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Boundary work: understanding enactments of 'community' in an area-based, empowerment initiative

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Title

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initiative

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Abstract

Engaging the community in initiatives to improve health and inequalities is a prominent feature of contemporary public health approaches. Yet, how 'community' might be differently interpreted and experienced through mechanisms of engagement is little understood, with potential implications for how the pathways of effect of such initiatives, and their impacts on health inequalities, might be evaluated. This study sought to explore how community was enacted through the delivery of an area-based, empowerment initiative underway in disadvantaged areas of England. An ethnographic approach was used to identify enactments of community arising around the core activities and decision-making processes of the resident-led initiative in two sites. Enactments comprised 'boundary work': the ongoing assertion and negotiation of boundaries around who or what was, and was not, eligible to contribute to decision-making, and / or benefit from the initiative. Boundary work arose around practices of connecting with and consulting residents, protecting locally-defined interests and autonomy, negotiating different sets of interests, and navigating representation. The multiple, shifting enactments of community and its boundaries highlight implications for understanding processes of inclusion and exclusion inherent to community engagement, and for interpreting pathways between collective empowerment and improved health. The study also raises questions for evaluating similar complex, community initiatives, where community cannot be taken as a fixed analytical unit, but something continually in process through the interplay between the initiative and the wider context. This must inform interpretations of how, and for whom, community engagement might – or might not – improve health.

Keywords

Community, engagement, health inequalities, evaluation, participation

Background

The prominence of the concept of 'community' in contemporary public health practice and discourse has been acknowledged (Green, 2015), and reflects an increasing commitment towards participatory models for health improvement (Milton et al., 2012). Yet, while engaging the community might reasonably be considered a 'good thing' (Parry, Laburn-Peart, Orford, & Dalton, 2004), how the community is constituted through engagement activities, and the potential implications of this for

understanding evaluating impacts on health remain underexplored. Questions of what constitutes engagement in practice have been met with attempts to develop typologies of engagement models reflecting the different levels of power over decision-making they offer to the community (Sallnow & Paul, 2015). However, the same level of critical attention has not yet been paid to how the concept of community is operationalised within engagement approaches for initiatives that may improve health, and what forms of community may be (re)produced through participation in the design and delivery of such initiatives, and with what consequences. This paper seeks to explore how community was enacted through a UK-based empowerment initiative, with particular focus on how the boundaries of the community – and therefore of who might or might not benefit from the initiative – were negotiated.

Engaging the community in the design and delivery of health and social initiatives is hypothesised to influence health outcomes in several ways. These can include: improving the relevance and uptake of health-oriented services and programmes (Morgan, 2001); building individual capacity for engaging in health improving behaviours (Campbell & Jovchelovitch, 2000); and shaping the broader social determinants of health such as social capital (O'Mara-Eves et al., 2013). Increasingly, it is theorised that when community engagement models are more empowering – for example control over decision-making rather than community consultation – further health benefits may be experienced at both the individual and collective levels, with potential to reduce health inequalities (Whitehead et al., 2016). This might occur through direct pathways, for example community members coming together to address environmental conditions such as housing (Popay et al., 2007), or more indirectly via increased social capacity, which might reduce feelings of powerlessness associated with poorer health (Whitehead et al., 2016).

Despite this increasing theoretical literature, evidence of the impact of community engagement strategies on health remains limited. While there is evidence that community engagement / participation can improve some health behaviours (such as breastfeeding and smoking) and perceived levels of social support (O'Mara-Eves et al., 2013), its impact on health inequalities remains unclear (Popay et al., 2015). There also remain concerns that participatory approaches continue to exclude those already most excluded (South, Jackson, & Warwick-Booth, 2011) and may thus entrench existing inequalities (Cornish & Ghosh, 2007). The reasons suggested for this lack of conclusive evidence include the plurality of models of engagement, and lack of detail in reporting on them, which hinders interpretation of the mechanisms of change for improved health (Bagnall et al., 2016). Yet, before better understanding can be developed of how to employ engagement to improve health and inequalities, a key dimension of these processes requires further, critical

interrogation: how to interpret 'community' within engagement mechanisms, and the implications of this for understanding how a participatory initiative brings about change to health.

