EXPLORING ENGAGEMENT AND VALUE CREATION IN HEALTH SOCIAL MARKETING. A SERVICE PERSPECTIVE

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'What is essential is invisible to the eye' (Antoine de Saint-Exupéry, 1944)

Abstract

Complex social problems (the continued rise in chronic disease; resource depletion, environmental protection, inequality etc.) and the evolution of the social marketing field has brought the acknowledgment that focusing only on the individual is often not enough and that social change programmes require collaborations with multiple actors (government, public and private sector). A call has been made for a shift towards 'midstream and upstream' action and collaborative approaches in social marketing in order to address external factors that influence behaviour (Hastings 2007; Hoek and Jones, 2011; Wymer 2011). However, this shift requires the social marketing field to explore new concepts to complement its theoretical foundations which privilege a downstream/individual focus. Social marketing is grounded in the traditional goods-dominant model of marketing (Domegan et al., 2013, Peattie, Peattie and Thomas, 2012; Vargo and Lusch, 2008a). Comparison of the theoretical roots and key concepts of goods-dominant and service-dominant models of marketing highlights the limitations of traditional social marketing's fundamental principles in supporting a collaborative systems approach (Domegan et al., 2013; Vargo and Lusch, 2008a). Service-dominant logic (SDL) (Vargo and Lusch, 2008a) has marked a shift in marketing thinking from a transactional model to an interactional open process where value is created with customer involvement and other network actors. SDL theoretical developments suggest a better compatibility with the collaborative, multi-stakeholder approaches required by midstream and upstream social change (Russell-Bennett, Wood and Previte, 2013).

This thesis interrogates the applicability of SDL concepts to social marketing. The study examines the process of value creation (facilitation, co-creation and resource integration) and actor engagement as central principles of SDL. Given the wide application of social marketing in health (Andreasen, 2012), and the call to refine approaches for improvement of public health programmes aiming for sustainable change and overall well-being, this study focuses on examining the implications of service oriented social marketing in a health context. Citizen participation in co-production of solutions and services in health is advocated as essential in the process of empowering individuals and democratising the process of change (Guta et al., 2014). Yet, there is still little empirical attention to the realities of different forms of participation and co-production in health (Butterfoss, 2006; Fotaki, 2011; McDonald, Rogers and Macdonald, 2008) and social

marketing contexts (Dibb and Carrigan, 2013; Whitelaw et al., 2010). The study also examines the factors influencing engagement, actor motivation and perceived value, contributing to the scarce empirical research available on network actor engagement in value creation in a health social marketing context (Domegan et al., 2013). The study adopts a case study approach and draws upon interviews, observation and document analysis to examine a Smokefree homes and cars programme ('Smokefree') in a city in England.

Key findings of this research indicate that adopting a service orientation facilitates contextualising social marketing programmes, building capacity at the community level and adopting a long-term approach which suits better the realities of individuals. The interaction approach emphasised by Smokefree enabled co-creation spaces for members of the public and staff's resource integration processes. The findings of this research suggest that a collaborative interaction based approach can challenge the criticism that social marketing aims 'to govern at a distance' rational individuals without taking into account the wider determinants of health (Crawshaw, 2012; Wymer, 2011). However, it also reflects that understanding and addressing contextual factors means considering the fluidity of individuals' goals and the subjective dimension of value which might challenge pre-set programme objectives. The myriad of actors involved in the Smokefree programme, the relationships and complexity of the networks around the 'customer' suggest the relevance of a collaborative model of value creation in social marketing. Most importantly, this study indicates that a collaborative approach to value creation poses challenges in addition to the benefits. The study suggests that networks, roles, practices and institutions may both, facilitate and constrain actor engagement with a health social marketing programme. The thesis contributes to the three literature streams (social marketing, SDL and public health) that informed its development. This study is one of the few (Domegan et al., 2013; Lefebvre, 2012; Russell-Bennett, Wood and Previte, 2013) to contribute to the efforts to examine the implications of a service perspective for extending social marketing theory to accommodate midstream and upstream action. One of the main contributions of this study is illustrated by the articulation of service dominant benchmarks for social change programmes. The study also has important implications for health policy and practice. A key implication is that building collaborations with community services is essential to understanding individuals in context, customising offerings and supporting skill development.

Publication Declaration

The following is a list of my publications arising from the research carried out for this PhD.

