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Title: Understanding behaviour change in context: Examining the role of midstream social marketing programmes

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Abstract

This research examines how midstream social marketing programmes that adopt a relational and community-based approach create opportunities for individuals to make incremental changes to health behaviour. Specifically, it applies Bourdieusian theory to explore how interactions between community healthcare workers (CHWs) and members of the public generate impetus for change and foster individual agency for improved health. Qualitative interviews were carried out with members of the public and CHWs engaged in a Smokefree homes and cars initiative. The findings suggest that although CHWs are challenged by resource constraints, their practices in working with individuals and families build trust and enable dialogue that bridges smoking-related health insight with home logics. These interactions can promote individual agency with a transformative effect through small changes to smoking-related dispositions, norms and practices. However, tensions with the habitus of other household members and other capital deficits can inhibit progress towards embedding new practices. The study concludes that interventions built upon community relationships show potential for addressing limitations of information-focused campaigns but there is a need to also respond to key social structures relating to the field of action for new health dispositions to become embedded in practice.

Keywords: Bourdieu; midstream social marketing; transformative agency; social context; behaviour change.

Introduction

This paper applies Bourdieusian theory to explore how social marketing programmes that adopt a relational and community-based approach create opportunities for individuals to make incremental changes to health behaviour. Specifically, it examines relationships and interactions through which community healthcare workers (CHWs) and members of the public negotiate the conflicting logics of their respective social fields and coalesce constellations of capitals, creating opportunities for individual agency to make health improvements that transcend social conditions and may have a transformative effect. Over a period of 50 years, social marketing has become a primary approach to behaviour change in health promotion but, in a similar vein to other health behaviour change interventions, it has been criticised for its limited power to engage the populations most affected by inequalities (Cohn, 2014; Crawshaw, 2012; Maller, 2015). To a large extent this limitation stems from social marketing's focus on individuals, its reliance on psychology theory and the assumption that people are rational agents (Baum and Fisher, 2014; Crawshaw, 2012).

As a consequence, it has neglected the impact of structural factors (Andreasen, 2006) and implementation issues, especially the need to collaborate with community actors (Dibb, 2014; Domegan et al., 2013). More recently, social marketing scholarship and practice has responded to these criticisms by espousing a shift towards a relational paradigm that advocates co-creation with citizens and other network actors mediated by a midstream (i.e. community oriented) service approach to the development and implementation of programmes (Dibb, 2014; Luca, Hibbert and McDonald, 2016; Russell-Bennett, Wood and Previte, 2013). Scholars that support this shift recognise that social theory provides a suitable conceptual foundation to explore the relationship between social structures and health

inequalities and reveal novel approaches to address the context of behaviour (Cherrier and Gurrieri, 2014; Luca, Hibbert and McDonald, 2016). However, extant literature is predominantly conceptual and empirical studies are needed to inform theoretical development on the social context and the facilitators and constraints on behaviour change realised through relational and community-based interventions (Ong et al., 2014).

In this paper we build upon Bourdieu's work to explore processes of health behaviour change, more specifically, how individual agency emerges as manifested through new health dispositions, rules, logics of the field and adaptive practices which may have a transformative effect leading to change. In so doing, we aim to understand how context can be incorporated into social marketing seeking health behaviour change and support a more culturally sensitive model of developing health and wellbeing programmes.

Bourdieu's work has been traditionally used to explain reproduction or change due to hysteresis - a major disruption to the field (McDonough and Polzer, 2012). A small number of studies investigated how incremental change may occur when the habitus is challenged by biographical and biological moments and crisis such as illness (Angus et al., 2005; Behague et al., 2008). However, his work has been less used to investigate change that occurs gradually as a result of new adaptive practices, norms, dispositions and logics which emerge in a relational context through collaboration and in the absence of major disruptions. There is a lack of research on how interventions implemented by health institutions can create small disruptions that afford opportunities for changes to health dispositions, norms and practices.

In this paper, we explore these processes by focusing on a social marketing intervention that aims to reduce smoking indoors, entitled 'Smokefree'. This campaign incorporates traditional social marketing tools (e.g., the Smokefree brand, 'step outside' as a core message,

educational and persuasive communication materials, branded mugs, signing a pledge) but it also has a significant relational dimension. The campaign is implemented by practitioners from various professions, who work in low social economic status (SES) communities and are asked to extend their relationships and interactions with community members to address smoking and, create smoke-free indoor environments. We propose that this type of programme has potential to disrupt community members' habitus in relatively modest (rather than major) ways. It does not only present social conflicts, but the relational and community-based approach provides platforms to negotiate the contrasting health logics of CHW and home fields and creates opportunities for individual agency. Furthermore, it offers the possibility of a transformative effect through incremental change to social structures that shape health habitus.

This research contributes to the emerging body of literature drawing upon Bourdieu to explore the notion of agency and change in a health context (Angus et al., 2005; Behague et al., 2008; Crossley and Crossley, 2001; McDonald, 2009). We draw upon scholarship on Bourdieusian constructs that are central to our conceptual view of relational and community-based interventions, such as habitus, field and capital and review extant literature on sources of disruption, agency and structural transformation. The exploration of habitus, field, and capital enables us to articulate more clearly the socio-cultural dimensions influencing change in a health context. In so doing we provide an alternative perspective to the traditional psychology lens on the social and institutional processes underlying interactions around behaviour and social change. The research also adds to the sociology informed body of social marketing literature (Gurrieri, Previte and Brace-Govan, 2013; Luca, Hibbert and McDonald, 2016; Szmigin et al., 2011; Spotswood and Tapp 2013) providing a social theory informed framework for analysing change in a collaborative social marketing programme.

First, we discuss the background of this research and then we provide an overview of social theory concepts central to the theoretical perspective adopted. We then discuss the context of the current research, the methodological approach adopted and the findings of the study. The article concludes with a discussion of the main findings and implications of the study.

Background: behaviour change in context and midstream social marketing

The need for alternative paradigms that acknowledge the interplay between agency and structure in health has led to an emerging body of research informed by social theory (Abel and Frohlich, 2012; Frohlich, Corin, and Potvin 2001; Frohlich et al., 2012; Maller, 2015; Williams, 1995 etc.). The vast majority of behaviour change interventions to improve health and wellbeing, including social marketing programmes, adopt voluntarist approaches that centre on individual agency and privilege the role of beliefs, desires, attitudes and actions as drivers of change. A structuralist approach seeks to explain individual thought and action primarily through the 'structures' (i.e. the material, economic, and social conditions) that form society (Williams, 1995). A number of authors have challenged this dualism using Bourdieu to unveil how change happens through incremental modifications triggered by individuals who navigate the existing practices, habits and other institutional conditions (Angus et al., 2005; Behague et al. 2008; Gleeson and Knights, 2006). This work illustrated how crises, such as biological factors and illness, might trigger both transformative agency and changes in social positions (Angus et al., 2005), and how creative practices have the potential to modify power structures (Behague et al., 2008; Crossley, 2003; Dyson et al., 2011; Lee et al., 1999; McDonald, 2009). There is little understanding of how changes to the habitus, new health dispositions and practices emerge and how midstream actors such as

community services staff seek to shape the socio-cultural context to facilitate behaviour change in health programmes. A primary challenge is building a better understanding of 'behaviour in context' in order to develop programmes that understand people's practices and strategies and confront structural barriers to change (Baum & Fisher, 2014; Ong et al., 2014).

