a national strategy to improve health and to reduce inequalities in health (Department of Health, 1999). Issues such as food poverty will be addressed by tackling the causes of poverty and wider determinants of ill health (Social Exclusion Unit, 1999). Responsibility for consumer information and protecting public health in relation to food has been transferred to the newly formed and independent body, the UK Food Standards Agency. The time has never been better, therefore, for health and local authorities to work collaboratively to promote and improve health. However, such a dramatic shift in policy and greater emphasis on public health requires health professionals to adopt a different approach.

It is now well established that dietary behaviour, like any other health-related behaviour, is complex, and in order to change people’s eating patterns an interdisciplinary, multifactoral approach is needed. The WHO framework for a health promotion approach (WHO, 1986) recognizes that health is related to social, cultural and structural factors in addition to biological and psychological factors. This approach recommends changing the physical and social environment to facilitate lifestyle change. Despite this framework, there is little evidence that a wider understanding of health promotion and the necessary practical experience has been achieved. This has weakened the potential impact of health promotion and has possibly encouraged inappropriate use of health promotion principles in practice.

The European Food and Shopping Research Project (SUPER project) was established under the WHO European network of Healthy Cities between 1989 and 1997, to help local projects to implement the principles of health promotion (WHO, 1986) in practice. Action research and participatory appraisal techniques are central to the model developed and adopted by member countries and fundamental to the project’s contribution in understanding the process of health promotion (Vaandrager, 1995; Boonekamp et al., 1996a).

This paper describes the SUPER project and its implementation in Liverpool (1989–1997), where levels of unemployment, deprivation and ill health are amongst the highest in the UK. Participation in SUPER is appraised to identify the various benefits and obstacles involved, and to identify links with progress at the local level. This appraisal is discussed and the use, and potential misuse, of participatory appraisal techniques to elicit information and mobilize communities is examined.

**METHODS**

**Programme description**

SUPER is a collaborative research programme looking at the application of health promotion principles and theory to address food and nutrition problems in five designated European Healthy Cities: Eindhoven, the Netherlands; Liverpool, UK; Horsens, Denmark; Rennes, France; and Valencia, Spain. SUPER is modelled on the factors shown to be effective in community prevention projects such as Heart Beat Wales (Nutbeam and Catford, 1987) and North Karelia (Puska et al., 1985). The emphasis is on changing the physical and social environment to facilitate lifestyle changes by individuals (Vaandrager et al., 1992). The stated aims of SUPER are:

- to describe the food patterns, nutritional problems and food policy issues in five European cities;
- to describe the processes relating to health promotion activities in communities and to identify the optimum conditions for best practice;
- to achieve a positive change in dietary behaviour, and attitudes to food and health;
- to decrease differences in nutritional status between higher and lower socio-economic groups within the study population; and
• to develop more sustainable nutrition promotion in communities by incorporating activities initiated by local projects into organizational structures.

Each city has adopted the same principles and methods, adapted locally according to geographical and cultural differences, and follows a four-step methodology: planning, development, implementation and evaluation (Vaandrager et al., 1993), based on the WHO principles of health promotion (WHO, 1986), which are:

• intersectoral collaboration for planning and implementing community activities;
• environmental interventions that help create opportunities or remove barriers for action to achieve a healthy diet;
• community action to facilitate health promoting behaviours by individuals; and
• efforts to encourage individuals to adopt and maintain personal behaviours that would prevent disease and promote health.

The process followed by projects is illustrated in Figure 1 (Koelen et al., 1995).

The research programme functions at two levels: the international level (SUPER project) and the local or city level. Each year SUPER holds a 'business meeting' to exchange research findings between participating cities. At the city level, projects are responsible for co-ordinating their own programme, choosing their alliances and deciding on local activities. In Liverpool, a collaborate initiative was established between the Liverpool Healthy Cities Office (local government), The Department of Public Health at the University of Liverpool (academic), and the Community Dietetic Department (local health authority). The project was managed locally by a multidisciplinary steering group involving key partners with health and community interests, open to anyone working or living in the community and interested in tackling nutrition inequalities.

