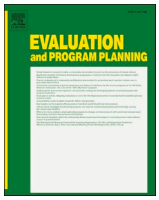
Evaluation and Program Planning 115 (2026) 102745

Contents lists available at ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan



Using theories of power and place to evaluate community health promotion

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ARTICLE INFO

Keywords:
Evaluation
Context
Complex interventions
Community health promotion
Figurational sociology
Place-based health inequalities

ABSTRACT

There is some consensus that better ways of evaluating complex public health programmes are needed as experimental methods are limited in explaining the 'how' and 'why' of change. Methods like 'theory-of-change,' 'realist evaluation,' and 'systems evaluation' try to give a more complete picture of change by looking at the context of the programme. However, when these methods are used to study programmes that aim to reduce health inequalities, they often miss a crucial issue: how power affects people's health and engagement with programmes. This paper addresses that gap by reporting an ethnographic study of a community health promotion programme that was informed by a social theory of power (figurational sociology). When looking at how power dynamics played out in the targeted community, we could see why residents often did not trust the people running the programme, and why local status was so important to them. When programme staff understood these power dynamics, they were better able to connect with residents and help them improve their wellbeing. We argue that combining this way of looking at power with our observational approach gives us a much clearer understanding of how complex public health programmes work and why they succeed or fail in their aims.

1. Introduction: expanding the evidence base for community health promotion

Community health promotion aims to improve health by creating supportive social and physical environments and strengthening community action (World Health Organization, 1986). In England, this work often happens through interventions targeted at people living in socio-economically disadvantaged neighbourhoods to reduce inequalities in health outcomes compared to more advantaged neighbourhoods (OHID Office for Health Improvement and Disparities, 2022; PHE Public Health England, 2018). These "place-based approaches" are a key part of English policy to reduce inequalities in health between neighbourhoods and regions (PHE Public Health England, 2021).

Area-based initiatives are one place-based approach to health promotion that aims to involve communities in the provision of local services. The policy expectation is that "involving people leads to more appropriate, equitable and effective services" (PHE Public Health England, 2015 p. 5). While these initiatives are acknowledged to be complex because of the range of activities and people involved (Skivington et al., 2021), other aspects of complexity (such as community dynamics) are often overlooked in evaluation. There is emerging consensus that experimental methods are limited in explaining the 'how' and 'why' of change in complex interventions (Bambra et al., 2019; Ogilvie et al., 2020; Threlfall et al., 2014). Methods like 'theory-of-change,' 'realist evaluation,' and 'systems evaluation' try to give a more adequate account of change by examining the context of the intervention. However, when these methods are used to study programmes that aim to reduce health inequalities, they often overlook a crucial dimension: how power affects people's health and engagement with programmes.

Research into place, health and disadvantage (discussed below) has demonstrated the explanatory value of a relational, dynamic view of 'place' which puts power at the core of its analysis (Kelly & Green, 2019). This relational and neo-materialist work demonstrates how compositional (human) and contextual (material) factors interact to produce geographical inequalities in health (Bambra, 2022). To better understand how community health promotion can bring about change, evaluation needs to draw on theories in this research that explain why health inequalities endure. This paper contributes to that gap in knowledge by reporting an ethnographic study of an area-based initiative that was informed by a theory of community power dynamics. Our methodological approach blended figurational sociology with grounded theory to evaluate change through a case study of an area-based

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https://doi.org/10.1016/j.evalprogplan.2025.102745
Received 25 May 2022; Received in revised form 3 October 2025; Accepted 16 December 2025
Available online 17 December 2025

initiative (Yin, 2003). The evaluation sought to identify consequences that emerged for residents who participated in the initiative and the role of relations between residents and providers. To illustrate the benefits of our methodological approach, we first outline issues associated with current evaluations of complex public health interventions and place-based community health promotion.