Midstream social marketing programmes emerged as an attempt to understand and address these issues (Russell-Bennett, Wood and Previte, 2013). Scholarship on midstream social marketing has followed early research rooted in community-based models (McKenzie Mohr, 2000). Such models rest on the principle of recognising the value of community assets (in particular knowledge, skills, ideas and culture) (Morgan and Ziglio, 2007) and aim to promote a sense of ownership over interventions and participation. To illuminate this perspective, empirical research has focused upon initiatives that involve the collaboration of diverse members of the community. This body of work has provided valuable insight into the ways in which people and diverse organisations within communities, form coalitions and collaborate, and has set out steps in the process of planning, implementing and evaluating interventions to provide guidance on best practice (Stead, Arnott and Dempsey, 2013; Bryant et al., 2007). However, there has been limited research into how these types of interventions work (McLeroy et al., 2003; Dibb, 2014) and, more particularly, collaborative processes amongst community-based actors that facilitate transformation (Luca, Hibbert and McDonald, 2016).

An emerging body of work has engaged with critical approaches and sociological theory to develop understanding of institutions (Cherrier and Gurrieri, 2014; Gordon and Gurrieri, 2014); social capital (Glenane-Antoniadis et al., 2003) and culture in social marketing (Hargreaves, 2011; Gurrieri, Previte and Brace-Govan, 2013; Szmigin et al., 2011;

Spotswood and Tapp, 2013). However, research has not yet examined the interplay of structure and agency in the context of midstream social marketing, despite calls to explore health promotion approaches that can confront contextual constraints (Baum & Fisher, 2014; Gordon and Gurierri, 2014; Luca, Hibbert and McDonald, 2016; Ong et al., 2014). We address this gap in the literature by focusing on the Smokefree programme. This empirical context represents a model of midstream social marketing in which local health organisations seek to address structural constraints in low socio-economic status communities by harnessing the capacity of established community-based services. The primary aim of the study it to examine whether the relationships and interactions between CHW and members of the community can challenge social conditions by creating opportunities for individual agency to make small health improvements and their potential transformative effect.

Some theoretical considerations

Theoretically, our research is rooted in the work of Bourdieu, which provides a useful conceptual framework for our analysis because it accounts for structural constraints but avoids simple structural determinism, acknowledging that there is also scope for individual variation and change. For Bourdieu, human action takes place in fields which are systems of structured relations between social positions where actors struggle over resources (Bourdieu, 1990). Each field is characterised by a specific logic of action, and institutionalised forms of power (Bourdieu 1990, p. 61). The individual's position in a social field is influenced by the resources available to them, or different forms of capital (Bourdieu & Wacquant, 1992). Fields can be restricted in size and scope and smaller fields might be more appropriate for investigating health practices (Robinson and Robertson, 2014; Veenstra and Burnett, 2014). For example, in the context of smokefree homes programmes, community health and the home are different fields, each of them carrying different logics and practices (Angus et al.,

2005). Capital is field specific and can be economic (financial resources such as income and wealth), cultural (behaviour; capabilities; education; skills, competences), social (family, groups, class, networks, trust, social connections and communities) and symbolic (honour and recognition) (Bourdieu, 1997). The value of the capital is influenced by the social field as some forms of capital might not be perceived as such if transferred to other social fields (Behague et al. 2008). More recently, the concept of cultural health capital was introduced to stress a specialised form of cultural capital (e.g. knowledge of health topics and vocabulary, behaviours, ability to interact with healthcare staff; orientation towards the future etc.) in the context of healthcare (Shim, 2010). Closely linked to capital and social field is the concept of habitus which is seen as a set of dispositions (e.g. schemes of perception, thought and action), norms and rules emerging from individual interactions with social fields (Bourdieu, 1997). According to Bourdieu (1997), values, beliefs and views are a product of the habitus which is also associated with class, gender, cultural and social position. Thus, the 'habitus' can be more or less favourable to healthy lifestyles depending on the access to cultural, economic, social and symbolic capital. This suggests that the habitus is generated by social conditioning, and influences individuals to reproduce the existing practices and the structures of society (Elder Vass, 2007). The concept of habitus is useful in exploring and understanding individuals' dispositions regarding healthy behaviours and how these dispositions have been shaped by their context and life history. This concept also indicates a certain reliance on pre-reflexivity which assumes that actors' actions are influenced by habitus below the level of consciousness (Bourdieu, 1990) and that they may occur without explicitly articulating the 'how-to' behind them (Bourdieu and Wacquant 1992). The Bourdieusian view suggests that understanding how change emerges requires examining interactions between habitus and the field of action (Bourdieu, 1990).

Bourdieu's emphasis on the habitus and continuity rather than change (McDonald, 2009) seems to suggest that agency is conceptualised as structurally reproductive - reproducing the existing structures through practices (Hays, 1994). In the context of health, 'structurally reproductive agency' is illustrated by certain health behaviours such as sedentary lifestyles, unhealthy eating, smoking habits leading to reproduction of certain social patterns and health disadvantages over time (Abel and Frohlich, 2012). However, Bourdieu recognises creativity and transformative agency leading to change (i.e. changes to habitus, structural and social conditions) when he argues that actions are adapted to the social setting and practices are generated through interactions of various forms of capital with habitus by entering the fields of action (Bourdieu, 1990; Lessard et al., 2010).

Triggers for change to social conditions may include events and interactions with others that involve exposure to other types of capital (e.g. cultural, symbolic) and conflicting logics leading to reflexivity (Accardo, 1999; Sayad, 1999). Social encounters, biographical moments and events such as an exam or a biological moment or crisis (e.g. illness, ageing) may act as triggers for reactivating aspirations and change (Accardo, 1999). For Bourdieu, reflexivity -as self-analysis, self-critique, self-confession and questioning of the 'status quo' – is a key process which might lead to actions of emancipation and liberation from the current situation (Bourdieu & Wacquant, 1992; Sayad, 1999). The literature building on Bourdieu suggests that a key point in activating the transformative power of capital resources to stimulate change is when people use schemas (rules, norms, schemes of legitimation and meaning) to interpret these resources and reflect upon the situation (Crossley, 2003). Faced with new situations in different fields of action and encounters with other actors, individuals apply their existing schemas – which are shaped by their habitus - and appropriate capital, to derive new practices. Change is also explained through major or minor disruptions to habitus.