Study design was determined at the international level. At the time SUPER was initiated,
working towards health promotion principles was relatively new, therefore appropriate working methods and research techniques had to be developed. The project recognized that experimental or quasi-experimental designs were inappropriate for examining the process of implementing health promotion theory. An action research approach, whereby planning and implementation is strongly linked to local participation and intersectoral collaboration, was chosen. This resulted in the four-step framework outlined in Figure 1 to help cities implement the principles of a health promotion approach and to evaluate progress. Justifications for the research methods have been published elsewhere (Koelen and Vaandrager, 1994; Koelen and Vaandrager, 1995).

Participatory appraisal techniques were selected to evaluate local health needs at the city level. Rapid appraisal is one of the best known of the participatory appraisal techniques used in extension work in developing countries. Moreover, it has also been shown to produce action plans in a relatively short period of time, 3–6 months, thus capturing people’s initial enthusiasm, and it also requires limited resources (Engel, 1995). Its popularity rests on three principles, all of which are conducive to health promotion research: ensuring the quantity and quality of data collected is relevant and appropriate to the study purpose; adapting investigations to reflect local conditions and specific situations; and involving community people in both defining community needs and identifying possible solutions.

Rapid appraisal was used to build a community profile, incorporating research and secondary data from four different sources to develop an action plan.

1. A community profile is produced using existing data and local statistics on mortality and morbidity and other indicators of health and social deprivation.
2. Dietetic and other health students were then involved in developing profiles of the local food-retailing situation. Inventories and mapping exercises were used to illustrate and describe variations in levels of accessibility to food shops for local residents and the range and cost of foods available locally. This was used to identify ‘food deserts’ or problem areas to highlight and prioritize action.
3. Respondents or households \( (n = 200 \text{ per district studied}) \) were randomly selected from the electoral register. Local people were recruited and trained by the University to survey households by a semi-structured questionnaire, to identify perceived health and social concerns, and demographic data.
4. Researchers (typically dietetic students) worked alongside the Community Dietitian assigned to that particular neighbourhood. Their role was to select and interview ‘key informants’ in order to identify salient health and social problems in their neighbourhoods.

Overall, internal validity was increased through triangulation. Feedback and information was cross-checked, using several different sources of data and multiple methods [e.g. focus groups, key-informant interviews, existing data sets (i.e. census and General Practice data) and formal/policy documents]. Techniques such as inter-observer comparison, inter- and intra-respondent comparisons and multiple questioning were used to test validity and emerging consensus in the feedback provided. In addition, members of the community and participants in the research were given the opportunity to comment on the project’s interpretations of the appraisal and the resulting community profile at a local forum. When participants agree on interpretation of the results, the threat of biased interpretation is reduced.

At the international level, results exchanged between the five cities were compared and cross-referenced, providing opportunities to draw conclusions about the important processes involved in a health promotion approach (e.g. community involvement, professional orientation and policy development).

**Participants of the Liverpool SUPER project**

Between 1989 and 1997 the total population in Liverpool was ~450 000. In addition to baseline studies (Vaandrager et al., 1992), the framework advocated by SUPER and rapid appraisal was applied in five low-income neighbourhoods in Liverpool, each averaging 1500 households. In each area 200 households were randomly selected from the electoral register. The average response rate, across all areas, for the household survey was 54%. In addition, an average of 35 key informants from each locality was interviewed. Informants represented a range of professional and lay interests or community groups in the local neighbourhood (i.e. schools, youth clubs, community centres, church leaders, primary care
professionals, police, social workers, shopkeepers and community representatives).

Methods of appraisal
An appraisal of the experience and impact of participating in SUPER as a Healthy Cities Multi City Action Plan was undertaken by the co-ordinating team in Liverpool. This developed out of the need for each city to write and present a progress report at the annual business meeting. In preparation for the 1996 report I proposed that all members of the local project and the multidisciplinary steering group should participate. Due to the diversity of emerging opinion, it was agreed that the project needed to reflect on the involvement with SUPER and establish what factors were potentially helpful or unhelpful in attempting to address food and health issues in Liverpool. This initiated the review currently reported, which resulted in identification of the strengths, weaknesses, opportunities and threats listed in Table 1.