2. Evaluator struggles with 'context'

Despite calls for more careful consideration of the context in which interventions take place (Craig et al., 2018; Chouinard & Milley, 2016), operationalising context remains a challenge for evaluators (Orton et al., 2017; Shoveller et al., 2016; Wagemakers et al., 2010). Theory-informed evaluations have attempted to "take account of context" in complex public health interventions (Craig et al., 2018 p.1) but "definitions of context vary widely" (Pfadenhauer et al., 2015 p.104) with elements frequently poorly defined (Shoveller et al., 2016). Evaluators often treat public health programmes as separate from the environment into which they are introduced. 'Context' is considered secondary or even unimportant (Mykhalovskiy et al., 2019). This way of thinking tends to focus on individuals, separating them from the social and physical environment in which they are embedded, encouraging the pursuit of simplified, direct links between the 'context' and people's actions. This approach can unwittingly depict social influences on health as individual problems, identifying elements of people's social context as isolated risks for certain behaviors (Mead et al., 2022). Greenhalgh and Emmel (2018) suggest, realist evaluation does allow for the use of social theory. However, review work indicates that realist evaluations most often focus on the organizational setting where programmes are delivered, neglecting wider social dynamics (Nielsen et al., 2021). As a consequence, explanations of how programmes work tend to focus on influences that are close by in time and place (Greenhalgh & Manzano, 2021; Nielsen et al., 2021). The separation of context and intervention has given rise to implementation studies underpinned by the rationalist assumption that change can be planned, with evaluation given over to identifying the correct method for implementation of initiative goals (Sanderson, 2000). As a result, much public health evaluation is focused on the implementation of policymakers' goals and rarely critiques the problem definition on which programmes are based (Bacchi, 2016). Sanderson (2000, p. 439) argued that by neglecting social theory, this work "neglect(s) the task of explanation – of seeking to understand links and interactions between policy interventions, the cumulative impact of policies and the influence of institutional regimes." Complex public health interventions targeted at "communities of place" claim to influence change at the collective rather than individual level, aiming to "capitalise… on infrastructures, relationships and trust already established by partner organisations from different sectors working with communities" (PHE Public Health England, 2021). Evaluators would therefore benefit from a theory that explains how public health issues, particularly inequalities, are "created and sustained in context" (Moore & Evans, 2017, p. 134). Given our understanding that evaluation evidence is rarely used instrumentally in policy and practice unless hyper-local (Hampshaw, 2020), understanding how local interventions relate to broader and longer-term social processes is important.

Drawing on complexity science, public health evaluators and practitioners are increasingly directed to define interventions as events in complex and adaptive systems (Egan et al., 2019), which are characterised by "properties such as emergence, feedback, adaptation, and self-organisation" (Skivington et al., 2021 p. 23). Systems approaches to evaluation, however, tend to be under-theorised (Salway & Green, 2017) with uncertainty over how to determine system boundaries or to explain connections between local experiences and longer-term socio--political events (Orton et al., 2017). Systems approaches have provided a means for evaluators to think about how interventions relate to the social context into which they are embedded (Hawe et al., 2009; Jolley, 2014) but have not provided a means of specifying how the 'system' targeted by an intervention changes over time, with or without planned intervention (McGill et al., 2021). As such, systems approaches rarely identify processes that perpetuate conditions of health disadvantage. Mowles (2014, p.162) cautions that widespread use of a systems metaphor "allows scholars to avoid explaining their theory of social action" which perpetuates the notion that "social change can be wholesale and planned".

3. Developments in the theorisation of place, disadvantage and health

Three interconnected theoretical developments in the field of place and health could be applied to the evaluation of complex health interventions. First, established (Massey, 2005; Cummins, 2007) and more recent research (Bambra, 2022; Fox & Powell, 2023) into place, health and disadvantage has demonstrated the explanatory value of a relational, dynamic view of place. Massey (2005) drew attention to the different meanings of place across time and between people, illustrating that routes to health vary for different people living within the same locality. For example, the ways in which local events are understood and talked about collectively by local people, impacts area reputation and health and wellbeing (Halliday et al., 2021). A consequence of defining place in fluid and relational terms is that relations between people in neighbouring areas might be of relevance to understanding the experiences of people targeted by interventions (Cummins et al., 2007). Public health practitioners and evaluators increasingly acknowledge the difficulties of establishing shared understandings of geographical boundaries, historical meanings and identities of places targeted for intervention (Cummins et al., 2007) and yet much evaluation still defines 'place' in homogenous terms.

Second, research has increasingly explored the interdependence of material and relational aspects of place, challenging the problematic separation of compositional and contextual factors that shape health (Cummins et al., 2007). Work in social geography has explored places as affective assemblages of "human and non-human matter" (Andrews et al., 2014; Foley & Kistemann, 2015). Bell et al. (2018) and Yuill et al. (2019) demonstrated how material things impact health through their temporary coalescence within dynamic networks of human relations. Fox & Powell (2023) used a materialist conceptualisation of space to show how different assemblages of people and material things (including buildings, geological features and physical infrastructure) produce different consequences for people's health. The analysis showed that capacities of places to influence health are always context-specific, contingent upon what other material and social elements assemble within a spatial location. In explaining change, evaluation of complex interventions could benefit from greater attention to the interdependence of social and material elements of places.