It occurs through the adaptation of actions to different social settings, through the interaction of habitus and different forms of capital as people enter a field of action. In other words, individuals' experiences and interactions with actors within different fields influence the system of dispositions composing their habitus (Bourdieu & Wacquant, 1992, p. 133). Disruptions may be a result of the hysteresis effect caused by a conflict between new and modified 'fields' and the habitus. This occurs when there is a gap between a change in the field and habitus's ability to adapt to the new rules. Bourdieu argues that this lack of harmony between habitus and the field may lead to rational action, reflexivity and transformative agency (Bourdieu and Wacquant, 1992). For example, encounters between families and community health staff in different fields (e.g. home, community health services, etc.) act a source of minor disruption by bringing in a different health logic. When combined with a biographical event such as having a baby, these encounters may become sources of disruption to the habitus.

Most of the emerging work on transformative agency in Bourdieu's work (Abel and Frohlich, 2012; Angus et al., 2005; Behague et al., 2008) focuses on how change occurs in the context of hysteresis envisaged as a major disruption leading to resistance against institutional structures or due to disruptions created by biological factors, such as aging and illness. There is little understanding of sources of change relevant to preventative health improvements and the ways in which health bodies can promote change and enable forms of individual agency that have potential for a transformative effect. This study adds to the extant literature by investigating how collaboration of multiple actors in a community health context can be a source of disruption and change and whether they stimulate individual agency and facilitate transformation. It specifically seeks to examine how Bourdieusian concepts may bring new insight on the opportunities for small and incremental health improvements and the

associated transformative effects that this type of intervention facilitates. Bourdieu's writings have not been widely applied for the study of behaviour change (for work on the influence of culture on behaviour see Nairn and Spotswood, 2015; Spotswood and Tapp, 2013) and to the best of our knowledge there are no studies investigating how agency manifested through health dispositions, norms and practices, emerges in the context of a midstream social marketing programme delivered through service encounters.

Methodology and study context

Despite progress in tackling smoking in the overall population in many western countries, smoking rates amongst low socio-economic status populations have remained high (MacAskill et al., 2002; Robinson et al., 2011). Since 2011, the 'Smokefree Homes and Cars programme' (Smokefree) in the UK has been dedicated to encouraging individuals to change their smoking practices and not smoke in their homes or cars and support a change of the social norm regarding smoking. The programme under analysis is a local initiative in a city in England. Its aims include to increase the number of people who sign a smokefree pledge and commit to keeping their homes and car smoke free; and to develop understanding among the general public and in areas of greatest health inequalities and highest smoking prevalence, of the potential harms of second-hand smoke. An important area of action developed by Smokefree involves the focus on midstream services, to develop the understanding and ability of frontline workers such as Children's Centre staff; health visitors, Community Health Development Workers and community midwives to address smoking environments; support staff to integrate the Smokefree conversation with their service users within their practice and generate referrals for the NHS Stop Smoking Services (STOP) (through a pledge form) (Anonymous Group, 2012). The approach employed by Smokefree is centred on

supporting community services staff to develop knowledge about second hand smoke and how to have a conversation about smoking. The Smokefree collaboration was based on the rationale that involving community actors in the programme would encourage the development of new practices to support change by increasing access to various forms of capital specific to community health. Unlike traditional social marketing campaigns relying on leaflets and promotion and limited interaction, the Smokefree programme aimed to provide the chance for dialogue and customisation to the individual user's circumstances.

Smokefree homes programmes encourage change in relation to the space of the home. Such programmes require understanding of the logics of the home as a private intimate space where family members have control over what behaviour and practices are expected and permitted (Angus et al., 2005). Visitors and guests are typically granted only partial or temporary access to the home and limited power to question the routines and practices of this space (Robinson et al., 2011). In the context of collaborative Smokefree programmes, interactions between community health staff and their service users often occur in people's homes generating the space for contrasting the logics of the community health field and the logics of the home. The logics of community health, in particular in western countries reflect a 'rational' model wherein individuals are encouraged to make healthy choices by providing them with information and support (Mol, 2008). Previous work has unveiled the tensions between this choice logic and the challenges brought by the practice of disease prevention and social contexts (Henwood, Harris and Spoel, 2011; Mol, 2008).

Study design

We conducted interviews to explore the views and experiences of a range of stakeholders. We asked participants to reflect on their everyday practices around health behaviour and their

interactions with Smokefree. The study includes 45 semi-structured interviews with participants involved in the programme (hereafter community healthcare workers -CHWs- such as STOP staff; Children's Centre staff, including family support officers, receptionists, managers, childcare teachers, play leaders; health visitors; midwives; community health development coordinators -CHDCs-; and members of the public). The interviews with members of the public included two smokers, three ex-smokers and six non-smokers who lived with a smoker. Table 1 provides a list of the participants in the study. All interviews were conducted by the same researcher, digitally recorded and transcribed verbatim. The interview length ranged from 30 minutes to 2 hours. Staff interviewees were identified in collaboration with the Smokefree project manager and/or the host organisations. The invitation to participate in the study was sent to those centres/services which had received the Smokefree training on how to talk about smokefree environments with their service users. Children's Centres, midwives and health visitor managers also informed their staff about the opportunity to participate in this study and helped to plan the interviews with the staff. Children's Centre staff informed their users about the research facilitating their recruitment in the study. Further, members of the public who signed the Smokefree pledge were informed about the opportunity to participate in this research during a phone survey conducted by Smokefree. Those who agreed were contacted afterwards by the researcher and recruited in the study.

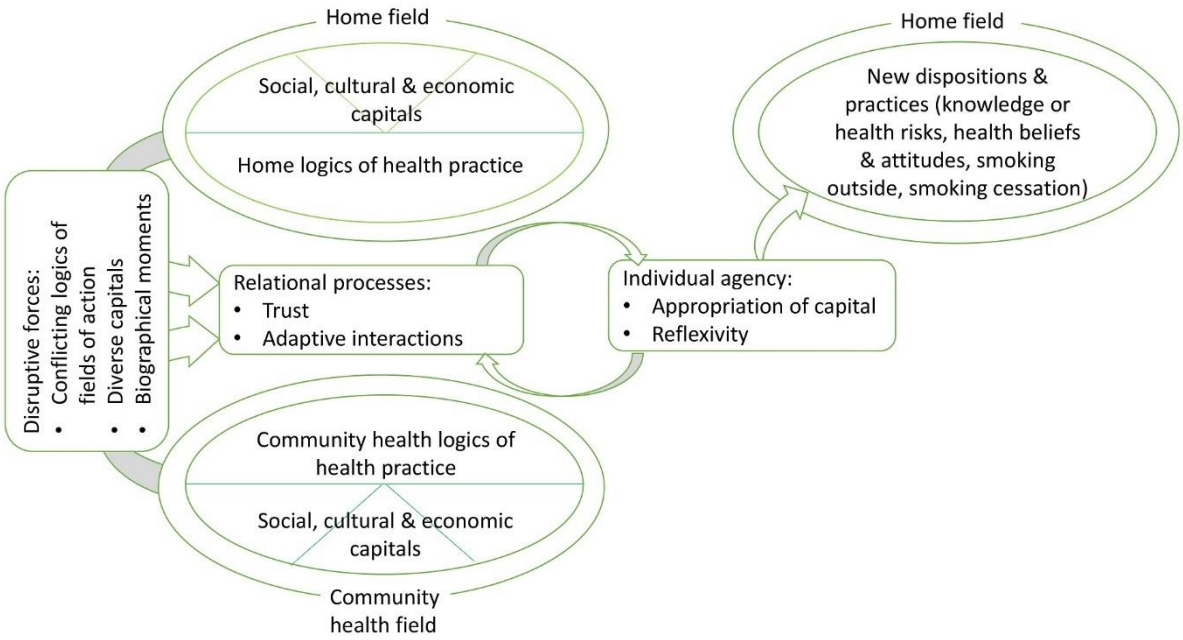
Data were inductively and deductively coded using NVivo software and organised thematically. The authors iteratively reviewed the coding framework and emerging themes at team meetings. The study received approval from the Research Ethics Committee (REC), and the National Health Service (NHS) Research & Development departments of the hospital and community Trusts where the research took place. Pseudonyms are used to protect participant