Community can be conceptualised in multiple ways (Crow & Allan, 1994) and has long been debated and theorised across the social sciences, underpinning fundamental social theories of 'modern society'. Among others, these include accounts of the rise of the individualised, bureaucratised and capitalist state reflecting loss of the community as a traditional mode of social organisation (see for example Durkheim, 1997 [1933]). The community has been presented as a political and moral ideal, for example in theories of communitarianism, balancing the interests of individuals and the state (Etzioni, 1996). It is also engaged in theories of relating and of identity beyond spatial boundaries (Anderson, 1983), in a world of increasing globalisation and mobility (Appadurai, 1996). In more applied fields, such as community development, there has been critique of assumptions (often for pragmatic reasons) that community can be usefully conflated with locality for the delivery of participatory development programmes (Bhattacharyya, 2004) and of assumptions of a fixedness and homogeneity to the community, which can mask inherent power imbalances (Kothari, 2001). In community health psychology, attention has been paid to the social constructive processes through which community identities are shared, negotiated and contested, with potential impacts on access to power and resources for individuals and groups (Campbell & Murray, 2004). Furthermore, in global health fields, there has been critical consideration of community in relation to engagement mechanisms for biomedical research programmes, particularly in low-income settings (see for example Marsh, Kamuya, Parker, & Molyneux, 2011). Here, community has been framed as a normative and contingent concept, reflecting values such as the privileging of the 'individual' in the biomedical research consent processes, and different interpretations of the risks and benefits of participating in research (Marsh et al., 2011).

Given this acknowledgment of the contingent nature of community, reflecting complex relations between people, place, identity and power, it is surprising then that recent reviews of the evidence of community engagement and its impact on health inequalities have paid little attention to how community is defined and how it plays out through participatory initiatives (Milton et al., 2012; O'Mara-Eves et al., 2013). It seems problematic that evaluations of these initiatives would adopt a single, fixed definition of what counts as the community, as this would likely mask the way in which the relations constituting communities might shape, and be shaped by the mechanisms of the initiative. Attention to how community might be varyingly performed through the delivery of initiatives is likely important for interpreting the complex pathways through which engagement mechanisms might promote collective empowerment and bring about changes to health and inequalities (Reynolds, Egan, Renedo, & Petticrew, 2015). Thus it has potential implications for

informing public health decision-making about how, and indeed whether, to deliver engagement-based initiatives to address health inequalities.

This paper describes research undertaken to explore how 'community' was enacted through an area-based, empowerment initiative in England. It highlights a key dimension of the enactments observed: the ongoing negotiation and (re)production of boundaries that shape how the community leading the initiative can be interpreted, and who and what are included and excluded from the collective action of the unfolding initiative at any one time.

Study context and methods

The initiative

This study focused on *Big Local* (*BL*), a long-term (ten-plus years) initiative underway across multiple, relatively disadvantaged areas of England, which seeks to empower communities to make their local areas 'even better places to live' (Local Trust, 2015). The participating areas were selected by the organisation funding *BL,* identified as having been previously 'overlooked' for funding and investment, and through consideration of their population, relative deprivation and geographic location (Local Trust, 2015). The areas are geographically defined, ranging from urban neighbourhoods to rural villages and typically comprising between 5000 and 12000 residents. The geographical boundaries of the selected areas were identified prior to the delivery of the initiative, through a process of discussion between representatives from the funding organisation, and the local authority and voluntary and community sectors in each area (Local Trust, 2015). The 150 participating areas started on the initiative in different waves between 2010 and 2012, and are progressing through the stages of the ten-year *BL* initiative at different rates. At the outset of *BL*, residents in each area were facilitated to form a committee to start consultation with the wider community, supported by a 'rep' allocated to each area who was employed for a few hours a month by the organisation coordinating *BL* at the national level. Committees tended to form after residents were invited to meetings by the reps, publicised for example through posters, advertisements in the local paper, and through existing networks of local contacts. This 'getting people involved' phase (Orton et al., 2017) would typically occur over several months, until residents felt able to form a committee and begin working through the subsequent stages of the initiative, the first of which was to conduct consultation to identify priorities for the local area and develop a plan to address them over the next ten years. The approved plans would then be delivered using an allocated £1million

per area by a partnership of elected members, all of whom are volunteers and the majority must be residents of the designated area