Finally, there are renewed efforts to refocus analysis of place-based health disadvantage on power relations (Kelly & Green, 2019). Popay et al. (2021) and McCartney et al. (2020) set out frameworks to help identify the types of power that impact health in disadvantaged places, while Bambra et al. (2019) argued for a political economy approach to researching place and health that connects local experiences with national and international decision making. As Minary et al. (2019) argued, for alternative research methods to be used in evaluation of complex public health interventions, evaluators need more guidance on how to use social theory in evaluation. To this end, this paper seeks to show how social theory can be integrated into an evaluation.

4. Towards a sociological understanding of community health promotion

Figurational sociology provides a framework for understanding social change in communities of place. The central premise of figurational sociology is that social phenomena can be best explored through an examination of the interdependencies between people (van Krieken,

1998). These interdependencies are conceptualised as forming figurations, or networks, of "reciprocally oriented and dependent people" (Elias, 1994, p. 214). Elias developed the initial aspects of his figurational perspective through a large-scale study (first published in 1939) of the long-term, intergenerational and unintended processes through which modern societies were formed (Elias, 1994). Elias' concept of 'game models' has been applied to explain organisational change in healthcare revealing the unintended consequences from the interweaving actions of professionals (Mowles, 2011). Comparing life to a competitive game, Elias (1978, p. 82) argued that, as all "players" are interdependent, their "moves" are limited by those of others. There will, therefore, always be unexpected outcomes in a game. His concept of habitus or "personality structures" (Elias, 1994, p. 184) has been used to explain processes of partnership working in area-based initiatives (Powell et al, 2014, 2017).

Unlike a systems perspective, a figurational perspective emphasises the state of flux that characterises human experience. The interweaving actions of large numbers of people results in shifting balances of power over time. People have different levels of power at different times and in different contexts (for example different levels of power at work versus social contexts, in both of which power might change with the integration of new people). Figurational analysis is therefore focused on process – the forming and reforming of figurations. Elias (1991) argued that because social phenomena emerge from the interweaving of individual actions, it is impossible to locate their origins to any precise moment in time. As such, figurational sociology encourages analysis of the historical context of social relations. Although giving primacy to human relations, the emphasis placed on understanding interdependencies within shifting networks of relations allows for the role of material features to be made apparent.

Of particular significance to the study of place-based communities is Elias and Scotson's concept of established-outsiders, which provides a way of thinking about the lines along which power might be demarcated in small communities (Elias & Scotson, 1965, p. xv). Elias and Scotson (1965) showed how power in communities is not always related to traditional forms of social stratification such as class, gender or ethnicity. In the community they studied, working-class residents in a more established neighbourhood were, frequently, able to exert greater control over local flows of communication (or 'gossip' than the middle-class families in a newly built estate (1965). This, they argued, was important to help understand that focus on the more traditional forms of social stratification can lead to a monocausal understanding of power. The established-outsiders concept helps us appreciate the polymorphous relations of power where no one group has complete control.

The concept of 'established-outsiders' has been applied to studies of group formation and social conflict between a range of groups, including multi-sector professionals within local public health partnerships (Mead et al., 2022). The introduction of new services in a small town, like the introduction of a new estate in Elias and Scotson's (1965) study, has the potential to influence how groups of people are interdependent. The established-outsider concept might usefully be applied to examine power relations between providers and residents whose relation to one another is shifted in light of the introduction of a public health intervention.