identities and the programme and research site are anonymised. Interviews took place at Children's Centres, Community libraries or in participants' homes.

Findings

The findings are organised into three sections. We start by briefly describing the social contexts of CHWs and members of the public, in terms of field and habitus, that were prominent features of the background to their interactions relating to the Smokefree programme. We then advance two themes, relating to social capital expressed through trust, connections and adaptive practices (which are central to the relational processes and social encounters) and, finally, show how such interactions may act as sources of disruption and triggers for individual agency and reflexivity, leading to changes to norms, new smokefree dispositions and practices in the context of the home field. Figure 1 provides a visual depiction of the conceptual framework informing the interpretation of the findings. It highlights the sources of disruption to the habitus and the processes facilitating opportunities for reflexivity and change in the Smokefree context.

Figure 1: Midstream social marketing processes promoting agency for new health dispositions, rules and practices



Understanding the context for the emergence of smokefree dispositions, norms and practices: Field and habitus of community health and home

Understanding the context of Smokefree – as a midstream social marketing programme - requires examination of the habitus specific to CHWs acting within the community health field and families in their home field. CHWs are central to the implementation of the Smokefree health programme. Their accounts reflect their beliefs that this type of programme should be core to their job and most sought to incorporate it within their work. Participants espoused a community health logic of practice in which the approach to advancing health and wellbeing in communities is based on principles of empowerment and facilitating informed choice.

Examining the community health habitus of frontline staff (health visitors, CHDCs and Children's Centre staff) indicates that they went beyond 'scripts' and information, to provide

different forms of support that help people to build capacity to incorporate new practices over time and, on occasions, acting on their behalf to expedite access to material resources. Despite the information focus of the community health field's logic, staff's practice was informed by a logic of care that involves empathy, discussion with individuals about their wellbeing priorities and local realities, consolation, encouragement, customised courses of action and offers of support (Mol, 2008).

> "…we do a lot of signposting, […] but I'll still want to try and empower them to do it for themselves, and help those that maybe I can help a bit more. […] I can do extra by doing housing letters, […] to the City Council, to advise them that this family are more needy and need to move sooner, […] I've contacted managers of pest control..." (Margaret, health visitor, centre 10)

The interactional approach specific to the community health logic created opportunities for acting to address barriers to smokefree dispositions and recognising wider structural issues such as limitations of economic and social capital. The support and service provided by CHW facilitated opportunities for members of the public to reflect on their financial situation and use smoking as a small step towards improving their financial situation. For example, they used smokefree to reduce debt and save enough money for a holiday or house redecoration. Such examples indicate the potential transformative effect of these changes on individual structural factors such as economic capital:

> "It was […] trying to talk about how much money that you'd save, how much time and money and how they could spend it in different ways. We linked it more with the work as well, so obviously if they're coming in debt crisis then we could say-, […], 'Debbie, do you smoke? What you could be saving.' [how stepping outside may help reduce the number of cigarettes smoked]" (Estelle, family support officer, centre 4).

"…we talk about things like a holiday or putting that money into a jar and saving it for a new-, actually there was a guy that he'd saved enough money to get his kitchen done." (Connie, childcare learning officer, centre 4)

The habitus of members of the public in those communities, was shaped by structural factors which inhibited aspects of healthy lifestyle.

"…we had a situation where […] the child was on oxygen and they couldn't get any money to put in their prepaid meter for electricity out from the bank, […] the mother was completely distraught and […] you'd think there would be systems in place wouldn't you? [...] There was not, it was awful, we went to social care they couldn't get a crisis loan, […] we're not meant to be a crisis service, but we lent the money to the mother in order to keep her electricity going over the weekend." (Jennie, manager, centres 5 and 8).

With reference to smoking in the home in particular, it was noted that smoking is an embedded practice in their families and communities.

"[some people would say] [smoking] [has] never done me any harm, my father smokes all around me and I used to sit on his knee while he had a [cigarette]... I remember of one of my early childhood memories, catching my dad's cigarette with my arm while I was sat on his knee and it burning me." (George, member of the public, ex-smoker, area 8)

"My mum hardly smokes at all and my dad, he's always got a roll up hanging out of his mouth. I don't think he'd ever quit. No, I don't think anyone-,[told me to quit] but I don't think my mum has ever told me [to quit]..." (Kassia, smoker since 15, administrator, centre 7).

Although smoking is inherent to the habitus of many families in those communities, some of them, especially parents of young children are aware of the connection to health risks. Other, participants suggested that having a cigarette is a normalised way to cope with stress emanating from factors such as lack of money, work, insecurity and poor social relationships. The participant quoted below refers to this stress as key to her lack of 'readiness to change'.

> "I've tried the patches, I've tried the gum, I've tried the sweets, I've tried everything. […] No good. […] I think to be truthful, I think you've got to be in the right frame of mind to do it. [what might help is] less stress…" (Helen, member of the public, smoker, centre 7)

Our participants' accounts evidence the role that capital constraints and home and community fields play in shaping habitus relating to smoking, echoing findings reported in recent literature (Cohn, 2014; Abel and Frohlich, 2012). Barriers to change are not restricted to cultural health capital or smokers' attitude to change at an individual level, which is the assumption of information-based interventions and reflected in CHWs' logic of informed choice. Rather, there is conscious awareness that the difficulties of changing smoking practices are deeply rooted in structural factors that mould their everyday lives.

