Chapter 17
Context as a Fundamental Dimension of Health Promotion Program Evaluation

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Context can be broadly defined as "the circumstances or events that form the environment within which something exists or takes place" (Encarta, 1999). That 'something' can be health behavior, another health determinant, an intervention, or an evaluation. Each of these events unfolds, not in a vacuum, but in a complex social context which necessarily shapes how the phenomena are manifest, as well as how they may be taken up, resisted or modified. In this chapter we unpack the nature and significance of social context for health promotion practice and evaluation. Drawing on critical realism, we develop a framework for understanding key dimensions of social context that impact on three key levels: the target phenomena (what health promotion practice is seeking to change or enhance), the intervention (how it is received and plays out, its impact), and efforts to evaluate health promotion interventions (we propose that evaluation practice is also embedded in social context).

That social context matters is widely recognized and nothing particularly new. Context is identified as a fundamental dimension of program evaluation (Suchman, 1967; Weiss, 1972), and person-environment and program- environment interactions can be traced back to the human ecology work of Broffenbrenner (1977, 1979). Applications of these concepts and ecological systems theory, in various guises, are found in the health promotion literature (see Best et al., 2003; Chu and Simpson, 1994; Green and Kreuter, 2005; Green, Richard and Potvin, 1996; Stokols, 1992, 2000). Although context receives attention in many health promotion texts (Bartholomew, Parcel, Kok, & Gottlieb, 2000; Green & Kreuter, 2005), it is not routinely integrated into or adequately accounted for in most program evaluations. The complexities involved in mapping contextual factors in evaluation pose significant evaluation challenges. Some interventionists and evaluators may lack the necessary theoretical breadth and methodological skills to adequately unpack, theoretically and empirically, how context matters. Nor may they feel they have the 'luxury' of time or breadth of mandate to tackle what may be seen as more challenging conceptual and methodological issues associated with doing so. This

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chapter identifies some of these challenging issues and proposes a critical realist framework for addressing these lacunae.

The overwhelming emphasis within the dominant post-positivist paradigm in health promotion evaluation research has been to treat context as a source of potential confounders that need to be either 'factored in' (as variables that apply across cases) or 'factored out' ('controlled for' statistically or through study design such as randomization). Identification of 'best practices' that can be disseminated across space and time with predictable outcomes following the results of promising pilot research, also treats context as something of a nuisance to be addressed only insofar as it threatens to seriously compromise implementation fidelity or program outcomes. Further, following Malpas (2003), we believe that increasingly dominant managerial regimes that privilege efficiency and tight fiscal and legal accountability in health and social service delivery seek to tighten administrative control through the standardization of practice. Standardization accords only grudging acknowledgement to the difference that context makes. The inherent 'messiness', unpredictability, and uniqueness of context is difficult to reconcile with an administrative rationality intent on procedural standardization. In short, epistemological, political, and administrative factors have conspired to either obscure the relative importance of social context to program design, implementation, and evaluation or, at the very least, leave largely unexamined or unexplained the ways in which context matters.

From studies of small area variations in healthcare practice (Wennberg & Gittelsohn, 1973), to studies of community-based health promotion interventions (Bracht, 1990; Minkler, 1990, 1997), the evidence that context matters is increasingly difficult to ignore. In some fields, such as tobacco control, there is growing awareness that the failure to sufficiently understand the social context of smoking has compromised the field's success record (Flay & Clayton, 2003; Poland et al., 2006). The social distribution of smoking has changed, and thus the social distance between target populations and interventionists, whose assumptions and world view are reflected in programming (Poland et al., 2006). The popularity of a settings approach in health promotion reflects, in part, an understanding of the importance of aligning program design and intervention activities with the realities of the setting for which they're intended (Chu & Simpson, 1994; Dooris et al., 2007; Mullen et al., 1995; Poland, Green, & Rootman, 2000, Poland, Lehoux, Holmes, & Andrews, 2005; Whitelaw et al., 2001). For example, considerable expertise has emerged in school-based health promotion with respect to the essential features of schools, as well as variability in their expression (e.g., inner city versus rural), that impact on program delivery and outcomes. The identification of aspects of context that impact on practice has also been undertaken with respect to community-based programming, workplace health promotion, and interventions tailored for other settings such as hospitals, Aboriginal communities, and prisons, among others.