5. The case study: a complex area-based initiative

In 2006, the BIG Lottery Fund launched its Well-being Fund to allocate £ 45 million to organisations across England to "deliver a portfolio of projects [within targeted localities] to support the development of healthier lifestyles and to improve wellbeing" (BIG Lottery Fund, 2006, p. 3). The (now renamed) Lottery Fund remains an important funder of place-based interventions to improve wellbeing in England (for a list of current funding activities see The National Lottery Community Fund, n.d) and its delivery model is mirrored in many statutory-funded community health promotion programmes (see for example One to One Development Trust, 2021). A group of voluntary and community sector (VCS) and public sector workers partnered to bid for a programme of activities in the north of England, which they called 'Target Wellbeing' (TW). The partnership identified 10 geographical areas of 'disadvantage' for funding, defined in terms of physical and mental health, obesity rates, diet, incidence of coronary heart disease and benefit claims (TW Partnership, personal communication, 2006). The programme was further targeted at people living in the most socio-economically disadvantaged neighbourhoods and was designed to positively improve resident engagement with local service providers (TW Partnership, personal communication, February 21, 2007). Public health authorities in each of the 10 areas were asked to lead a bid for a programme of activities in their area. The TW programme in one town (which we call 'Seatown') constituted the unit of analysis in this single case study. One programme was chosen to examine the social context in which TW was implemented, not as a backdrop to the intervention, but rather to explain how the particularity of the context shaped the way in which it developed. At the outset of the TW programme in Seatown, 12 neighbourhoods were ranked amongst the 20 % most 'deprived' in England (Communities and Local Government, 2010). The age and sex profile of the town's population during the period when TW was commissioned was similar to that for England as a whole. Seatown was a site to which we had good access, alongside which its history and levels of deprivation made it a suitable context for exploring how TW was implemented. Reflective of the size and organisation of other programmes, Seatown's TW programme was made up of eight projects, delivered by six different organisations: five VCS organisations and one publicly funded organisation. Projects supported access to physical activity, employment and healthy eating and were targeted at a range of age groups, with two projects targeting people with mental health issues.

6. The research process

The TW programme in Seatown was conceptualised as a figuration of people who were simultaneously interdependent with a range of others both inside and outside of the town. The case study design enabled interdependencies between people and events to be explored (Yin, 2003). In particular, understanding the historical basis for contemporary power relations between providers and residents in Seatown had the potential to explain the ways in which relations between these groups unfolded when the initiative was introduced. Examining social processes prospectively, and thus developmentally, also had the potential to better explain unplanned events. Ethical approval for the study was obtained from a National Health Service Research Ethics Committee in May 2009.

Over a period of 36 months from the first few weeks of delivery in May 2009, documentary analysis, observations and semi-structured qualitative interviews were used to explore TW. Methods explored interactions between residents and service providers working in the neighbourhoods targeted by the initiative and their relations with service providers out-with the area which emerged as important to the development of TW. Events and activities were purposively and progressively sampled for observations and people identified for interviews according to the potential they afforded to explore the research questions. Following a grounded theory approach, as set out by Charmaz (2006), the parameters of the case were thus defined in relation to events emerging as important from the data.

Using grounded theory methods enables inductive theorising from empirical data and this was supplemented with the testing of a number of figurational ideas. These ideas were used as sensitising concepts to develop a substantive theory about an area-based initiative, what Timmermans and Tavory (2012) refer to as abductive analysis. Blending a figurational approach with grounded theory in this way, with dynamic interaction between existing theory and empirical data, enabled a theoretically informed approach to data generation (Kislov et al., 2019). Theoretical sampling of events, documents and interview participants

was enabled by concurrent data collection and analysis, allowing an emerging understanding of the ways in which events and participants were related to one another to shape the direction of data collection and analysis. Emerging explanations about resident-provider relations were tested by generating data that might support or contradict the theory being developed. For example, it became apparent early in the research that the Eliasian concept of 'established and outsiders' might provide a useful sensitising concept with which to explore project experiences. Differences in resident engagement methods between 'local' and 'outside' delivery organisations were described by several local service providers in early interviews, so TW providers with no experience of working in the town prior to the initiative were interviewed to explore whether and how their experiences differed from more established providers. In this respect, data generation became "progressively focused on key analytic ideas" that might explain provider-resident engagement (Charmaz, 2006, p. 22).