Processes facilitating change: fostering social capital, relationships, trust and adaptive interactions

The community health field is structured by struggles over forms of capital such as what is health and good support and best forms of delivering care (Collyer et al, 2017). According to Bourdieu (1999), being successful in these struggles depends on appropriation of capital (e.g. cultural, social, economic) and encounters and events that trigger moments of reflexivity. Participants' stories of 'what works' centred upon the interconnected processes of building trust and adapting Smokefree interactions, translating the knowledge to better align with

community members' home and habitus. The findings suggest that the relational approach and social capital of connections and ties worked as a factor supporting alteration of structures such as norms around smoking and practices of smoking (for members of the public) and care (for staff members). Both CHWs and members of the public recounted stories that illustrate the ways in which trust is built up within the relationship through regular contacts to provide various forms of support and access to new sources of social and cultural health capital.

> "Sometimes it can be just isolation, that [service users]'ve just moved into the area, they don't know anyone, and they don't feel comfortable to come out of the house, and […] come to the Centre […]. So, we could go to the home with them and walk with them and then you sort of break that down and then you meet them half way, so they leave the house, and you meet them half way and then you walk down and then again you break that down and then they meet at the Centre on their own." (Kally, family support officer, centre 3)

> "I was stuck at home basically, I'd just had the twins and I was sick of being at home all the time but I'd come here, I was nervous to come out, you know, because I had two babies […] and because I was on my own I couldn't hold both the babies, put my pushchair away and so I ended up not coming again [to the CC]. One of the Sure Start people […] came to my house and they said 'if you come we'll help you […] put the pushchair away and keep an eye on [the babies]', and after that they couldn't get rid of me so I'm here all the time now." (Cornelia, member of the public, centre 14).

The findings indicate that, in the context of community health, to facilitate the emergence of new health practices and dispositions, and support trust and bonding, relationships require time and prolonged contact to build and maintain. The relationships and the position in the

community health field contributed to the development of symbolic capital, leading to trust and recognition and people being more inclined to engage with the community workers.

> "…but it's really from sitting down and talking to people that I hear what kind of issues there are, […] my job is to go in and have a brief intervention with somebody and coordinate other people to act or get involved with them but that's not how it works because, […] I was born here and I've lived in the community all my life. So, my job and my role as a resident are very merged, it's very difficult for me to have [only] a brief intervention with somebody, because it doesn't happen…" (Carla, CHDC, areas 4 & 8)

Social capital is not only inherited through kinship or family affiliations but can also be augmented through long-term 'investment' in building a network of external relationships (Adler and Kwon, 2011). Our participants' experiences suggest that community health teams' efforts to build trusting relationships pave the way for meaningful social interactions relating to smokefree homes and cars and create opportunities to build social capital within communities. In turn, these relationships and social encounters may facilitate access to cultural health capital and individual agency.

> "But, they [the Children's Centre staff] gave me a lot of support and, 'have you tried this, have you tried that?', and […] would help you with this […] 'cause sometimes actually I come here and I'm like 'I've got enough today' and […] I've got the support there, any questions, anything, they're there again, you know, I just find anything…instead of googling it I come to the centre…" (Corrie, member of the public, centre 5)

> "As long as you've got a good support network round you, a bit of encouragement and then you'll get your motivation and you'll think 'Right, I'm going to do this [stop

smoking in the house, try to stop smoking] now'"(Helen, member of the public, smoker, centre 7).

The actions of community staff show how they apply their knowledge of the field and understanding of 'the rules of the game' to promote Smokefree (Bourdieu, 1984, p. 471). Faced with the social needs of the families they needed to support, staff acted with care and 'mindful' of the 'right way' to respond to the habitus of those families (Collyer, Willis and Lewis, 2017). For instance, Children's Centre family support staff and health visitors suggested that it was important to introduce the Smokefree message only when it was 'the right time' and to address contextual factors such as access to healthcare, support for mental health and domestic violence before targeting health behaviour.

> "So whatever advice I give them they will not be able to take it on board and manage it, because themselves, they aren't feeling […] too great themselves. If they need help or support themselves, if it's isolation, then we'll sort of break that down, or if it's referring them to […] a freedom programme maybe, or maybe a domestic violence programme, or maybe if they [need] a counselling programme, or they need to go to the doctor, we'll support them with that, before we will work on behaviour, or the eating, or the sleep time..." (Kally, family support officer, centre 3)

> "And something like registering at the doctors that can be a really quick action and then the family can feel quite good about that because they think 'I've already done that action now' and then you think okay, now let's move onto something a bit more tricky." (Saddie, family support officer, centre 2)

Addressing the structural context of the 'service users' meant adaptive interactions, seeking to gradually adjust health schemas such as rules, norms and schemes of legitimation and meaning to support their service users in their field. The emphasis was on empowering them to make

the change themselves and co-creating solutions which ranged from taking small steps such as cleaning the house and applying for jobs to going to see the smoking cessation advisor. Such actions mediated by the encounters with staff have potential for transformations of some of the structural barriers to healthy lifestyles.

> ”sometimes [families] expect you to be able to come in with a magic wand and change everything and we need to get parents to a point where they’re ready to make change themselves […] so, I might say to a family ‘if you could wake up tomorrow and things would be different how might they look if they were different and you felt like things were really good how might they look’ and they might say to me ‘oh well I’d have a job’. So, then I would say ‘okay so if we look at that and we look at where you are now what are the sort of steps that you think that we could make together with my support to get you to that job” (Saddie, family support officer, centre 2).

As found in other studies (Robinson et al., 2011), the norms and practices which are part of the field of community health are in conflict, at times, with those of the home and people struggled to change that in order to protect children from second hand smoke. Frontline staff were keenly aware of forces that inhibit the emergence of smokefree practices, but their accounts suggested that tensions between the Smokefree message and the home field stimulated reflexivity and creativity in their efforts to implement the programme rather than consolidating a view that they are insurmountable barriers to change.

> ”Sometimes when I’ve been in homes it’s been difficult because you walk in and it’s smoky, it’s a smoke screen and you know that they’re not, although they may not smoke when you’re there. I’ve never had to say to a parent, ‘Whilst I’m here can you not smoke?’ It’s a difficult one, because you’re in their home aren’t you?” (Jillian, childcare learning officer, centre 9)

The staff's accounts also revealed the changing field of community health where changes to job roles, increased workload driven by limited funding and rising numbers of people in need and conflicting job priorities were challenging the habitus and the logic of care of the community staff and as result the availability of and time that CHWs were able to allocate to health promotion, building relationships and collaboration with other services. The structures of the field including organisational and social norms, roles and institutional support might also act as barriers leading to resource loss such as the trust and relationships that were built in those communities as illustrated by Allie, below:

> "It's [their health community role] not appreciated, and it's not recognised. And what they say, health promotion is key and parcel of our work, actually no, it's safeguarding [preventing children from going into social care]…" (Allie, health visitor, centre 12)

The changes to the role of health professionals and community support services seemed to create a misalignment between the habitus of CHWs and the community health field where health promotion routines and practices were challenged by new norms which often created a conflict between what their job required to do, what they thought was needed in the field and the resources to support that work. The institutionalised norms and power-dynamics that emerge in the context of community public services may constrain the staff but also act as a resource to stimulate creativity, reflexivity and agency when confronted with the field of the home of their service users, each with individual needs and particularities. CHWs talked about their practice being influenced by targets, procedures and assessments, but also indicated that interacting with families often required a different logic of practice to provide care and respond to their needs.