Context is fundamental to understanding the adequacy of program conceptualization and design: do interventions adequately address the social context within which target phenomena, such as health behaviors, are created, sustained and socially distributed in time and space? Context is also fundamental to program implementation

and outcomes: are interventions optimized to take advantage of the unique confluence of opportunities available in each local context and which intervention components produce which results under what conditions? Finally, context shapes the production and utilization of evaluation findings: the influence of key assumptions and stakeholders on the design and implementation of the evaluation, as well as the impact of timing and other factors on research uptake. The organization of this chapter reflects the ways in which social context is implicated at three overlapping levels: (a) the nature of the phenomena that are the object of health promotion intervention (the social context of target phenomena); (b) interventions themselves (the social context of health promotion practice); and (c) knowledge development and utilization (the social context of evaluation research).

At this juncture it is worth clarifying what we mean by evaluation. We adopt the definition proposed by Rossi and Freeman (1985, p. 19): "the systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs". We prefer this over less comprehensive definitions because it explicitly makes room for a critique of the adequacy of program conceptualization and design, whereas many evaluation definitions do not and are restricted to determining the extent to which intended outcomes are achieved.

The premise of this chapter is that although context is of inescapable importance in health promotion program evaluation, better conceptual, theoretical, and methodological tools are needed to reposition it at the centre of evaluation efforts. Following a review of each of the three layers of context identified above, we draw on diverse disciplinary perspectives to assemble some of the conceptual, theoretical, and methodological tools necessary for a deeper and more satisfying treatment of context in health promotion program evaluation. In particular, we draw on critical social theory and critical realist perspectives to fashion an understanding of how social relations (at the heart of any social intervention) function in different social contexts, for these are critical to understanding how context matters.

Three Layers of Context

The Social Context of Target Phenomena

The determinants of the status quo are an obvious starting point for thinking about what interventions are needed and how should be structured to shift those determinants most critical for health enhancement. Understanding what created and sustained the phenomena that interventionists wish to change, be it specific lifestyle behaviors, organizational practices, or policies, is fundamental.

Health promotion seeks to influence human behaviors as a key target of intervention (either as a means or as an end in itself). The focus may be risk behaviors linked to particular disease outcomes (e.g., diet, exercise, smoking), organizational behaviors (organizational policies and practices), or the decisions of policy makers.

For Agnew, “in order to explain human behavior one must deal with the ‘micro-episodes’ of everyday life and their embeddedness in concrete milieux or contexts” (1993, p. 264). Interventions need to address not only the cognitive or psychosocial elements of behavior change, be that lifestyle behavior, organizational behavior, or the behavior of policy-makers, but also the social environments in which these behaviors are shaped or maintained. For example, in school-based health promotion, there is an attempt to integrate curriculum components with school level changes (e.g., removal of soft drink vending machines; changes in cafeteria menu), extra-curricular activities, parental involvement, community programming, peer-to-peer, and other initiatives in comprehensive, multi-component (and multi-modal) approaches. These have been shown to be more effective at bringing about and sustaining healthier behaviors than more narrowly cast interventions (Soubhi & Potvin, 2000).

When it comes to health behavior modification (which remains a central focus in health promotion practice), it is still the case that for the most part social context is understood primarily in terms of ‘social influences’ (peers, parents, media personalities), ‘social norms’ (as a focus for ‘denormalization’ efforts in tobacco control, for example), or as ‘social environment’ (in, for example, ecological and systems theory models that specify the inclusion of variables from a variety of interacting contextual levels). Health promotion and health education efforts aimed at smoking is an instructive example of how social context matters and how it has been addressed. Attention has traditionally focused on genetics, parental influence, peer influences, pricing and availability of cigarettes (including retailer compliance regarding sales to minors), restrictions on smoking in public places, visibility and impact of public education campaigns, local pro-smoking or non-smoking community norms and social sanctions (see Chaloupka, 2003; Flay & Clayton, 2003). However, more recently researchers have drawn on anthropology and sociology, and on qualitative, feminist and cultural studies traditions, that focus attention on the role smoking plays in adolescent cultures (Amos, Gray, Currie, & Elton, 1997; Ioannou, 2003; McCracken, 1992; Plumridge, Fitzgerald, & Abel, 2002), the role of gender (Elkind, 1985; Greaves, 1996; Graham, 1987; 1993), and other dimensions of social context.