Non-participant observation of 52 TW activities was carried out, providing an opportunity to learn about TW through immersion in the on-going activities of residents and service providers in their everyday setting (Angrosino, 2007). This included meetings between service providers and co-ordinators, promotion events and project delivery activities for residents (such as food growing clubs and work mentor training sessions). In addition to informal interviews, more formal semi-structured interviews were conducted with residents in the target neighbourhoods (n = 14). Residents were purposively sampled (using provider insights and a database established by TW funders for their own monitoring) to identify male and female interviewees from a range of age groups and targeted neighbourhoods with differing degrees of involvement in TW activities, including non-participants. All TW service providers working in direct contact with residents (n = 15) and TW service co-ordinators responsible for commissioning and monitoring local TW activities (n = 5) were interviewed. Pursuing promising lines of enquiry, four TW providers and one TW co-ordinator were interviewed twice to examine changes over time. Interviews were also conducted with other providers and co-ordinators working in the town who became prominent in the analysis of the TW figuration – 'Non-TW providers' including statutory health providers (N = 4) and 'Non-TW service Co--ordinators' with leadership roles relating to VCS and statutory service provision in the town (N = 5). Interviews examined how it felt to live and work in the town, particularly in terms of relations with residents and service providers. Documentary analysis provided insight into the development of TW over time. Publicly available data and historical documents relating to resident characteristics and service provision in the town were also explored using:

- Regional and local TW funding calls and applications
- Quarterly TW project monitoring reports submitted to funders (reporting demographics of project users)
- TW provider meeting minutes
- TW publicity documents
- E-mail communication between TW co-ordinators and TW providers
- Minutes from Seatown's multisector Local Area Partnership board meetings
- Department of Health area profiles
- Historical council reports
- Local area history books

In line with Elias and Scotson's approach to data triangulation (1965) documents were read with the context in which they were written in mind (Coffey & Atkinson, 1996). For example, TW advertising materials were compared against interview data to understand the messages that providers were trying to convey to the public. A rich description of the social and material context in which TW activities unfolded was developed and the initiative was conceptualised as emerging out of a particular context of health disadvantage. In this respect, the small-scale figuration of interdependent people connected to TW could be situated within the context of the wider figurations in which it had developed. The interplay between induction and deduction, using figurational concepts as sensitising ideas, was crucial in moving towards a different conceptualisation of change processes.

7. Findings

The findings below show how figurational sociology informed a historically based understanding of resident and service provider relations in Seatown, which explained how some providers influenced meaningful change for residents. The findings are presented in two sections to demonstrate how a substantive theory of health disadvantage (living on the periphery of a network) informed understanding of processes of change influenced by the concept 'being local'. Quotations with pseudonyms illustrate the findings.

8. Theorising health disadvantage - living on the periphery of a network

Important processes shaping current resident-provider relations in the town were identified by exploring the history of these relations with reference to concurrent social, economic and political processes that had unfolded regionally and nationally. Analysis of documentary and interview data showed that the closure of several of the town's largest employers towards the end of the 20th century (reflecting a national decline in manufacturing) influenced a decline in local economic interdependencies and increasing economic and social interdependence with others across the region. Interviews revealed that this had strongly influenced resident experiences with service providers. Seatown residents had formerly been at the centre of a network of interdependent people. The town had developed through rapid economic success in the early nineteenth century when a canal port was opened on the edge of a rural settlement. For several generations, resident interdependencies had pivoted around local industrial employment, with schools, shops, services, recreation facilities and local government services all located within the most populated ward, close to, and often co-ordinated by, the largest industrial employers. Residents expressed a sense of pride in descriptions of the town's former industrial success and older residents were keen to describe how "thriving" the town had once been (TW user 09, female). A discourse of decline, however, that residents perceived was perpetuated by 'others' dominated accounts of current life in the town, one resident saying, "they knock [Seatown] saying it's… a bit of a dump" (Non-TW user 01, female).

Local employment data indicated that new opportunities in retail and financial services on the outskirts of the town and in neighbouring cities (the stated economic focus for local government at the time of the research) had not been filled by residents in Seatown's most disadvantaged wards. Residents described long and expensive commuting routes as a barrier to many of these jobs as well as a deep-seated sense of isolation from the rest of the borough with which Seatown was seen to be "utterly out of kilter" in terms of industrial history, urbanity and health and social outcomes (TW provider 08). The closure of large employers in the area was associated by residents with the relocation of shopping and leisure facilities to the outskirts of the town, leaving one resident to describe her ward as "pretty dead down here" (TW user 09, female).

Local government reorganisation late in the 20th century had also shifted residents from a socio-political network in which they were key players – forming the largest town in the local government area by some margin – to a peripheral position as residents in one of several large towns – all overshadowed by a significantly more affluent city. This was experienced by residents as a reflection of their decreasing sense of influence over local service provision, making them suspicious about fair allocation of funds across the region:

> Because we're part of [the new area], which is another reason now we're feeling more deprived … people are now making the comparison with what's going on in [the city] … We've all got the same budget, supposedly … But it looks like [the city] is getting a bigger share … People from Seatown it's … like [they've] given up. (Non-TW user 04, male).