While *BL* is not a specifically health-oriented initiative, it is the subject of an independent public health evaluation study – the *Communities in Control* study (Orton et al., 2017). The evaluation study sees *BL* as potentially influencing broader determinants of health and therefore an opportunity to explore likely pathways from increased collective control to improved health and reduced inequalities (Whitehead et al., 2016). The evaluation has similarities with the design of a 'natural policy experiment', advocated for evaluating the impacts of population-level environmental and non-health sector policies or programmes on health and inequalities (Craig et al., 2012). This scenario of a public health evaluation of a community empowerment initiative also posed a valuable opportunity to explore critically how community is enacted through such mechanisms. This could contribute to understanding pathways between control and reduced health inequalities and to approaches for evaluating complex interventions to inform public health decision-making at the population level (Hawe, 2015). The research described in this paper comes from a study that was separate from but linked to the public health evaluation and the dynamics of the relationship between the study described here and the evaluation are explored elsewhere (Reynolds, 2016).

The study sites

To explore how community was enacted through the delivery of *BL*, I selected two participating areas in which to conduct ethnographic fieldwork over 13 months between 2013 and 2014. One site, to be known as 'Westin Hill', is an urban area on the outskirts of a large city, and represents an electoral ward of around 12000 residents. At the time of research, the residents' committee were beginning to implement the plan they had developed previously, which identified local priorities including improving the local economy and increasing community spaces. The second site, to be known as 'Craybourne', is part of a medium sized town near to the coast, and its boundary seems to reflect a locally-recognised neighbourhood with around 6000 residents. The residents' committee here were at an earlier stage in the initiative pathway and at the time of research, were beginning consultation with the community to identify priorities for change in the local area.

Theoretical framing and methodology

The design and structure of *BL,* as an area-based initiative, denoted an assumed conflation of a geographic, residential area (and its inhabitants) with 'community'. However, for the purposes of this study, a theoretical framing was selected that acknowledged the likelihood of enactments of community beyond, or in addition to, a socio-geographic one, as the initiative unfolded. The framing

drew on principles from actor-network theory and its ontological assumptions that the world is pluralistic and performed into being through socio-material networks of relations (Law, 2007). This perspective reflected a theoretical decision not to draw on any one existing conceptualisation of what community is, such as a bounded socio-geographic space, or a symbolic entity. This would denote an assumption of community as an entity pre-existing *BL*, and would potentially limit the kinds of enactments that might be identified as unfolding through the delivery of the initiative. Instead, the framing offered by actor-network theory enabled exploration of how community *becomes* (Farías, 2010), identifying and following the range of actors (human, spatial, material), and their interactions, that constituted enactments of community in multiple forms.

An ethnographic approach was selected to explore how community was enacted as *BL* unfolded in each site. Privileging 'being there' (Lewis & Russell, 2011) as the mode through which to generate ethnographic knowledge of enactments of community, I spent time in each site over 13 months, moving between sites depending on the schedules of *BL* activities. A major component of the ethnographic fieldwork included observations of the regular residents' committee meetings and of events delivered locally as part of *BL*, such as festivals or sports programmes funded by the initiative, and informal conversations with those actively involved in the initiative, and with other residents and local workers. I also conducted in-depth interviews with committee members and other relevant stakeholders such as local councillors. Observations were captured through detailed notes, and I wrote reflexive field notes daily to record more informal interactions, and emerging interpretations. In-depth interviews were audio-recorded and transcribed verbatim. Analysis was conducted iteratively as fieldwork continued, with field notes, observation notes and transcripts being coded 'bottom-up' to explore and identify themes and categories of how community was being enacted around *BL*. One such category – the ongoing assertion and negotiation of community boundaries – is the focus of this paper.