Journal articles

- **Luca, N. R**., Hibbert, S. & McDonald R. (in press) Towards a service-dominant approach to social marketing, *Marketing Theory*
- **Luca, N. R**., Hibbert, S. & McDonald R. (under review) Moving midstream? Unfolding collaborative value creation in social marketing

Conference Papers

- **Luca, N. R**., Hibbert, S. & McDonald R. (2014) "A collaborative approach to value creation in social marketing", *European Social Marketing Conference, 25-26 September, Rotterdam, Netherlands.*
- **Luca, N. R**., Hibbert, S. & McDonald R. (2014) "From information to interaction. A collaborative approach to health improvement programmes", *ISA XVIII World Sociology Congress, 13-19 July, Yokohama, Japan.*
- **Luca, N. R**., Hibbert, S. & McDonald R. (2014) "Applying SDL to social change", *AMA Marketing and Public Policy Conference, 5-7 June, Boston, US.*
- **Luca, N. R**., Hibbert, S. & McDonald R. (2013) "Towards a co-creation perspective in social marketing", *World Social Marketing Conference, 21-23 April, Toronto, Canada.*
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Chapter 1: Introduction

1. 1 Introduction

Social marketing as a consumer centred behaviour and social change approach owes its origins to commercial marketing. Social marketing has been applied to a wide range of problems such as environmental protection (Shrum, Lowrey, and McCarty, 1994; McKenzie-Mohr, 2000), road safety (Rothschild, Mastin and Miller, 2006), fire prevention (Peattie, Peattie and Thomas, 2012), domestic violence (Donovan and Vlais, 2005) and a plethora of health problems (Andreasen, 2002; Price, 2001). Research indicates that social marketing can form an effective framework for behaviour change interventions (Carins and Rundle-Thiele, 2013; Stead et al., 2007; Truong, 2014) but reveals confusion and a certain resistance of practitioners regarding the social marketing definitions, concepts and process (NSCM, 2009).

Social marketing theory was grounded in the exchange paradigm, classical transactional marketing theory with little progress on creating its own theory and concepts (Peattie and Peattie, 2003; Peattie, Peattie and Thomas, 2012; Sheth and Parvatiyar, 2002). Benchmarks have been proposed to define core principles of social marketing and distinguish it from other approaches to social and behaviour change (Andreasen, 2002; French and Blair-Stevens, 2007; Peattie and Peattie, 2003). The benchmarks emphasise the reliance of social marketing on exchange and transactional marketing theory and the focus on downstream - individual behaviour change (Peattie and Peattie, 2003; Sheth and Parvatiyar, 2002; Domegan et al., 2013). Despite social marketing's wide application and reasonable record of success (Stead et al., 2007) the debates over its definition and area of application have slowed down the transition from a domain to a discipline (Andreasen, 2002; Sheth and Parvatiyar, 2002). Criticisms have been raised about the relevance and appropriateness of social marketing as a commercially-rooted model that applies marketing concepts to influence behaviour and social change (Andreasen, 2002; Buchanan et al., 1994; Crawshaw, 2012; Hastings and Haywood, 1991; Luck, 1969; Peattie and Peattie, 2003; Peattie, Peattie and Thomas, 2012).

Prominent social marketing criticisms are centred on a number of key areas. Firstly, social marketing has long been criticised for its downstream orientation, focusing heavily on individual behaviour (Brennan and Binney, 2008; Wallack, 2002; Wymer, 2011) neglecting the external factors that shape behavioural contexts (Crawshaw, 2012; 2013; Gordon, 2013; Robinson and Robertson, 2010a). Secondly, solutions were developed around dyadic transactions and exchange rather than relationships and longer term interactions with multiple network actors (Brennan and Binney, 2008; Cherier and Gurrieri, 2014; Hastings, 2003). Thirdly, the traditional, goods-dominant roots of social marketing have stimulated a managerialist mentality in which practitioners developed social marketing campaigns targeted at audiences as passive recipients (Brenkert, 2002; Crawshaw, 2012). This orientation meant fewer opportunities for stakeholder engagement to develop locally and personally relevant solutions (Domegan et al., 2013). Fourthly, the focus on the psychology of behaviour change has led to the neglect of implementation challenges at the organisational level (Grier and Bryant, 2005) and the inter-organisational issues that arise when partnership approaches are required (Dibb, 2014; Osborne, Radnor and Nasi, 2013).