All members of the steering group were invited to attend a brainstorming session to explore the strengths, weaknesses, opportunities and threats associated with involvement in SUPER. The aim was to establish a consensus about the possible link between the partnership with SUPER and the approach taken locally, and any changes or improvement in the food and health situation in Liverpool.

During the analysis common themes were identified. Through focused discussion and debate, weak or marginal themes were eliminated, gradually reducing the total number and increasing clarity about the meaning and relevance of each. By building consensus in this way we were able to identify with confidence the salient themes linking involvement in the SUPER project with the activities, approach and results in Liverpool (Table 1). This formed the basis of the

<table>
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<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>Provides a multidisciplinary forum for discussing food and health issues</td>
<td>Lack of project ownership or local control versus centralized control</td>
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<td>Promotes joint working between health, local authorities and academic partners</td>
<td>Created additional pressure on decreasing resources (human and financial)</td>
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<td>Provides mandate for inter-agency working and joint policy on food and health</td>
<td>Using RAP technique has hidden resource demands</td>
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<td>Provides a framework for local action on food and health</td>
<td>RAP can raise expectations for unrealistic deliverables</td>
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<td>Research process encourages effective dialogue with local communities</td>
<td>Lacks financial support at the local level</td>
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<td>Framework encourages wider acceptance of health promotion approach</td>
<td>Emphasis on nutrition problems is too narrow versus community priorities</td>
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<td>Increased use promotes acceptability at the organization level</td>
<td>Dependant on voluntary commitment and goodwill, which weakens sustainability</td>
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<td>Approach helps increase visibility of nutrition services in neighbourhoods</td>
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<td>Health professionals exposed to learning experiences (health promotion)</td>
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<td>Research (RAP) helps identify real needs and local priorities</td>
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<th>Opportunities</th>
<th>Threats</th>
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<td>Reorientation of nutrition and community dietetic services</td>
<td>Current health reforms oppose principles of health promotion</td>
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<td>Increased access to nutrition services</td>
<td>Creation of NHS ‘internal market’ and pressure to do more clinical work</td>
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<td>Prioritization of nutrition work according to local needs</td>
<td>Competing demands—obesity clinics in primary care versus community work</td>
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<td>Increase community involvement</td>
<td>Accountability—short-term targets (numbers) versus health outcomes</td>
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<td>Evaluate and understand processes of a health promotion approach</td>
<td>Job security depends on meeting targets in clinical areas not community</td>
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<td>Policy development</td>
<td>National policy on prevention/health promotion considered mere ‘rhetoric’</td>
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<td></td>
<td>RAP raises real issues versus health agenda</td>
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expanded report presented to the international business meeting (Vaandrager et al., 1996) and wider dissemination (Kennedy-Haynes, 1996). Moreover, the process was used to facilitate further discussion and influence strategy to promote good nutrition in Liverpool.

RESULTS

Twelve of the 20 ‘core members’ (determined as those individuals who had attended three out of four previous quarterly meetings of the steering group) attended the brainstorm. Representation was heavily biased towards the health authority ($n = 9$), with the local authority and academic partners forming the remainder.

During the review, members accepted that progress towards achieving the aims and objectives set by SUPER was limited. This was linked to difficulties in trying to apply the WHO principles of health promotion to practical situations in the field. By exploring the strengths and weaknesses of the model developed by SUPER it was possible to identify links between theory and the mechanics of practice locally.

Translating principles to practice

Since 1989, SUPER and the underlying principles of health promotion have guided food and health strategy in Liverpool. However, until the latter years, there was little evidence from the type of activities developed (see Table 2) that the principles of health promotion were being adopted and translated into practice. According to project reports, in the period 1989–1995, the approach remained focused on nutrition education and disseminating information. Nevertheless, over time the content and style of these reports changed, suggesting that the professionals involved became more aware of the social context in which these people lived and its influence on health-related behaviour. This was also reflected by changes to the style of approach adopted by health professionals linked to the project and by the type of activities initiated during 1996 and 1997 (Table 3).

Table 2: Settings and activities to promote healthy eating in neighbourhoods in Liverpool, organized by the SUPER project (1989–1995)

| Source: (Smit and Rolling, 1993). |
The employment of ‘lay’ food workers in 1996 marks this change in approach and signifies the gradual reorientation of health workers, resulting from the involvement with SUPER, as a major strength. Health professionals also realized that local people have an important role. Local people have a better understanding of the difficulties in adopting a healthy diet faced by their peers. Research suggests that this empathy is key to their role as ‘culture brokers’ between communities and the formal health care system, thus increasing access to services for the socially excluded (Love *et al.*, 1997).