Emerging smokefree dispositions, home norms and practices

From a Bourdieusian perspective, exploring how agency emerges in the context of a health programme moves the focus on the sources of disruption to the habitus, the practices of Smokefree participants, their decisions and the resources they draw upon, including those which involve more conscious reflection on their alternatives. Bourdieu's 'logic of practice' indicates that actors locate their practices not only in their own interests, but in their 'own experience of reality (i.e., their practical logic)' (Williams, 1995, p.582). The Smokefree interactions created opportunities for staff and members of the public to change aspects of their own practices or others (i.e. family members), depending on their position within the field, their capital and knowledge of the rules of the field.

The possibility for change may emerge from reflexive analysis caused by sources of disruption to the habitus and field, which enables individuals to identify their dispositions and social structures (Bourdieu & Wacquant, 1992). A biographical event such as becoming a parent was a source of such disruption and seen as a crucial time for change and even emancipation (Accardo, 1999). Social encounters which facilitate opportunities for reflexivity may also act as a source of disruption for change in Bourdieu's work (1999). Encounters with CHWs working with people in their homes may act as a source of disruption to home practices and norms by bringing in a conflicting (health) logic to the one specific to the individual home environment. When combined with the biographical event of becoming a parent and/or having to look after a young child the disruptive effect of such encounters indicated potential for change, acting as a reminder for adopting healthy behaviours and facilitating gradual adaptation of the habitus and even more significant changes such as quitting smoking. Participants talked about challenging families' practices and habits and creating new and better 'models' for their children.

> "If my kids growing up see me do that, then, I mean they're at an impressionable age, or they will be soon, so it's important for them to see me being a good role model. […] and have a healthier lifestyle. So, I think it's important in that sense, […] I try and sign up to things [health campaigns], or at least implement things within my lifestyle." (Sissi, member of the public, her partner smokes, area 15)

> "I am going to stop smoking. And I want to improve my quality of life because I am not able to run after my child because I am getting breathless, I am going to stop smoking. I am not going to give passive disease, lung disease to my child, I am going to stop smoking." (Dennie, member of the public, ex-smoker, area 5)

Participants in Smokefree were made consciously aware of aspects of their habitus through the conversations around second hand smoke and impact on children. Although motivation and aspects of families' practices seem 'unconscious and subliminal' (Custers and Aarts, 2010; Lunnay, Ward and Borlagdan, 2011) the interactions with Smokefree mediated by community services acted as a trigger for reflexivity creating opportunities for people to 'make conscious' such motivations. They facilitated a first step towards changing habits and routines such as starting smoking outside, washing face and arms after smoking and even stopping smoking, as illustrated by the accounts below:

> "[the Smokefree information received through my wife] it's very useful […] That gave me the momentum to stop smoking. So, it was very useful." (Sol, member of the public, Namissa's spouse, ex-smoker, centre 5)

> "…oh, no not second hand, no I didn't realise how bad it was. I knew it was bad, […] but you do not know how bad it is until, […] they showed how much of that smoke affects the child and how much of that nicotine is in the air and that's what really scared me." (Namissa, member of the public, Sol's spouse, centre 5)

> "…it made my husband wash his face and arms, because I've told him about […] and then I think he realised how dangerous…I don't think you realise, until someone tells you […] how dangerous smoke is […] I don't think he realised…when I took some of the leaflets home they were just laying around, […] he must have read it, cause now he washes his hands and face after he smokes… and sometimes he doesn't come that close to the boys either, if there isn't anywhere where he can wash his hands…" (Jemma, member of the public, centre 5)

Members of the public who viewed the relational processes of their interactions with CHWs positively, often developed positive smoke-free attitudes and dispositions, though not all were able to incorporate them fully into new smoking practices in-home and in family vehicles. Members of the public varied considerably in their ability to influence their immediate social network to embed smoke-free practices into their everyday lives. The 'home field' as a private space comes with its inherent logics, rules and routines (Angus et al., 2005) which influence the social dynamics. Here, even if one member of the family was advocating for a smokefree environment, they had to work with the rules and routines of other members of the family who did not share the same concern regarding second hand smoke. This sometimes meant having to challenge ingrained habits and the 'private' space of those who used to smoke inside. The quotes from Kali and George below show that people drew upon their own persuasion tactics (i.e. 'nagging') in combination with the codified knowledge embodied within the physical materials (leaflets, information sheets, mugs) that were provided as part of the social marketing programme to persuade others to keep a smokefree home environment:

> "But […], it is very difficult when you try to explain to family members and they just don't get it. Or they say, 'yeah, okay, fine we'll stop', but they don't, and you know it is quite difficult. […] but you need to actually do something about it and that is where

> the nagging comes in, that's my role at the moment. Nag and nag and get him [the partner] to stop." (Kali, member of the public, non-smoker, her partner smokes, centre 5)
>
> "[The Smokefree conversation] made me take that [the Smokefree] pack to her [my partner] and show it to her and made it, brought it up in her mind and made the issue more ... not just me nagging at her, it made it more in black and white, like official and 'the NHS says in the pack'." (George, member of the public, area 8)

These accounts illustrate ways in which members of the public deploy their cultural and social capital when trying to persuade their family members to stop smoking in the house. It also shows that social capital exhibited through trust in and connections with the community service staff acted as a channel that stimulated reflexivity and enabled people to challenge ingrained habits and norms around smoking. George's and Kalli's micro-negotiations to convince other members of the family and visitors to stop smoking around their children and Kassia's refusal to smoke in the home despite being a long-time smoker and growing up in a smoking environment illustrate attempts to break 'the circle of reproduction' (Crossley, 2003) where smoking was part of people's routines and family time.

> "No, I'm not going to smoke in the house,' because it's shocking to think. You can't see it, that's the main thing, you can't see the smoke. […] I smoke, and I wish I didn't, but that's me, that's my choice, not my children, so I shouldn't inflict it on them and I realise that from the [Smokefree] training." (Kassia, administrator, smoker since 15, centre 7).

Adjusting one aspect of their habit and stepping out to smoke was also a manifestation of individual agency and a first step towards reducing the number of cigarettes smoked per day. These small changes are illustrative of the actions that 'ordinary people' take to change their current circumstances and transform their lives (Bourdieu et al., 1999).

"But you can do the small steps, like stop smoking in the house or stop smoking around children, even in the park, you can stop smoking around the children's area. […] Those kinds of steps are the first steps which gradually will lead to you stopping smoking." (Sol, member of the public, Namissa's spouse, ex-smoker, centre 5).