Ethics approval for this study was granted by the ethics committee of [*Institution*] (reference 7116) and permission to conduct research in the two areas was negotiated first with Local Trust, and second with the residents' committees in each area. Individual consent was sought for all in-depth interviews, and all participants were made aware of when informal conversations and observations would be included in the research.

Findings

This paper focuses on practices that contributed to the ongoing assertion and negotiation of community boundaries, a prominent way in which community was enacted through the delivery of *BL* in the two sites. While these interpretations emerged through analysis of the empirical ethnographic data, borrowing from the theoretical concept of 'boundary work', and social theories of knowledge and knowledge production (see for example Gieryn, 1983), helped consolidate this analytical framing. The term has been used to depict the everyday work of maintaining ideological demarcation between disciplines, or between 'science' and 'non-science', and its use here reflects a view that "*boundaries do not sit still*" (Barad, 2003 p. 871). Thus, a focus on 'boundary work' helps challenge assumptions that the community engaged in an empowerment initiative is fixed, and draws attention to the practices that shape how the community boundary is (re)drawn as the initiative unfolds.

The *BL* areas had been defined for the purposes of the initiative by clear geographical boundaries. However, these geographical boundaries were expressed and challenged in different ways through a range of practices arising through the delivery of the initiative which also highlighted other ways in which community boundaries were enacted. These practices, constituting ongoing 'boundary work', seemed to serve different functions in the delivery of the initiative. As such they demonstrated that neither community nor its boundaries are pre-determined but contingent and continuously 'in process' through the dynamics of the initiative. Spatial, material and discursive practices arising through the decision-making processes and day-to-day work of the residents' committees delivering the initiative demonstrated assertions of different kinds of boundaries. This seemed to serve two functions; first, as a mechanism to draw people in and connect them with the ongoing work of *BL,* and second, as attempts to protect the community's control and interests from perceived threats by others, such as non-residents. These practices also highlighted processes of boundary negotiation, reflecting attempts to navigate and align competing sets of values arising through the work of *BL*. Challenges and questioning of boundaries arose around negotiations of perceived eligibility of different groups of people (and spaces) to contribute to and / or benefit from the initiative, and through attempts to put into practice ideas and values of representation through the delivery of *BL*. As such, these varied practices constituted ongoing (re)production of boundaries, as one form of enacting community through the initiative.

Asserting boundaries for connection

The geographic boundaries of the Westin Hill and Craybourne areas had been designated as part of the initial design of the *BL* initiative, and their ongoing assertion was prominent in each site, particularly through activities conducted by the residents' committees to consult and engage with

the wider community. These geographic boundaries were clearly displayed on maps on websites linked to the initiative and in various material forms which were used as part of the different activities conducted in each area. In Craybourne, a large-scale version of the map with the clearly demarcated geographical boundary was employed by members of the *BL* committee at several public events during my fieldwork, displayed at a stall erected to attract members of the public to give their opinions on what local priorities should be addressed through the initiative*.* I noticed how the large map would become a tool of engagement, not only communicating the boundary of the Craybourne area participating in the initiative, but prompting people to identify and discuss their own eligibility to participate and contribute, as indicated in an excerpt from my fieldnotes from attending a local festival:

> *"Also on the stall [was]. . . a large, colour print map of the Craybourne area, with the boundary for the BL area marked in black. This proved to be a good focal point for conversations between members of the committee and members of the public, with lots of people tracing the line of the boundary, and using the map to indicate where they live (in a couple of cases, down to the exact house plotted on the map), whether just in or just outside the boundary. Others, when looking at the map, seemed to find it a little challenging to orientate themselves by the map and to find their location."* (Craybourne, fieldnote O-01, May 2014)

Here the map, as a tangible depiction and assertion of the geographical boundary, seemed to serve a connective function, producing new relations between those most actively involved in the initiative and the wider community with whom they sought to consult. It also prompted people to consider their own relationship with the local spatial landscape in new ways, via interpretation of the boundaries within which *BL* was unfolding.