The concept of “collective lifestyle practice” (Frohlich, Corin, & Potvin, 2001) captures many of these dimensions of social context. Drawing on Giddens and Bourdieu, the heuristic, “collective lifestyles”, is a framework for understanding behaviors like smoking, as social practices, that is, routinized and socialized behaviors common to groups (Frohlich et al., 2001; see also Cockerham, Rutten, & Abel, 1997). Collective lifestyles comprise interacting patterns of behaviors, orientations and resources adapted by groups of individuals in response to their social, cultural and economic environment (Abel, Cockerham, & Niemann, 2000, p. 63). These practices are generated at the intersection of social structure (norms, resources, policy and the institutional practices that organize society), and agency (individual action, volition and sense of identity). This is expressed recursively, with social structure influencing agency and agency, in turn, influencing the structure. Conceptualising health behaviors in terms of collective lifestyles has the potential to

offer more to an understanding of the social context of target phenomena than serving as a synonym for patterns of individual risk behaviors. A theory-driven collective lifestyles approach helps not only to prevent a reductionist and individual centered perspective, but also takes into account both behaviors and social circumstances (Abel et al., 2000).

The collective lifestyles was extended by Frohlich, Poland and colleagues (Poland et al. 2006), who propose a model for understanding the social context of smoking and other 'behavioral risk factors'. Highlighting the centrality of power relations in shaping the uneven socio-spatial distribution of smoking, their model identifies the following dimensions of the social as key to our understanding of smoking: the sociology of the body as it relates to smoking, collective patterns of consumption, the construction and maintenance of social identity, the ways in which desire and pleasure are implicated in these latter two dimensions in particular, and smoking as a social activity rooted in place.

Sometimes the 'social context' is the primary target of intervention. In a settings approach to health promotion, there has been growing recognition of the need to move beyond simply seeing setting as a way of targeting 'captive' audiences, but instead to act on the setting itself (Poland, Green, & Rootman, 2000). For example, workplace health promotion can include not just educational and stress reduction seminars for employees, but also changes to the workplace to reduce injuries and exposures to noxious substances, improvements in cafeteria menu, installation of a breastfeeding room, family-friendly workplace policies, and efforts to address labour-management relations, workload issues and decision latitude (democratization of the workplace) (Polanyi, et al., 2000).

The Social Context of Health Promotion Interventions

As previously noted, context impacts both program delivery and program outcomes (Potvin, Haddad, & Frohlich, 2001). A key issue is the fit and responsiveness of interventions to situational context. Intervention success reflects the ability to embed programs in context over time (community ownership, routinization). Responsiveness to environment (adaptiveness) is key. Several attempts have been made to systematize evidence regarding the effectiveness of interventions in different settings (e.g. school-based health promotion, community development). But few attempts have been made to systematically 'unpack' those aspects of settings that most impact health promotion practice, and how interventions are experienced by program participants, in a way that could directly impact policy, practice, and research. Context is of great interest when a program 'fails', but its contribution to program success is rarely examined.

Poland, Krupa & McCall (2008) propose a framework that can be utilized by practitioners to systematically analyze features of settings that impact intervention design and delivery, in the form of a nested series of questions to guide analysis. The analytic framework addresses how settings are commonly understood (unpacking assumptions, variability within and between types of settings, etc), localized

determinants of health (including local manifestations of broader economic, socio-political and cultural trends), making explicit stakeholder interests, and understanding power relations. With respect to context, specifically, we address the history of health promotion efforts in the category of setting (e.g. schools vs. workplaces), then the specific setting itself. What efforts have been aimed at changing behaviors within the setting or changing the setting itself? How have approaches changed over time, and how might we explain these changes? We ask what the health promoter brings to this particular setting: the skills, capacities, resources, and relevant sensitivities. This includes similarities or differences with key stakeholder groups (e.g., race, class, gender, physical ability, sexual orientation) that may act as points of friction or affinity. An analysis of the context for change efforts must also grapple with what supports must be in place (or barriers removed) outside the setting in the broader socio-political, community, and/or economic context. This may necessitate advocacy, coalition building, strategic partnerships or deepening and widening community participation.

The Social Context of Health Promotion Evaluation

Having briefly reviewed the first layer of social context in which determinants of health are created and sustained, and the second layer of social context within which interventions are inserted and unfold, a third layer of context must be addressed: that in which the evaluation itself is conducted.