Sensitivity to the figurational concept of 'established-outsider' relations helped to uncover the processes through which current resident-provider mistrust had arisen. One of the ways in which residents responded to an increasing sense of living on the periphery of a network, was to emphasise the importance of other interdependencies that existed between residents at a more local level. 'Being local' emerged as an important aspect of many residents' experiences of living in the town and was reflected in 'privileged understanding' of the area and 'identification of outsiders'. Being local was sometimes defined in relation to the town, but often in relation to the ward or even the street in which residents lived. The sense of powerlessness that residents experienced in relation to people in the wider borough influenced the value of local identities. These local identities facilitated a sense of belonging which justified their residence in an area that had lost other sources of prestige. Residents who had lived in the town, or a particular area of the town, for their whole lives were proud of this fact, but their accounts acknowledged that outsiders might not understand this pride. One such resident in her late 60 s defended her decision to live in the town. She said: "I've lived here all my life and I've no intentions of moving. I'm quite happy … all I've got to say is, if I didn't like it, I wouldn't be here" (Non-TW user 02, female).

Conversely, investment in relations with service providers (usually people in organisations based outside of disadvantaged wards) had historically led to disappointment among residents. This influenced low expectations of services: service co-ordinators and residents commonly described experiences of service neglect in the most disadvantaged wards with several people describing outright hostility in relations. Two co-ordinators (both resident in a disadvantaged ward) described what they saw as a common resident reaction to local pilot council schemes (such as a new scheme for recycling):

> Non-TW co-ordinator 04 (female): "People [on the estate] just think, "Oh, it's [name of the estate] they don't care".

> Non-TW co-ordinator 03 (female): And the residents say that themselves, you know, "Just dump any shit you like [here] because it won't matter" … and that's how they see it.

This illustrates the relative power and influence of this established group of residents over narratives about the town and the discourse relating to service providers working locally.

9. Theorising processes of engagement - 'being local'

Initiative providers who understood what 'being local' meant to residents were better able to engage them in wellbeing activities and, in some instances, to support shifts in resident expectations of services. These providers explained the importance of valuing local places and relationships and the tactics this influenced when engaging residents. Outreach was used by these providers to convey their understanding of the importance of local status to residents. One TW provider described how he and a colleague had visited a local pub to speak to local people about their project. He disregarded warnings from other providers about potential 'trouble' in the pub to develop familiarity with local people and "get recognised" when spending time in the town (TW provider 01, male). Within the same project, a resident was employed to speak to other local people to promote the project, her role was loosely defined to allow her to take opportunities in her day-to-day life, in the school playground or at a bus stop, for speaking to other residents who might be interested in the employment course. Her local status convinced the TW providers that "as a role model she's really powerful" (TW provider 13, female).

"Outreach" was also defined as using "community venues" (TW provider 12, female), which conveyed providers' understanding of the significance of local places to many residents, what providers described as "working at that sort of grass roots level" (TW provider 13, female). The accessibility of venues also reflected residents' sense of entitlement to access it. One resident who had taken part in some of the walks organised through a physical activity project described her response to a flyer put through her letter box for an activity at "the bottom end" of the town. Her feelings towards the area influenced her decision to take part in the activity, as the following quotation shows:

> [The flyer] said, "Come and enjoy the walk" or something nice… meet at the [ward name community centre], 10 o'clock". I thought, "Ooh, oh it would be going down the bottom end, oh, [I] was going on this."(TW user 09, female).

Monitoring data showed that TW providers working predominantly inside target areas (for example within schools) recruited more target residents than other projects. TW providers who predominantly ran sessions from town centre locations tended to recruit higher numbers of residents from outside of the target areas. Reflecting the strength of local identities among residents, word of mouth played a significant role in resident engagement. This was visible in the geographical clustering of project participants - often from the same street. Resident and provider interviews showed that accessing information from trusted sources helped residents to assess the relevance of TW services and the social acceptability of using them within the networks that were important to them.