In Westin Hill, the assertion of the geographical boundary via a map frequently reproduced on leaflets and newsletters prompted committee members and others to consider the spatial dimensions of the community in terms of who was or was not 'represented' through the actions of the initiative. The particular shape of the Westin Hill boundary on a map gave rise to references to one part of the area as 'the appendix' or 'the wedge', particularly when people were considering which groups of residents were most actively involved in delivering *BL*. Caroline, a committee member, described how she had started referring to her end of Westin Hill as 'the wedge' when she realised that this part was not being 'represented' at committee meetings, and she was concerned that residents in the 'posher' parts of the area were more dominant. Thus, the reproduction of the geographical boundary in a visible form led to considerations of the scope of community in terms of

who was more and less engaged in shaping the trajectory of *BL*. This subsequently prompted attempts to connect more with those considered absent, for example through Caroline's ongoing efforts to encourage her neighbours to attend meetings and get involved with the initiative.

Asserting boundaries for protection

In Westin Hill, discursive practices of demarcating a boundary around who was eligible to contribute to decision-making were exemplified in boundaries asserted between 'residents' and 'the council', reflecting attempts to protect the control allocated to the community over delivering the initiative. Discursive constructions of the community as necessarily distinct and separate from the council arose in numerous contexts, such as in committee meetings when members debated whether they should meet with councillors to discuss the position of *BL* in relation to other local, council-led regeneration work. This was illustrated in one committee meeting where Nadia, the development worker employed on a part-time basis by the committee to help deliver the initiative, announced that she had been invited to a meeting about council plans for improving Palmer Grove, a large housing estate in Westin Hill:

> *"At this point, Nadia said she'd been approached by someone from the council to attend a meeting about Palmer Grove. She said the councillors had suggested she be invited . . . Derek and Lydia both asked why Nadia had been contacted, with Derek saying that they wouldn't be getting any of the BL money as the council are supposed to fund the community centre at Palmer Grove. Derek told Nadia that she shouldn't go to the meeting as she isn't allowed to make any comments or recommendations on behalf of the committee, and shouldn't go as they haven't been able to discuss it as a committee."* (Westin Hill, observation O-07, January 2015)

Here, an emphatic and direct demarcation of the boundary between the community and the council was conveyed through the forbidding of Nadia to engage with councillors regarding an issue that was of interest to both the council and the *BL* initiative – improving Palmer Grove housing estate. This highlights a protective function of boundary making, to avoid scenarios in which the community's control and financial resources allocated through *BL* might be encroached upon by external groups. Furthermore, this example also highlights internal forms of boundary making, whereby Nadia, as the employed worker, was not considered eligible to speak on behalf of the committee members who, by nature of their elected positions, were considered representatives of the broader community. The boundary asserted around Nadia's position and the committee

members here reflected an attempt to protect against a possible threat to the authority and eligibility of the committee members as representatives of the community.

Negotiating eligibility to contribute and benefit

In Craybourne there emerged a narrative of the ongoing negotiation of a boundary between the residents and the 'traders', a term commonly used to refer to people who owned shops and other small businesses in the local area (though a few were also residents in the area), and which reflected perceptions of eligibility to contribute to and benefit from the initiative. I learned that prior to my fieldwork there had been ongoing tensions at committee meetings between residents and traders, and that the 'agendas' of the local traders who had attended committee meetings had been questioned amid criticisms that they were just interested in 'getting money' from the initiative for their own businesses (irrespective of whether they actually lived in Craybourne). I was told that the traders had since stopped attending the committee meetings, and I came across several residents who also said they had withdrawn from *BL* during this period, due to the uncomfortable dynamics at meetings. While this boundary between the two groups was often clearly asserted by committee members, I identified several practices that emerged that seemed to challenge the articulated boundary by recognition of the potential value of the participation of the traders in various aspects of delivering the initiative.