Evaluations do not take place in a vacuum: they are deeply shaped by context. Context shapes the many assumptions that animate the evaluation, including what is considered knowable and worth knowing, how it can be known, and what is seen as doable within given time and resource constraints. It also shapes the agendas of key stakeholders, including funders, intervention staff, and those targeted or impacted by the intervention. There is always potential for stakeholders to hold different perspectives on what is important and what is doable. And there are ways in which stakeholders can intentionally or unintentionally selectively share or withhold information, seek to discredit, derail, downplay or ignore the evaluation, or steer it in directions more favourable to their perceived interests (e.g. Brousselle, 2004). Evaluations often require the consent, cooperation, and permission of gatekeepers who control access to certain settings and populations. This influences the evaluation through subtle pressure to frame the evaluator's stance in 'gatekeeper-friendly' terms or through effects on respondents to appear aligned with the gatekeeper (e.g. employee candour when workplace health promotion evaluation requires implicit endorsement of the workplace manager).

Evaluation research is inherently political (Shadish, Cook, & Leviton, 1991) because programs are embedded within dynamic organisational, interorganisational and community systems which may relegate evaluation research as secondary to program delivery interests (Weiss, 1972). In the evaluation of health promotion programs, researchers develop relationships with a variety of health professionals, practitioners, bureaucrats, politicians, and members of special interest groups (e.g., teachers, nonprofit organisations, recreation workers, health and social policy

makers, Aboriginal representatives, community members, parents). The nature of relationships developed between evaluation researchers and program professionals or advocates can range the spectrum from friendly to hostile.

Evaluation research is differentiated from other forms of research because it takes place in an action setting, marked by competing agendas and power relations that can become extremely asymmetrical depending on the issue at hand. Most service organisations see the first order of priority as implementing the program; evaluating the program often is considered secondary to program delivery (Weiss, 1972). Weiss argues that researchers may try to change the order of priority and for good reason. The mandate of the evaluation researcher is to determine whether the program works, under what conditions and for whom (see earlier discussion of Rossi's definition of evaluation). Differences in perspective on the primacy of program delivery versus program evaluation from different stakeholders can lead to tensions. The evaluator must be sensitive to the political landscape within which their program is embedded when making evaluation decisions, otherwise their evaluation efforts can be undermined. Where multiple stakeholders and agendas are implicated in complex interventions, evaluability assessment may be warranted (Smith, 1989; see also Poland, 1996, for an application in health promotion evaluation).

The uptake of research findings needs to be considered in any discussion of the social context of program evaluation. Here too, contextual factors weigh heavily on the possibilities for successful knowledge translation and uptake. The *Ottawa Model of Health Care Research Use* is one example of a framework that explicitly addresses the nature of the practice environment and the need for an adequate diagnosis prior to knowledge translation intervention (Logan & Graham, 1998; Santesso & Tugwell, 2006).

While these and other issues have been raised in the evaluation literature, the dimension of context that we address here is the politics of evaluation associated with understanding and navigating competing stakeholder interests. These can be seen as 'extrinsic' to the evaluation (something to be avoided, skillfully managed, or factored in) or as 'intrinsic' to more participatory forms of evaluation research. We have argued that all three layers of context – the context of the target phenomena, the context of intervention, and the context of evaluation – can be essential to solid program planning and evaluation. What is missing is a framework for identifying which elements of context are most critical in each layer. This is discussed in the next section.

A Framework for Understanding Key Dimensions of Social Context

Interventions in health promotion are essentially complex, *social* interventions: they are intentional change efforts inserted into pre-existing social relations. To quote Pawson and Tilley (1997), "it is not programs that make things change, it is people, embedded in their context who, when exposed to programs, do something to activate

given mechanisms, and change" (cited in Stame, 2004, p. 62) Further, following Pawson, Greenhalgh, Harvey, and Walshe (2004), we can assert that in many cases in health promotion the interventions themselves are people. It is therefore necessary to take into account how programs, as complex social interventions, manage to embed themselves in these social contexts by aligning with existing incentive structures and mobilizing key opinion leaders. Or, alternatively, how they fail to take hold by generating unanticipated resistance, and attempts to discredit, resist, reframe or ignore change efforts. One promising, and as yet underutilized approach to unpacking how interventions work or fail in particular contexts (viz., which elements of context matter, and why), is critical realist evaluation.