Since the introduction of the lay food workers, the approach in Liverpool has become much broader, focusing more on health promotion and less on nutrition education. Various activities have been introduced to help local people achieve a healthier diet. In addition to providing more socially and culturally relevant advice on food and health they are also positioned to refer people for help on non-food matters including welfare benefits, education and employment. Following its evaluation, the food workers scheme now receives permanent funding through Liverpool health authority, illustrating the extent of organizational and policy development in support of a health promotion approach in Liverpool. Similar schemes in the region have also been successfully implemented (Kennedy *et al.*, 1999).

Professional and organizational reorientation

A major strength, and possibly the most important outcome, of the project in Liverpool was the process of reorientation experienced by participating health professionals and organizations. This process can be described as developing the understanding of what it means to apply the principles of health promotion in practice. Without this first hand experience it remains difficult for professionals to recognize situations where health promotion principles are merely part of rhetoric, contained in policy or strategy documents, waiting to be implemented.

Members of the project team soon recognized that participatory approaches, by their lengthy process, could only be properly implemented with appropriate organizational support. In addition, support needed to come from the highest level and be part of organizational policy. At the start of the SUPER project, support came from management but not organizational level. There

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**Table 3:** Settings and activities to promote healthy eating in neighbourhoods in Liverpool organized by the SUPER project (1995–1997)

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<th>Activities for the period 1995–1997</th>
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<tr>
<td>Increased involvement in the work of the West Everton Community Health Forum.</td>
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<td>Liverpool Food and Health Strategy Development Group established to represent wider agenda (1999).</td>
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<tr>
<td>Food workers use an outreach work approach and consult communities to develop responses to help local people address barriers to healthy eating.</td>
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<tr>
<td>Practical advice on ‘how-to’ implement healthy eating messages is provided for small community groups.</td>
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<tr>
<td>Represent community members on health forums or committees to place local food issues (e.g. lack of shops) on the agenda.</td>
</tr>
<tr>
<td>Offer referrals to people requiring help with non-nutrition problems (e.g. debt).</td>
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Sources: (Judd and Jones, 1995; Heeson, 1996).
was an emphasis on producing research reports, adversely affecting the process that followed.

This changed in 1995 when the project steering group was invited to participate in developing a nutrition strategy to be incorporated into the Liverpool City Health Plan (Taylor, 1998). This was a joint initiative between the Healthy Cities Office, local government agencies, the health authority and the people of Liverpool. The City Health Plan provided the opportunity and the necessary policy support, at chief executive level, to take forward the more progressive ideas and initiatives promoted by SUPER. Moreover, it gave the necessary mandate for professionals to adopt the health promotion approach. Once support at the city level was established it was easier to see the strengths and opportunities of a collaborative Multi-City Action Plan to promote dietary change.

Supportive policy

In 1997/98 a new government and health policy emphasized the importance of the principles of health promotion and called for greater community involvement and greater collaboration to improve health. The SUPER project provided a mandate for collaborative working to address food and health in Liverpool. The foundations of a multi-agency forum were already in place, with a history of joint planning and joint working. The reorientation of health professionals involved in SUPER enabled us to move swiftly into developing a broader and more locally relevant strategy to address food and health problems for the people of Liverpool (Liverpool Health Authority, 1997). It was evident that this wider acceptance of health promotion approach was cascading to other individuals and organizations. Increased acceptance by individuals led to increased acceptance by organizations. This was evident through increased co-operation and commitment of partners in health and non-health sectors to work towards a common health agenda.

Community involvement

Experience demonstrated, however, that community involvement or community participation was much more difficult to achieve in practice. Routine monitoring of activities showed that it was difficult to encourage local people to get involved in activities or programmes to promote healthy eating. For example, in one neighbourhood only 7% of the eligible schools participated in the recipe competitions.