Shortly after I started my fieldwork in Craybourne I followed Katy – newly appointed by the residents' committee to assist with the consultation process – to a meeting of the local traders' association in a café. During the meeting, Katy introduced herself and mentioned that the *BL* committee planned to apply to a scheme available to *BL* areas which offered support for developing social entrepreneurship. Katy indicated that she thought this scheme would be of interest to the local traders, and said that she was aware that there had been some tensions between the traders and the *BL* committee previously, but that she wanted to try to bridge the relations between the two groups again. This prompted discussion among some of the other people at the meeting about their various experiences of attending committee meetings in the past:

> "*There was more discussion about the feelings of division between the traders and residents and the experiences some traders had had at earlier [committee] meetings where they found people rude and unwelcoming, so didn't come back . . . They discussed how they'd been questioned as to whether they're 'residents' of Craybourne, but a woman said 'we're here because we believe in Craybourne, not because we make money out of it'.*" (Craybourne, fieldnote R-02, June 2014).

By the end of this meeting, many of the traders seemed to be more positive towards re-engaging with the initiative, offering to take copies of leaflets promoting the Craybourne *BL* from Katy and a couple of people indicated their interest in the social entrepreneurship scheme. The interest in collaborating through the social entrepreneurship scheme served as a link across the assumed boundary between residents and traders and their respective interests in the financial possibilities of *BL*. This indicated a re-negotiation of the demarcation between the groups by their values and eligibility to contribute to a community initiative.

In Westin Hill, there also emerged a persisting narrative of ongoing boundary negotiation around perceived eligibility to benefit from the initiative which reflected the geographical scale of the *BL* area. In an in-depth interview, Hardeep, a local council employee who had been involved in the early stages of establishing *BL* in Westin Hill, described the challenges of agreeing the 'right' kind of area for the initiative, in terms of a range of criteria articulated by the funders of *BL,* including levels of deprivation and lack of regeneration, but also a population of a certain size:

> *"***Hardeep:** *So that was the first challenge I think, in terms of them wanting a certain population size, but for the, for that population size not to have received any regeneration funding. . . So what we ended up doing was saying, well, we can't give you that because there will be nowhere in the borough that has a population of that size that is deprived that will have been overlooked. . . But what we can do is identify some of our really most deprived small areas that have been overlooked, literally because they're often islands within wider, there are, sort of, islands of deprivation within wider areas of, of non, non-deprivation . . . And if you're insisting on the money being, um, the population being there, what we'd have to do is look within that ward and see where we could, kind of, add bits."* (Westin Hill, interview, December 2014).

This historical narrative of negotiating boundaries around perceived deservedness to benefit was also echoed in the ongoing work of delivering *BL* in Westin Hill. It arose particularly in discussions around which projects to fund, whom they would be targeting and where in Westin Hill they would be situated. The notion of 'need' was often implicit in these negotiations, arising most commonly in discussions of potential projects that targeted smaller and more deprived parts of Westin Hill. Thus, the work of trying to deliver the plan for addressing the priorities identified for and by the whole community of Westin Hill was intersected by ongoing negotiation of boundaries around who and where was most eligible to benefit from the initiative's resources and anticipated outcomes.

Navigating processes of representation

Attempting to put into practice ideas of representation of the community through the day-to-day work of the residents' committee gave rise to negotiation, questioning and challenging of boundaries. A prominent example of this arose in Craybourne, around a commercial company's proposal for the development of waste land in the local area, which at once challenged the 'official' geographical boundary of the Craybourne community for the purposes of *BL.* The waste land lay just beyond the edge of Craybourne but the development proposal was of great interest to residents and *BL* committee members as it was felt that the land was a 'barrier' dissuading people from moving from the main town centre into Craybourne. Committee members were keen to find out more about the plans for the proposed development to understand how, if approved, it might impact on Craybourne, and whether to position the *BL* group as being publicly in support of the plans. The issue was discussed across several meetings including one arranged by Ryan, the Chair of the *BL* committee, who invited residents and traders to meet with representatives from the commercial company proposing the development. Residents asked about the kinds of facilities that would be created, and how pathways between the development and Craybourne would be enhanced for increased movement of people between the areas. This indicated negotiation of the geographical boundary in terms of the potential opportunities of the development and the anticipated flows of related resources (jobs, people, trade) into the Craybourne area.