A Critical Realist Approach

Critical realism is a logic of inquiry, drawing on the foundational work of Roy Bhaskar (1979) whose central premise is that constant conjunction (empirical co-occurrence) is an insufficient basis for inferring causality, and that what is required is the identification of generative mechanisms whose causal properties may or may not be activated, depending on the circumstances (Connelly, 2001; Julnes, Mark, & Henry, 1998; Stame, 2004; Williams, 2003). It is a theory-driven approach whose point of departure is in the distinctions made between the *empirical* (what is observed), the *actual* (events and experiences that may or may not be observed/observable), and the *real* (the domain of underlying causal mechanisms) (Williams, 2003). Further, mechanisms can coincide under real world conditions to produce *emergent properties* that are contingent in time and space (Sayer, 2000).

From a critical realist perspective, context is not an undifferentiated social ether in which programs and phenomena float, but rather it is a series of generative mechanisms in constant interaction with complex and contingent combinations of events and actors. The notion of contingency stands in contrast to positivist notions of universal logical necessity (natural laws, generalisable truths) by calling attention to the uncertain nature of phenomena (viz., that propositions may hold true under some circumstances but not others). The 'ideal-typical' positivist view is that the causal relationship can be said to exist when A is always or very nearly always followed by B. Such stance is consistent with relatively 'closed' systems, where external factors can be 'controlled for'. Yet we know factors which have 'causal powers' often manifest only under particular conditions – hence the importance of the total 'situation' or context.

Since underlying generative mechanisms may only be discernable on account of the effects they generate and since such effects are contingent in space-time, critical realist program evaluations must be grounded in theories that specify what generative mechanisms are triggered, or suppressed, by which intervention elements, under which conditions. Generative mechanisms refer to program mediators that interventions seek to modify. Weiss (1995, 1997) makes a strong case for developing sound program theory during the conceptualization and design phase of the

evaluation so that program mediators can be prospectively assessed and understood through multiple methods. Program theory can be made explicit through specifying the inter-related sequence of events that are expected to occur and how they relate to each other in space and time. Thus program theory is based on a series of micro-steps that aims to make transparent the underlying logic and assumptions of a given intervention.

Critical realism can be distinguished from two other meta-paradigms of social research that are often found in program evaluation: post-positivism which is associated with most controlled designs and quantitative evaluation methods, and hermeneutics which is most closely associated with qualitative methods and designs. Table 17.1 illustrates, in broad terms, how each of these differ in terms of key assumptions about what is knowable (ontology) and how it can come to be known (epistemology), the role of theory, and preferred choice of methods.

Critical realism is a logic of inquiry that privileges neither 'objective' facts nor subjective lived experience or narrative accounts, but rather seeks to situate both in relation to a theoretical understanding of the generative mechanisms that link them together, as a basis for interpreting the empirical or observable world. It follows that the questions posed in critical realist evaluation are of a different order from those derived from other evaluation approaches. As in other areas of social research, how the question is framed has fundamentally important consequences for what is found and consequent funding and intervention decision-making. In much conventional evaluation research, the central animating question that drives the study is either "which interventions work best?" (the best practice option), or "what are the vital ingredients of success?" (generalizable recipe for success). The question of context is largely ignored, except to specify what needs to be factored

Table 17.1 Three contrasting paradigms within which evaluations can be situated

Dimension	Post-positivist	Hermeneutic	Critical realist
Ontology (the nature of reality)	Verifiable evidence	What people perceive to exist	Appearances differ from underlying mechanisms (but mechanisms leave observable traces)
Epistemology (what is knowable)	Knowledge objectively acquired through rigorous application of method	Knowledge socially constructed, subjective	Knowledge actively constructed from facts, events & experience
Theory	Formal, predictive	Understanding people in their environments	Explain underlying structures
Methodology	Verification	Interpretation of meaning	Explanation based on theory + observation
Methods	Survey research Modelling, Manipulation	Depth interviews Observation	Mixed methods Case studies

in or factored out of the model. From a critical realist perspective, the central evaluative question is not so much *whether* certain programs, or parts of, work, what Stame (2004) refers to as 'black box' evaluation, but "to unpack the mechanism[s] of *how* complex programs work, or *why* they fail, in particular contexts and settings" (Pawson et al., 2004). It is precisely these how and why questions which are critical to decision-making regarding which programmatic components are worth replicating in which other contexts and settings.