This difficulty was partly explained by shortcomings in the process followed in Liverpool. Rapid appraisal was used solely to collect data, and its principal role in action research, to mobilize community involvement, was ignored. In contrast, the SUPER project in Valencia placed great emphasis on the process, with each stage of the rapid appraisal recognized as fundamental to the overall research and possibly more important than the actual data collected (Boonekamp et al., 1996b).

Community involvement is a key principle of the health promotion approach. The rapid appraisal technique is promoted as a workable system of mobilizing the local population to become more involved in identifying health needs and developing action plans. Participatory research is inherent to rapid appraisal because the process itself encourages local involvement at every stage. Success is based on the assumption that people’s engagement in the appraisal process involves raising awareness and building local capacity to address local health needs, resulting in plans that are supported locally rather than interventions imposed by outsiders.

In Liverpool there was, as Coit terms it (Coit, 1984), no effective system for organizing local action. The emphasis on data collection and written reports that prevailed in Liverpool was typical of the traditional research perspective. Local people were involved in the data collection process but because they were excluded from planning what questions to ask, were provided with no real sense of ownership. Moreover, we had overlooked the value of using rapid appraisal as a tool to facilitate local involvement in planning, data collection, community profiling, analysis, consensus building and action.

The project team, recognizing it was paying lip service to participation, revised its approach. This is illustrated by the project’s enhanced responsibilities for developing a wider food and health strategy for Liverpool, as part of a city-wide consultative process to develop the joint Healthy Cities and health authority ‘City Health Plan’.

It is essential that communities share responsibility for the rapid appraisal and help identify local needs in order to develop a sustainable programme of activities. Subsequently, in Liverpool, rapid appraisal was no longer just a research exercise, but an opportunity to encourage organizations and individuals to identify their particular role in the programme.
DISCUSSION

The most important outcome, and a major strength of the study design, was the gradual process of reorientation experienced by participating health professionals and organizations. Developing an understanding of what it means to apply the principles of health promotion in practice enabled professionals to examine practice and distinguish between genuine progress and rhetoric.

In the early years, professionals in Liverpool struggled to implement the health promotion agenda. However, rapid appraisal has demonstrated it is capable of identifying the range of factors influencing health, thus providing a vehicle for adopting a broader health promotion approach.

Success, in terms of health promotion, is threatened and much effort is wasted if professionals are forced to work against traditional medical views of health. Support for the health promotion approach and principles must come from local and national policy. If this does not exist then efforts must be directed at fostering support alongside other objectives.

Genuine community involvement remains a difficult principle to achieve in practice. Nevertheless, the rapid appraisal technique provides a workable system of mobilizing local people to participate in needs assessment and health promotion. However, rapid appraisal and other participatory research methods should not be seen as just another data collection exercise but as an opportunity to encourage professionals and members of communities to identify their role in the process of health improvement. It is essential for future sustainability that communities share responsibility for the rapid appraisal and local needs assessment.

CONCLUSION

In the most deprived areas of Liverpool, people’s ability to adopt healthy eating guidelines is threatened by limited access to food due to a lack of or inadequate shopping facilities in their local neighbourhood. In the past, professionals responded by telling people what they should eat and demonstrated ways of coping with their limited resources. Experience of using alternative approaches to tackling food and health problems, such as the WHO health promotion approach, is limited. Although some success is possible, progress in terms of encouraging multi-agency working and commitment towards community involvement is a lengthy process with less tangible outcomes.

The present study identifies the strengths and weaknesses, opportunities and threats involved in implementing a health promotion approach at the local level. This provides some insight into the complexities of health promotion practice, identifying pitfalls and suggesting possible indicators against which progress might be measured.

For the health care professionals and their organizations, involvement in the SUPER project itself provided the opportunity for capacity building through a gradual process of education and reorientation. This was fundamental in taking the work forward, but policy support brought about by changes at the organizational and city level was a critical precondition with respect to enabling the adoption of the health promotion approach to address food and health problems in Liverpool.

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REFERENCES


PLEASE NOTE

Copies of unpublished documents and/or reports relating to the SUPER project can be obtained by contacting the original author(s) at the individual institutes, or alternatively by contacting the Programme Director, Dr Maria Koelen at the Department of Communication and Innovation, Wageningen Agricultural University, Wageningen, the Netherlands.