Employing figurational concepts in this instance helped to raise the empirically derived concept of 'local status' to a more abstract level: it helped to identify the significance of established-outsider dynamics within intergenerational and unintended processes of shifting regional interdependencies. Attention to these dynamics showed that being local was not about where providers lived, but rather was about providers demonstrating that they valued local places and relationships. Here, the sensitivity to figurational concepts focused the analysis on the networks in which residents had been embedded over many generations and the power dynamics within them which TW providers were able to influence.

10. Discussion

This paper illustrates how figurational sociology can be blended with grounded theory to support evaluation of social change in place-based health promotion. The approach helps to reconceptualise public health intervention activity as emerging from and constitutive of its 'context.' This helped to explain the processes of change observed within an intervention with reference to intergenerational social processes beyond the immediate locality of the targeted place. Drawing on established sociological theory of power and place helped to explain why local residents distrusted intervention providers, why they valued local status and what this meant for their relationships with providers. Developing the case study based on emerging data with attention to the ways in which people were interdependent (as a figurational perspective enables) allowed the analysis to explore change in collective terms, rather than based on individual behaviour. Engagement with the concept of 'established-outsiders' helped to articulate the relevance of 'being local' in a context where residents in this locality experienced a lack of control over other dimensions of their lives. Providers who demonstrated insight into why local status was important to residents were better able to establish ways of working that engaged residents and built their trust. Thinking about the historical networks in which residents and providers had been embedded helped to identify how shifts in resident-provider relations could be supported. The emphasis on historical power relations within their national and global context helped to more adequately understand what providers did and to what effect.

Stephens (2007) has shown how residents' identification with their neighbourhood shifts in different contexts, which she attributes to calculations on the part of people about the potential value of social connections within particular social contexts. Residents in Seatown thought that they had little to gain from contact with services and invested in local relations with friends and family from which they perceived they could derive most benefit. Hothi et al. (2010) demonstrated how myths and rumours about services in particular areas impacted on residents' perceptions of services. This study had similar findings. One of the consequences of living on the periphery of a regional network and having a dense and limited social network was that word-of-mouth processes influenced the recycling of certain myths about services which were rarely, if ever, challenged. The findings indicated that, over time, the prevailing discourse of neglect became imprinted on the psyche of Seatown residents, shaping what Elias would refer to as "the habitus of a group" (Elias, 1991, p.183). Residents' sense of place in relation to a network of others started to shape their expectations, such that new initiatives and services in the town were often greeted with mistrust by residents. The actions of service providers were interpreted by residents as a reassertion of providers' power. Residents' interpretations of provider actions were based on what they expected to happen, on what their experience had taught them to expect. In this respect, residents' "taken for granted ways of perceiving, thinking and knowing" shaped their response to service providers (Paulle, et al., 2012, p.71).

Cox and Schmuecker (2010, p. 45) found that people in socio-economically disadvantaged areas can have a "greater mistrust" of services. Living on the periphery of a network provides a way of understanding how this mistrust might develop. Elias (1991) argued that all relationships are characterised by power balances and that even the most apparently disadvantaged people have power in relation to those who are seemingly more advantaged. Relationships between Seatown residents and service providers can be characterised in this way to explain how residents' networks influenced the ways in which providers worked. This is helpful because it encourages a view of 'engagement' as a complex process that is not solely shaped by the actions of providers. Understanding that provider-resident relations in particular localities develop over many generations as part of wider sociopolitical trends, supports attempts to engage residents in health promotion services. The findings in this study advance understanding of engagement beyond the identification 'barriers' to engagement (Cassetti et al., n.d), which can homogenise experiences between groups and across time. The theoretical perspective employed in this study prevented a separation of context and individual action, which necessarily precedes the identification of barriers to engagement in services and activities.

The methodological approach described here – which developed a substantive theory of intervention change within an empirically grounded and theoretically informed account of health disadvantage in place – provides a valid means of understanding what works in community health promotion. By blending broader sociological concepts with grounded theory, this paper shows the ways in which public health action is constrained by the interdependency of people in local, regional, national and global power networks, operationalising the political economy perspective others call for (Bambra et al., 2019). Analysis of the economic and political history of Seatown in this study was incorporated into the emerging explanation of changes in resident-provider relations rather than providing a backdrop to or an influence on isolated mechanisms. Social theory that "genuinely reflects the complexity of the social world and the multiple ways we can make sense of it" (Kislov et al., 2019, p.5) can help evaluators to scaffold an understanding of the context in which they are working, supporting interpretation of quantitatively defined indicators of change (Potvin et al., 2005). More recent studies have demonstrated the value of social theory in evaluation of community health promotion. Termansen et al. (2023) and Fox & Powell (2023) both drew on Cornwall's (2002) concept of space to understand engagement. For Termansen this facilitated an understanding of context in community health promotion as "both the life circumstances of people and the places where health promotion is carried out" which was key to ensuring participation in Denmark's neighbourhood initiatives. Our research complements these studies, articulating an approach for integrating social theory into the evaluation of complex public health interventions.