A key author in critical realist evaluation is Ray Pawson. Pawson and colleagues have articulated a theory of interventions that they argue is essential to critical realist evaluation (Pawson & Tilley, 1997; Pawson, 2006). It is the underlying intervention theory which drives the purposive, theoretical sampling of a wide variety of types and forms of evidence to shed light on the different generative mechanisms thought to be at play, and the conditions under which their causal properties are activated (or not), as well as how these combine to form emergent properties which in turn impact upon and become absorbed into the social context. As a point of departure, Pawson et al. (2004) identify a number of basic assumptions concerning the nature of interventions that inform a critical realist approach to program evaluation. First, they maintain that *interventions are theories*, which is to say that they are constellations of hypotheses about what will happen, which are resourced (funded, equipped, supplied with personnel) and inserted into existing social systems. Second, *interventions are active*: they work through stakeholder reasoning and intentionality, and understanding these is key to understanding how outcomes are achieved or thwarted. Third, *intevention chains are long and thickly populated.* A series of stakeholders and social processes are implicated over time (and space), and the chain of events can misfire or break down at any time, with unintended (and sometimes unpredictable) results. When multiple stakeholder groups with different power bases vie for influence, *interventions can sometimes follow a very non-linear path or even be thrown into reverse*. This is the fourth tenet. The relative influence of these actors to affect and direct implementation must therefore be considered as part of any evaluation exercise. Fifth, *interventions are embedded in multiple social systems*. Individuals, interpersonal relations, organizations, and broader infrastructural and policy elements are implicated, and the influence of factors at all these levels need to be considered. Sixth, Pawson et al. (2004) characterize interventions as *"leaky and prone to be borrowed"*. As actors struggle to achieve their interests and optimize interventions in the face of sometimes unique local obstacles and setbacks, processes of lateral communication and active agency cause programs to be copied (in part or *in toto*), refined, reinvented, adapted from one context to the next. These processes of informal adaptive learning are also underscored in the literature on 'communities of practice' (e.g., Brown and Duguid, 1991; Wenger, 1998; Wenger, McDermott, & Snyder, 2002). These dynamic aspects can be difficult, but no less important, to capture. Last, but not least, *interventions are open systems that feed back on themselves*: in changing the conditions in which they operate, they also act on themselves in ways that call for new adaptations, which in turn alter the conditions of practice, in infinitum. Both intended and unintended consequences must be considered.

One of the advantages of a critical realist approach is that it requires us to be explicit about our assumptions. Assumptions are often embedded and implicit (Eakin et al., 1996). This also fits well with, but also extends in several important ways, the use of logic models in health promotion program evaluation (Julian, 1997).

Drawing on the work of Sayer, Pawson, and others, we can thus (re)define context as: the local mix of conditions and events, social agents, objects and interactions which characterize open systems, and whose unique confluence in time and space selectively activates, triggers, blocks or modifies causal powers and mechanisms in a chain of reactions that may result in very different outcomes depending on the dynamic interplay of conditions and mechanisms over time and space.

Pawson and colleagues concern themselves primarily with the social context of intervention implementation, and secondarily with some of the politics of evaluation itself. What we add here is a third dimension critical to the adequacy of program design: the social context of the phenomena that are the target of change efforts. Here, it is incumbent upon us to more fully address what we see as some of the key enduring features of social context that evaluators need to pay closer attention to.

Key, Enduring Features of Social Context

In the same way that Pawson and colleagues offer a general conceptual schema regarding the key characteristics of interventions that they believe have important consequences for program evaluation, so too it's incumbent upon us to identify a few of the most salient features of the social to frame our general understanding of the generative mechanisms at work in most social contexts. In doing so, we wish to underscore that these take different forms in different contexts.

The Dialectic of Agency and Structure

Our first basic assumption is that phenomena are neither the result of unencumbered agency nor purely of structural constraints and opportunities, but rather result of the relationship between the two. Proponents of structural explanations emphasize the power of structural conditions in shaping individual behavior (Cockerham, 2005). Advocates of agency, on the other hand, accentuate the capacity of individual actors to choose and influence their behavior regardless of structural influences. Rather than view this as a dichotomy, we posit that health outcomes, behaviors, and social relations are the result of both of these spheres in a dialectical relationship with each other; each informing, producing and reproducing the other (Giddens, 1984). This has been termed recursivity by Giddens (ibid).

Our earlier discussion of 'collective lifestyle practices' (Cockerham et al., 1997; Frohlich et al., 2001) exemplifies how an understanding of the dialectical nature of agency and structure translates into an understanding of the social context of human behavior. As previously noted, practices are generated at the intersection of social structure (norms, resources, policy and the institutional practices that organize

society), and agency (individual action, volition and sense of identity). This is expressed recursively, with the social structure influencing agency and agency, in turn, influencing the structure.