Yet, the optimistic discussions of the development's possibilities for Craybourne were counteracted at a committee meeting a few days later, when residents debated how the *BL* committee should present their public support for the development. This reflected attempts to navigate the boundaries around who, where and what they represented as a committee. This was particularly prominent in disagreements arising around whether the *BL* committee should ask for financial benefits from the commercial company in return for their public support of the development:

> *"Geoff said that they're a group of residents looking to spend some money, and wasn't sure that they should be making a public statement [about their support for the development] as it might put barriers up with some residents who don't support the development. Ryan said they'd be speaking as the committee not as the whole of Craybourne; he emphasised the high level of support that had already been shown for the development and said there are already lots of people who don't like us [the committee] anyway."* (Craybourne, observation O-08, August 2014).

Here, the question of how to position themselves as a committee in relation to the proposed development prompted questioning of the distinction between the committee and the wider Craybourne community. This reflects attempts by committee members to grapple with the idea of

representation, and how events and issues unfolding beyond the scope of the initiative in the local area (geographically and conceptually) challenged the assumed boundaries of who, what and where is represented through the day-to-day work of delivering *BL* for and by the community.

Discussion

Increasing attention within public health towards community engagement, including in the delivery of social policies and programmes with potential to shape broader determinants of health, has led to questions of the potential impacts of engagement mechanisms on health inequalities, and which 'communities' might and might not benefit from such processes. This paper has highlighted the ongoing, shifting boundary work that constitutes enactments of 'community' arising in two sites participating in a UK area-based empowerment initiative. The geographical boundaries of the areas, as designated for the purposes of the initiative, were among a range of ways of asserting and negotiating the eligibility of different people and spaces to contribute to and / or benefit from the initiative in each site. The ongoing work of asserting and negotiating different boundaries around community occurred as the residents most actively involved in delivering the initiative sought to: connect with and consult wider groups of people, protect locally-defined interests and autonomy, navigate different sets of values and interests relating to the potential benefits of the initiative, and 'do' representation of the community.

The boundary work identified in this study can be interpreted as ongoing processes of inclusion and exclusion, inherent to enactments of community through the mechanisms of a participatory initiative (Reynolds, 2016). This corresponds with theorisation of inclusion and exclusion (of people, spaces, resources) not as fixed states but as dynamic sets of relations (Popay et al., 2008) that position people varyingly closer to, and further from, the material and social resources of a participatory initiative that could be expected to be influence health. Existing literature on inclusion and exclusion highlights how perceptions of skill and competence mediate who is 'included' in participatory practices (Barnes, Newman, Knops, & Sullivan, 2003), and thus who is likely to benefit from relations of collective empowerment. Yet, this study identifies further aspects of a participatory initiative which appear to shape who has eligibility to contribute to and / or benefit at any given time. These include practices and values inherent in the structure of the initiative itself, such as expectations for community consultation and representation, and the reality of delivering the initiative within a broader, dynamic context (Orton et al., 2017).