11. Lessons learned

This approach shows how social theory can be used to draw more useful boundaries for evaluation of complex public health interventions. Integrating figurational sociology with grounded theory allowed the unit of analysis for our evaluation (the intervention figuration) to be defined iteratively, informed simultaneously by the perspectives of people involved and the more detached insights available from social theory. By focusing on the interdependencies within a community of place targeted by the intervention, our evaluation critically challenged underlying assumptions about what it was intended to change. This approach demanded a reconceptualisation of the intervention as part of the context, rendering the context the main focus of analysis, (Hawe et al., 2009). One consequence of this conceptualisation is that evaluators would benefit from taking greater account of how interventions come into being, with more analytic attention focused on long-term processes (such as the origins of commissioning processes as examined by Powell et al. (2014). This encourages a more critical understanding of how the 'problem' targeted by an intervention has come to be framed (Bacchi, 2016).

The methodological approach described here provides a means of centralising power relations in the conceptualisation of place in social interventions as others have called for Popay et al. (2021), shifting the emphasis from individual lifestyle change to the relational dynamics that underpin place-based inequities in health. Rather than exploring shifts in the psyche of participants, change was described here with reference to the inter-generational social and political processes shaping resident engagement in services. Crucially, ceasing to separate intervention and context also makes participatory approaches to evaluation more feasible. The ontological perspective taken here simplifies analysis by removing the need to examine different layers of context or 'macro-meso-micro' interactions (Greenhalgh & Manzano, 2021), defining the phenomenon being studied as one entity (in this case a network of people interdependent with one another and with a physical locality). The focus on social processes in this analysis, and observed connections between events, also aligns better with lay understandings of place. As Springett (2001) argues, the identification of outcomes in temporal terms is a preoccupation of practitioners and evaluators, and rarely a consideration for residents targeted by initiatives. Prioritising localised perspectives and experiential knowledge in diagnosing local issues (Potvin et al., 2005) moves beyond the limited role afforded to practitioners and participants in many other evaluation approaches as assessors of implementation. There is enthusiasm within community groups to use case studies to explore what works in health promotion (Southby et al., 2021). Social theory provides a means to generalise from such cases. Efforts to make sociological theory more accessible to community evaluators thus have the potential to support a more participatory and empowering approach to evaluation of community health promotion.

12. Conclusion

Evaluation of programmes that aim to reduce health inequalities often misses how power affects people's health and engagement with programmes. This paper addresses that gap by reporting an ethnographic study of a community health promotion programme that was informed by a social theory of power (figurational sociology). When looking at how power dynamics played out in the targeted community, we could see why residents often did not trust the people running the programme, and why local status was so important to them. When

programme staff understood these power dynamics, they were better able to connect with residents and help them improve their wellbeing. We argue that combining this way of looking at power with our observational approach gives us a much clearer understanding of how complex public health programmes work and why they succeed or fail in their aims.

CRediT authorship contribution statement

Powell Katie v: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Miranda Thurston:** Writing – review & editing, Supervision, Methodology, Funding acquisition, Conceptualization. **Daniel Bloyce:** Writing – review & editing, Supervision, Methodology, Conceptualization.

Funding

This research was funded by a Gladstone Bursary from the University of Chester and NHS Western Cheshire. Writing time for this paper was supported by the National Institute for Health and Care Research (NIHR) School for Public Health Research (SPHR) (Grant Reference Number PD-SPH-2015). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Ethical approval

Ethical approval for the study was obtained from a regional National Health Service Research Ethics Committee in May 2009.

Declaration of Generative AI and AI-assisted technologies in the writing process

During the preparation of this work the authors used Google Gemini in order to improve readability of the abstract and some paragraphs in the introduction. After using this tool/service, the authors reviewed and edited the content as needed and takes full responsibility for the content of the published article.

Acknowledgements

We gratefully acknowledge the contributions of staff and residents who shared their experiences as part of this research.

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