There were similarly accounts from participants who were unable to fully exert their influence on others in the household. Inadequate social support is one of the main barriers to smoking cessation (Amey, 2011; Jones et al., 2011; Stewart et al., 2010). The capital associated with belonging to a cultural group and family may influence misalignments of the habitus with healthy lifestyles (e.g. different perception of what is 'healthy food' or how harmful cigarette smoke may be for non-smokers). Cornelia, cited below, changed her smoking routine to 'step out' when lighting up following interactions relating to Smokefree. But her attempts to quit smoking and implement new smokefree practices in the household were hindered by her partner who continued to smoke in the bedroom only:

"I'd need my partner to do it at the same [time], because […] if I quit and he's still smoking that would drive me insane […] He keeps moaning at me because I've got sleep apnoea so I'm on this air like mask thing at night so smoking in the bedroom gets into it […] so that can't' be good for me and he's always moaning about my health but then 'you need to quit, you need to quit', no, we need to quit then…" (Cornelia, member of the public, centre 14)

However, even if Cornelia's efforts were limited by her partner's smoking in their bedroom she persists in preventing visitors from smoking to limit children's exposure to second hand smoke. Through these interactions, her actions show potential for normalising the smokefree behaviour outside their own home field.

"I just say 'can you smoke outside?' […] even though G. [her partner] doesn't [he smokes in the bedroom only], 'we smoke outside, no smoking in the house' because if

> we have a visitor the kids are normally there so where are they going to go? in my bedroom?, I'm not having them smoking near the kids." (Cornelia, member of the public, centre 14).

Limited potential to deploy social capital was also evident amongst young parents living with their extended family, for whom issues of control and power challenged the principle of making choices for themselves. The findings point towards the hysteresis effect on social capital which may be observed in how the habitus of different generations within the same family has been developed at different points in time (Hardy, 2008). Shauna highlights her observation that there are contrasting views on 'expected' and 'reasonable' practices to protect children's health and young people often struggle to translate their own attitudes into household practices.

> "We still have families that are living in quite extended households that have a lot of influence over their parenting and the way they do things. So, you find that changing behaviour and helping them to make the right changes for their children can be difficult, because they've got the professional telling them, giving them the rationale, and often people say, 'I know you're right, that's why I like to come to you 'cause I like to know you're giving me the right advice and what I should do and everything, but I've got somebody else telling me something', […]" (Shauna, health visitor, centre 11)

Overall, despite these structural barriers, it appears that the relational approach taken by CHWs to implement Smokefree facilitated opportunities for incremental health change. Some participants talked about using CHWs' position and the Smokefree information to support smokefree rules in the home and nudge partners to try stopping.

> "I think it [Smokefree] does work […] because you can reel them in and say 'oh look it's a freebie, oh I'll just check the leaflet'. And if that leaflet is lying around, […] I shoved it underneath my partner's nose and said 'here, read this'. And even before, […] at the library there was a guy there who supported people to stop smoking and I got his details and I shoved that underneath my partner's nose, 'here, read that'. But, I think it is good because you've got what you wanted, they've taken the leaflet and all it takes is for one person in the house to read it and go that's all I needed and then do something about it." (Kali, member of the public, non-smoker, her partner smokes, centre 5)

Here, individuals' experience of Smokefree seems to translate thoughts and actions into 'durable dispositions' that will guide future smoking related behaviour and have the potential to change the home field (Bourdieu, 1993, p. 86). Where CHWs are able to interact with only one member of the family, the potential for change relies on the capacity of that person to influence others in the family. Preventative health changes such as adopting smokefree dispositions, norms and practices in the home are influenced by complex social contexts, the habitus of all family members, the hierarchal relationships within the home field and the rules and logics governing this field. Where a family succeeds in making small changes to keep their home smoke-free, this may have a transformative effect on that individual family and others with whom that family interacts as changing norms has the potential to lead to denormalising smoking indoors and changes of the home field more widely over time.

Discussion and conclusions

A central issue in health behaviour change programmes is accounting for context. This paper shows how sociology theory, in particular Bourdieusian concepts, provide a valuable

framework for understanding the interplay between structures and agency and how change emerges through processes mediated by collaboration of multiple actors in a midstream social marketing programme. The study highlighted that understanding the interactions between the members of the public's habitus, the home and community health fields and the role of social relationships is key to creating opportunities for agency and incremental health behaviour change. Understanding the habitus of members of the public revealed cases where people's constant struggles with their environment affected by poverty, inadequate housing, isolation and violence, consumed their psychosocial resources such as emotional energy and strength (Singh-Manoux and Marmot, 2005) and seemed to limit their capabilities to translate health messages into their lives. It is important to recognise that such 'negative capital' (Dyson et al., 2011) is not a sign of faults which can be easily fixed by providing information and motivational techniques. The above material conditions seemed to act upon individuals as structural barriers, limiting the transformative effect of cultural schemas (i.e. knowledge about second hand smoke) to stimulate smokefree practices. Despite these structural barriers, this study shows that individual agency - facilitated by access to cultural health capital, reflexivity processes emanating from biographical events such as becoming a parent, regular encounters with community staff supporting social capital and customised care, and changes to the community health field - emerged to challenge normative patterns both in the home and the community health fields, changing practice, dispositions and behaviour.

As with previous research (Hovell et al., 2000; Tyc, Hovell and Winickoff, 2008) this study suggests that programmes to reduce children's levels of second-hand exposure may benefit from engaging with health professionals and community services. The community staff that implemented the Smokefree programme were able to see individuals as embedded in their everyday experiences and work around potential structural barriers to behaviour change. For

staff of these services each individual was different, their world conveying multiple challenges to the image of 'idealised rational healthy subjects' (Crawshaw, 2012, p. 206). These findings indicate that a midstream social marketing approach centred on collaboration and interaction with community services takes a step further to challenge the criticism that social marketing aims 'to govern at a distance' individuals without taking into account the wider determinants of health (Crawshaw, 2012). It shows that collaborative processes mediated by community services staff had potential to generate small disruptions to the home field leading to reflexivity and changes to dispositions, norms and practices. The ability of community services staff to negotiate conflicts between a logic of choice underlying the practice of health promotion and a logic of care emerging from the interactions with communities was key to providing support and building readiness for change.