We have noted that evaluation research is subject to the same contextual influences outlined in our earlier section on critical realist theory of interventions: evaluations are theories, active, long chains, non-linear, embedded in multiple social systems, leaky, open systems with feedback loops. The blurred boundaries between program and context identified by Potvin (2007) are relevant here, insofar as the problematic they address (and to which, they argue, only critical realism has an adequate response) reflects the inherently recursive and dialectical relationship between intervention and conditions, program and context.

Power Relations

With few exceptions (e.g., Kuyek & Labonte, 1995; Eakin et al., 1996), power relations are frequently acknowledged but rarely adequately unpacked in health promotion. This is the more surprising given the emphasis that health promotion places on empowerment (Rissel, 1994), and the relative sophistication with which issues of power have been addressed in the sociological literature (Grabb, 2002; Jones, 2003). Indeed, according to Jones (2003, p. 130), "a key to understanding experiences of health and illness in late modern society is the operation of power at different interacting levels". Poland, Coburn, Robertson, & Eakin with members of the Critical Social Science in Health Group (1998) argue that such analyses are largely missing in contemporary debates in social inequalities in health which focus more on identifying the bio-psychosocial pathways through which social hierarchies impact on health than they do on explaining how social inequalities are produced and maintained in the first place.

Drawing on the work of Michael Mann, Jones (2003) argues that power is exercised by individuals and groups in a manner that is simultaneously *diffuse* (unconscious, decentred) and *authoritarian* (commanding obedience), *intensive* (actors are heavily invested in the exercise of power) and *extensive* (far-reaching in space and time). He argues that issues of exploitation and adaptation are keys to understanding how power is exercised.

In his review of sociological theories of inequality, from Marx and Weber to Giddens, Edward Grabb (2002) goes further, proposing a framework that acknowledges how power and exploitation operate via three key mechanisms, each of which are further stratified in their effects by race, class, gender and other social cleavages: control of material resources in the form of means of production, natural resources, capital; control over human resources and labour power; and control over ideas (ideology, hegemony, cultural dominance, control of media, ability to impact representation and social meaning).

An analysis of power and how power relations come into play in the field invites the practitioner to adopt a reflexive stance regarding her own role in reproducing or resisting existing asymmetrical power relations. Kuyek and Labonte (1995),

Poland (1992) and Boutilier, Cleverly, and Labonte (2000), address how health promotion practitioners can transform their inherent 'power-over' marginalized groups with whom they may be working into 'power-with'.

Emplacement

"Every action is situated in space and time, and for its immediate outcome [is] dependent on what is present or absent as help or hindrance where the events take place" (Hagerstrand, 1984). In other words, social relations are contingent in time and space. For contextualists, space or place becomes both 'condition' and 'consequence' of human activity (Gregory, 1994, p. 92). Deriving from the work of Hagerstrand (1984), and Giddens (1984), contextual theory is an approach which helps us identify "relations of coexistence, connection or 'togetherness', rather than the relations of 'similarity' that characterize compositional theory" (Gregory, 1994, p. 90) that "remove different classes of being from their habitats and place them in a classification system" (Hagerstrand, 1984 in Gregory, 1994). One of the protagonists of contextual theory, Simonsen (1991) has sought to codify the contextuality of social life in terms of the trajectories of social actors across time and space, emphasizing how different kinds and units of time and space thread together to constitute the social. He writes about the importance of situated life stories or biographies of human agents bounded in time and space, as a methodology for accessing these aspects of reality.

If contextual theory helps us understand how place matters for health promotion, then the concept of *culture of place* helps us understand how these factors come together in particular places to imbue them with a distinctive 'feel'. Jary and Jary (1995) note that culture of place encompasses the symbols, artifacts, manners, customs, language, norms and systems of belief that make up 'culture' as the 'way of life' of any society, setting or social grouping. A distinctive culture of place emerges from the pragmatic and routinised interactions between engaged participants and social processes (Poland et al., 2005). These are shaped by the ways in which material objects (artifacts), social relations (socio-facts) and ideas (mentifacts) come together in ways that are contingent in time and space (Gesler & Kearns, 2002). This understanding of 'culture of place' as infused with technologically-mediated power relations (Poland et al., 2005), allows us to represent in Fig. 17.1 the relationship of culture of place, technology, and power to health promotion practice.