Scholars in the field emphasise that social marketing has reached a mature capacity that allows the discipline to increase its actions midstream and upstream[1] to address external factors that influence behaviour (Andreasen, 2011; Beall et al., 2012; Gordon, Carrigan and Hastings, 2011; Wymer, 2011). Social marketing literature provides two perspectives on directions for social marketing future development. One that emphasises the multidisciplinary dimension of social marketing as essential for the field (Bhattacharya and Elsbach, 2002; Carvalho and Mazzon, 2013; Gregson et al., 2001; McKenzie-Mohr, 2000; Spotswood and Tapp, 2013; Wiener, 1993) and one that claims social marketing should look at new marketing concepts to evolve and address midstream and upstream issues (Desai, 2009; Domegan et al., 2013; Hastings, 2003; Russell-Bennett, Wood and Previte 2013). The applicability of all commercial marketing concepts to social marketing has been challenged and scholars argue that the field needs

[1] Upstream defines initiatives at the policy and legislation level whereas midstream defines initiatives at the community (meso) level. Some authors (e.g. Dibb, 2014) note that midstream interventions focus on inter-personal factors and social norms. However, the literature often uses the term upstream to refer to initiatives that address contextual factors of behaviour which may involve collaborations at the community (meso) level. In this study the term midstream is used to refer to the community level, including community services, family and groups.

to outgrow its condition (Glenane-Antoniadis et al., 2003), learn from other marketing sub-disciplines (Gordon, 2012) such as relationship marketing (Hastings, 2003; Wood, 2008) and service marketing (Desai, 2009; Dann et al., 2007; Domegan et al., 2013; Gordon, 2012; Russell-Bennett et al., 2009; Russell-Bennett, Wood and Previte, 2013) and adopt its specific language and theories (Donovan, 2011; Hastings, 2006; Peattie and Peattie, 2003).

This thesis concentrates on the call launched by recent scholarship (Blair-Stevens, 2011; Desai 2009; Fourali, 2009; Gordon, 2013; Hastings and Domegan, 2013; Wood, 2008; Russell-Bennett, Wood and Previte, 2013; Vargo and Lusch, 2008a) arguing that social marketing needs to consider the changes in commercial marketing inspired by the shift towards relationships, networks, value creation and a service-dominant logic (Dibb, 2014; Dibb and Carrigan, 2013; Vargo and Lusch, 2004). Such research is highly needed in response to the growing acknowledgement of complex social issues - such as public health crisis, increasing pollution and climate change, poverty and inequality to name a few – which require ecological approaches in the context of a globalised and interconnected world (Andreasen, 2012; Brennan and Binney, 2008; Cherrier and Gurrieri, 2014; Dibb, 2014; Gordon, 2013; Hastings and Domegan, 2013; Lefebvre, 2011; 2012; Shultz, 2007; Wymer, 2010). As Gordon and Gurierri (2014) stress, approaches which facilitate understanding of the networks, roles and power relationships of the actors are needed within the efforts to address ethical concerns in social marketing programmes (Brenkert, 2002) such as lack of citizen engagement (Domegan et al., 2013; Lefebvre, 2011) and creation of stigma and exclusion of groups and individuals (Gurrieri, Previte and Brace-Govan, 2013).

Service-dominant logic (SDL)[2] (Vargo and Lusch, 2004; 2006; 2008a; 2008b; 2014) is now embedded within marketing theory (Gummesson, Lusch and Vargo, 2010; Gummerus, 2013; Heinonen et al., 2010; Hibbert, Winklhofer and Temerak, 2012). This perspective has marked a shift in marketing thinking from a transactional model to an

[2] Grönroos (2008; 2011a; 2012) draws on the Nordic School of Service Marketing work to suggest the term 'service logic' as 'a perspective on business and marketing that is not only dominated by but also based on service' (Grönroos, 2012, p. 1520). Vargo and Lusch (2004) coined the term 'service-dominant logic' (SDL) which is used as a perspective on value creation, as both a 'logic of consumption' and 'logic of service provision' (Grönroos, 2008, p. 299). In this thesis the term service-dominant logic is used as a service perspective on value creation.

interactional open process where value is created with customer involvement and other network actors (McColl-Kennedy et al., 2012; Payne, Storbacka and Frow, 2008). This perspective is increasingly accepted to be applicable beyond commercial contexts (Osborne, 2010; Osborne, Radnor and Nasi, 2013). Value creation is conceptualised as a collaborative and systems oriented process where all participating actors have a role to play (Vargo and Lusch, 2008a; Ballantyne et al., 2011; Gummesson, 2008). The process and collaborative orientation of the service-dominant perspective promises new insights to address long standing issues in social marketing such as dyadic transactions, the downstream focus and collaborations of multiple parties. In addition, social marketing programmes often include services and support (Russell-Bennett, Wood and Previte, 2013; Tapp and Spotswood, 2013) which requires a different mindset than the traditional marketing management model.