In common with existing research (Henwood, Harris and Spoel, 2011; Ritchie et al., 2009; Mol, 2008), this study found that frontline community staff challenged new policies, restructuring their work through practices that defend a 'care' focused model of health and consider social factors. Faced with home fields marked by difficult circumstances (e.g. families who were at risk of losing their house, lack of resources to heat their home; distressed mothers no longer able to cope etc.) the staff acted creatively, sometimes beyond their role, to support them. They drew upon diverse forms of capital, showing empathy and emotional support, stepping outside rules and procedures to do that 'little extra' for their service users, to create a space for trust and encouragement. The study suggests such practices can be understood in terms of the community service habitus interacting with the changing field of community health. The habitus of staff enabled change since certain support staff such as health visitors and family support workers were more likely to adopt a comprehensive approach that suited the members of the public by acting as support resources for their service users. This approach may also counter the concern that traditional social

marketing programmes are centred on information and persuasion techniques only (Crawshaw and Newlove, 2011; Crawshaw, 2012; Langford and Panter-Brick, 2013) and the expectation that people will skilfully transfer that information in their life. Although it may be argued that information and persuasion are represented in Smokefree, through the leaflet and the 'conversation about smoking', the programme makes a step forward in engaging local service staff to provide support, customise and adapt the message to their own context. However, it is important to note that as shown previously (McDonald, 2009; Spotswood and Tapp, 2013) the habitus also constrained action of staff when organisational resources (i.e. management and role support, policies) to facilitate staff engagement with health promotion activities were lacking. As smoking rates are higher in disadvantaged communities (Hargreaves et al., 2010) programmes targeting smokers should adopt a broader ecological approach including policies that support community workers to address social inequalities.

This study reinforces the calls to consider the role of context as illustrated by the habitus and embeddedness of individuals in social networks when developing social change programmes (Hargreaves et al., 2010; MacAskill et al., 2002). Supporting previous research (Borganovi, 2010; Poortinga, 2006; Wakefield and Poland, 2006) the study emphasised the importance of understanding the role of social capital as a way of accessing and transforming other resources to facilitate change. Recent work highlights that social capital may have negative health effects since behavioural contagion may lead to both good and bad behaviour spread in a social network and neighbourhood cohesion can have different influences on individual behaviour depending on individual characteristics (Villalonga-Olivesa and Kawachi, 2017). As previous research suggests (Hays, 1994; Spotswood and Tapp, 2013; Vassilev et al., 2011) belonging to an affective network or community means cultural and social norms that sometimes can inhibit the development of new health practices. Mapping social networks and

identifying when social relationships act as resources for behaviour change through mutual support and word-of-mouth and when as barriers is key in facilitating culturally sensitive health programmes.

The findings suggest that the relational approach and social capital worked as a factor supporting alteration of structures and individual conditions (e.g. improved knowledge of second-hand smoke; provided support for mental health; addressed other contextual factors such as access to healthcare; framed changes of smoking habits as a form of addressing financial insecurity) and the development of new dispositions and rules towards smokefree practices. The Smokefree collaborative model mobilised resources through interactions with support staff in the community to provide different 'cultural schemas' for individuals to make sense of their smoking practices within the broader health discourse. By enabling encounters with Smokefree through professionals that were part of a network of support, the social marketing initiative has facilitated users' access to resources they could then use to build cultural health capital and legitimise their actions to challenge norms in their own 'home field' and change smoking practices.

This research has contributed to the body of work investigating Bourdieu and change in the context of a social marketing programme. Bourdieu's work provides limited discussion of the conditions and the processes that make actors to 'act rationally, be reflective' and adapt their habitus to the changing field (Yang, 2014). Similar to previous studies (Behague et al., 2008; Crossley, 2003) the findings highlight that the lack of harmony between the home habitus and the health field as well as biographical events may lead to reflexivity, transformation of resources to adjust the habitus to the new field and change (e.g. of smoking rules, beliefs, dispositions, practices, habits etc.). Bourdieu's concepts help to provide a contextual account

of how actors practise agency within the constraints of their environment. This research supports the view of other authors who build upon Bourdieu's work to develop a theory of social change (Calhoun, 1993; Crossley, 2003; Hays, 1994) and adds that agency and change occur not only through appropriation and transformation of capital, but also through encounters and events that stimulate reflexivity and may lead to gradual modification of new norms, dispositions and practices generated by the interplay between habitus and fields. We argue that agency may have a transformative effect on individual circumstances and manifests through small, gradual changes of home rules, decisions to change habits and simply do things differently. The actions to keep homes smoke-free, the 'nagging' of family members to stop smoking around children, the willingness to accept staff support to quit smoking, are examples of the struggles of 'ordinary people' to make a change in their life (Bourdieu et al., 1999). Small changes such as stopping smoking in the home may lead to reducing tobacco intake and act as a reflexive trigger for reconsidering smoking and quitting as illustrated by some of our participants' accounts. Norms on 'healthy behaviour' are one important factor influencing behaviour (Singh-Manoux and Marmot, 2005). This change in the smoking norms and practice may contribute to structural change in the home, by 'denormalising' tobacco use indoors and changing the norm that is acceptable to smoke around children for a healthier home environment. This paper provides a deeper understanding of the social processes and wider social relationships that influence individuals' perception, views and action regarding healthy behaviour and environments. It shows how collaboration with community services to develop and implement a health programme may activate the transformative power of cultural and social capital manifested through trust and relationships to support incremental preventative health change. The sociological framework employed in this study can be useful to social marketers seeking to understand the context of behaviour and the mechanisms for supporting change. Investigating

the application of Bourdieusian concepts to the development of health behaviour change programmes remains a worthy goal for future research.

Table 1: Participants in the study

Participant name (pseudonym)	Children Centre (CC)/community area
Vicky (CC manager) Bessie (CC administrator/receptionist)	CC1
Saddie (CC family support officer) Sallie (CC teacher)	CC2
Lizzie (CC manager) Kally (CC family support officer)	CC3
Collie (CC manager) Cassie (CC administrator/receptionist, smoker) Connie (CC childcare learning officer) Estelle (CC family support officer) Katt (CC senior family support officer)	CC4
Jennie (CC manager) Angie (CC administrator/receptionist)	CC5 & CC8 CC8
Dora (play leader) Sol (Member of the public (Namissa's spouse, ex-smoker) Namissa (Member of the public, Sol's spouse, non-smoker) Kalli (Member of the public, non-smoker, her partner smokes) Jemma (Member of the public, non-smoker, her partner smokes) Jackie (Member of the public, non-smoker, her partner smokes) Corrie (Member of the public, non-smoker, her partner smokes)	CC5
Dennie (Member of the public, ex-smoker)	Area 5
Mika (CC manager) Pam (CC administrator/receptionist) Missy (community health development coordinator)	CC6
Serena (CC manager) Kassia (CC administrator/receptionist, smoker) Helen (member of the public, smoker)	CC7
George (member of the public, ex-smoker, his ex-partner smokes)	Area 8
Monica (CC manager) Jillian (CC childcare learning officer)	CC9
Kathreen (manager Smokefree) Loraine (manager STOP)	STOP
Mellissa (Clinical team leader for health visiting and school nursing) Margaret (health visitor)	CC10 & C11
Lona (Health visitor team manager)	CC4, CC6 & CC8
Carla (community health development coordinator) Sandrine (health visitor) Pauline (health visitor)	CC4 & CC8
Shauna (health visitor)	CC11
Allie (health visitor)	CC12
Phoebe (community midwife) Cloe (maternity support worker) Clara (manager midwives team)	Area 13
Cornelia (member of the public, smoker)	CC14
Sissi (member of the public, non-smoker - her partner smokes)	Area 15

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