There are, understandably, many other generative mechanisms identified by various authors as being central to understanding the production, consumption and social geography of health: neoliberalism (Coburn, 2000), capitalism (Navarro, 2000, 2004; Navarro & Muntaner, 2004), racism (Porter, 1993), class (Bourdieu, 1990), to mention only a few. A detailed examination of each of these is beyond the scope of this chapter, but the reader is referred to Grabb (2002) for a useful overview in the context of explaining social inequality.

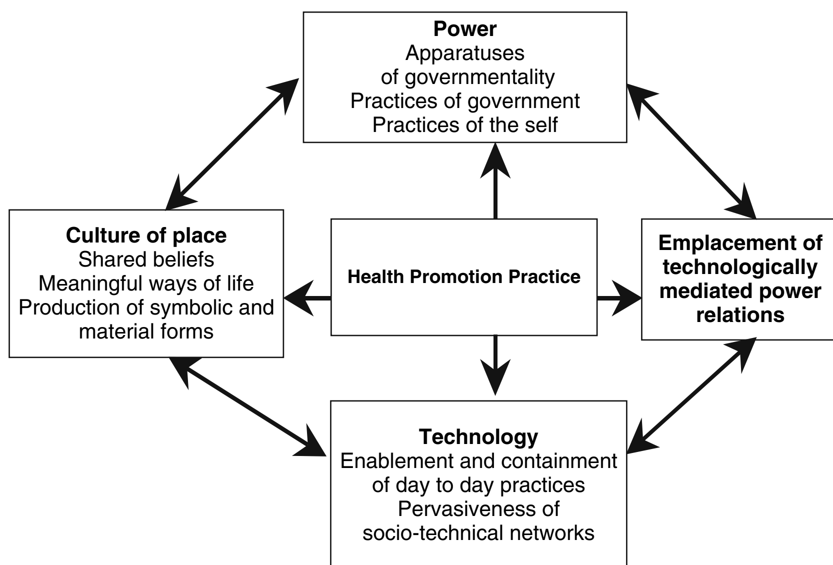

Fig. 17.1 Technologically mediated power relations, culture of place, and the constitution of health promotion practice in space-time
Source: Adapted from Poland et al., 2005

Conclusion

In this chapter, we have tackled the thorny issue of context as it applies to the evaluation of health promotion initiatives. We have argued that understanding context is fundamental to understanding how interventions thrust into such contexts (and seeking to be absorbed and routinised into these practice environments) are received, modified, resisted, and reinvented from place to place. Furthermore, we extend conventional discussions of context considerably by showing that context needs to be considered at three nested and overlapping levels: (a) the context of the target phenomena (what interventionists are seeking to change) as a basis for assessing the adequacy of program conceptualization and design (does it address the salient determinants and levers of change?), (b) the contexts in which interventions are mobilized and (c) the contexts in which program evaluations are conducted, and their results disseminated and taken up by others (or not). We have described critical realism and core tenets of critical realist evaluation, as proposed by Pawson and others. Our thesis is that critical realism allows a more sophisticated assessment of the relationship between context and program, and it offers a third alternative to the sometimes polarized debate about the relative merits of quantitative or experimental versus qualitative approaches.

Furthermore, we have sought to identify several enduring features of social relations as possible 'generative mechanisms' that can be said to act in each context, albeit somewhat differently from site to site. Those mechanisms are the

dialectical relationship between agency and structure, power relations, and processes of emplacement. We show, drawing on some of our earlier work, how power relations can be shown to be technologically mediated and constituted in, by and through, and constitutive of, particular places, as embodied in 'cultures of place'.

The complex and expansive nature of the social, together with the diversity of disciplinary and epistemological perspectives that can be brought to bear on it, mean that any chapter seeking to unpack social context will necessarily leave out as much as it includes. We have not, for example, addressed participatory approaches (Green et al., 1995; Israel et al., 2003; Macaulay et al., 1998, 1999) to evaluation, nor initiatives for the development of reflexive practice (McCormack, Manley, Kitson, Titchen, & Harvey, 1999; Schon, 1991), although we consider both highly relevant to this discussion. Nevertheless, we believe that the way we have brought together critical realism with an understanding of the overlapping levels of context implicated in health promotion practice has the potential to contribute to the field.

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