The theorised potential for participatory community initiatives such as *Big Local* to contribute positively to health inequalities via increasing collective control (Whitehead et al., 2016) rests on

certain assumptions around how collective relations of empowerment might be produced through engagement or participation. The ways in which community and its boundaries were multiply enacted via continual negotiation indicate that the pathways through which community participation might influence the wider determinants of health may be more complex and less unidirectional that currently theorised. Collective control, as a concept, becomes more difficult to define and identify if the collective unit of interest – here, community – is contingent, in production and shifting. Given concerns over the potential for participatory initiatives to exclude the already marginalised and entrench existing health inequalities (Cornish & Ghosh, 2007), this study also highlights the need for attending closely to the unfolding relations and processes of positioning, and to the range of values and practices that shape how and when boundaries are asserted. This is vital for understanding more about the pathways through which determinants of health will be shaped, and by whom health benefits will (and will not) be experienced, thus shedding more light on the mechanisms through which participatory initiatives may impact (positively or negatively) on health inequalities.

The ongoing boundary work inherent in enactments of community also holds important implications for methodological approaches to evaluating similar area-based, empowerment initiatives. The findings indicate the limitations of taking 'community' as a fixed unit for analysis, such as the target population against which health outcomes can be measured, given that its boundaries are continuously negotiated, shaped by and shaping the unfolding mechanisms of the initiative itself. This study builds on recent literature examining the framing and interpretation of the role of 'context' in evaluating the health impacts of complex interventions, and critiquing assumptions that the intervention and context can be easily distinguished (Shoveller et al., 2016). Orton and colleagues, exploring the influence of contextual dimensions on the *BL* initiative, highlight aspects of the pre-existing social, geographical and organisational system (as context) which shape the way the initiative embeds and progresses (Orton et al., 2017). Yet, what the findings of this study also indicate is the importance of understanding how the relations between geographical, social and material dimensions of the initiative-in-context are constantly in production. It also indicates implications for the very conceptual and analytical categories – such as community – underpinning both the design of the intervention, and the evaluation of its impacts. Thus, to understand better 'what happens' in complex health interventions (Petticrew, 2015), and therefore how better to inform public health decision-making, we should examine the interplay not only between the context and mechanisms of an intervention, but also the categories used to evaluate the impact of an intervention.

Limitations

Given that the research question focused on how community was enacted through the unfolding *BL* initiative, the people engaged with, and the range of activities observed, reflected only a very small proportion of the thousands of residents in each area and of the likely other forms of boundary work taking place in each site. Furthermore, this focus meant that much of the ethnographic 'gaze' was on those most actively participating in the initiative and therefore the enactments of community identified were the product of those people most included in the participatory mechanisms of the initiative. This potentially raises questions about how 'voices' are represented in the accounts captured through this research, and ties in with broader questions of how to include those most socially excluded (in initiatives *and* research) and how participatory initiatives can avoid entrenching existing inequalities. However, the small scale of interactions becomes a valuable illustration of the processes through which a large, almost intangible collection of people and spaces become performed as community through relations of representation (Connelly, 2011), and through the actions and interactions of a limited group of people.

A second limitation to note is that the ethnographic interpretations described here offer only a snapshot of the enactments of community occurring at relatively early stages of the ten-plus year lifespan of the *BL* initiative in Westin Hill and Craybourne. While this means that interpretations of any associations between the different enactments of community identified and impacts on health cannot be identified, this research does indicate the range of dimensions of the initiative and its delivery that are co-constructed with community even at this early point in the process. This reinforces the argument that how community and its members can be defined is wholly contingent on the unfolding initiative and its context, and must therefore be considered in the interpretation of health outcomes at a later stage.

Concluding statements

This study highlighted the importance of attending to ways in which the community and its boundaries are enacted through the mechanisms, values and contextual dimensions of a participatory initiative, with potential to influence broader determinants of health and inequalities. It provided understanding of the ongoing negotiation and assertion of different boundaries around who, what and where are considered eligible to contribute to, and benefit from a community empowerment initiative, that arise through the initiative-in-process. This holds relevance for evaluations of complex, community initiatives, and for interpreting how engagement processes may contribute positively or negatively to existing inequalities in health. Rather than continuing to assume that community engagement is an inherently 'good thing', more attention to the shifting positioning of people, spaces and resources that arises through unfolding mechanisms of

engagement is necessary for understanding whether, how, and for whom change to health is brought about.

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