Drawing on a different range of theories and marketing streams SDL marks a change from the economic and psychology models that have influenced marketing (and social marketing) for decades. SDL builds upon scholarship on service management (including work on services marketing, human resource management, operations and systems management), relationships (that shifted attention from dyadic relationships to multi-party networks) and the connectivity that emerged from developments in the on-line infrastructure (Gummesson, Lusch and Vargo 2010; Peñaloza and Venkatesh, 2006). Therefore, in contrast to the social marketing model derived only from marketing management, the multi-disciplinary groundings of SDL have potential to explain value creation processes from various stakeholder perspectives and the service management and collaboration issues across networks.

Learning from SDL provides an opportunity to review the theoretical foundations of social marketing and its framework for behaviour and social change (Desai, 2009; Gordon, 2011; Hastings, 2003; Peattie and Peattie, 2003). As such, a shift towards a service approach requires also a revision of the theories and models used to inform social change programmes. However, commercial sector concepts and models cannot be directly transferred to a social marketing context, rather they need to be carefully evaluated and adapted (Andreasen, 2003; Domegan et al., 2013). A systematic analysis is required to examine how SDL can contribute to social marketing, and the implications for its theoretical foundations and the framework for behaviour and social change (Desai,

2009; Dibb, 2014; Gordon, 2011; Hastings, 2003; Peattie and Peattie, 2003). Examining the relevance of SDL for social marketing requires going back to the principles and theories underpinning this perspective to interrogate their applicability to social marketing contexts.

Given the wide application of social marketing in health (Andreasen, 2012; Glenane-Antoniadis et al., 2003), and the call to refine public health approaches aiming for sustainable change and overall well-being, this study focuses on examining the implications of service oriented social marketing in a preventative health context. Public health is experiencing a shift towards a participation approach driven by community models, principles of empowerment, capacity building and co-production (Farrell, 2010; Hunter et al., 2007; Needham, 2008; WHO, 1986) challenging the logic on which social marketing has been traditionally operating. Other authors (French, 2009a, p. 260) emphasise the need for public health to adopt a customer centric logic where the aim is to listen and serve rather than 'dictate to the public'.

Social marketing criticisms combined with the changes in public health and marketing, support the call for updating the social marketing framework and learning from new developments in marketing. This research aims to interrogate the applicability of service-dominant logic concepts to social marketing. In doing so, it explores central principles of SDL - network actor[3] engagement and value creation - in a social marketing context. The study aims to explore the potential of SDL in supporting an updated framework for social marketing that moves away from the transactional, goods based model towards a service based model. The thesis adopts a case study approach. A Smokefree homes and cars programme ('Smokefree')[4] in a city in England is selected as an illustrative case for a social marketing programme that moves beyond the traditional marketing management model to a collaborative model of value creation. The chosen context illustrates a service approach in developing a health social marketing programme which makes Smokefree a useful case for investigating value creation and actor engagement.

[3] In this study actor refers to members of the public as service users and volunteers and staff from the services involved in the Smokefree programme

[4] In this study, the social marketing smokefree homes and cars programme under analysis is identified as 'Smokefree'. The real name of the programme is not disclosed in order to comply with confidentiality and anonymity requirements.

The following section (1. 2) sets the context of this research, describing the aims and research questions of the study. Section 1. 3 is dedicated to the methodology whilst section 1. 4 provides an overview of the structure of the thesis.

1. 2 Research aims and questions

1. 2. 1 Research aims

This thesis is centred on a key social marketing research priority, to explore the relevance of contemporary marketing theory for updating social marketing theory and framework. The thesis addresses recent calls for a shift to service thinking (Lefebvre, 2012; Russell-Bennett, Wood and Previte, 2013; Vargo and Lusch, 2008a), relationships (Hastings, 2003; Peattie and Peattie, 2003) and value creation application in social marketing (Domegan et al., 2013; Russell-Bennett, Previte and Zainuddin, 2009; Zainuddin, Previte and Russell-Bennett, 2011). The overall aim of this research is to examine the potential contribution of a service perspective to social marketing theory and practice. The study aims to examine how SDL is reflected in the context of a social marketing programme. Particularly, the thesis adopts a qualitative approach to explore a collaborative health social marketing programme in order to examine if and how a service dominant perspective can help better explain the process of value creation in a social marketing context.

As social marketing benchmarks (Andreasen, 2002) emphasise the reliance of social marketing on the exchange and transactional model of marketing, integrating learning from service-dominant logic requires re-examining and identifying new ways to apply them in practice. The study reviews the social marketing benchmarks and suggests other key concepts applicable in the management of behaviour and social change.

One aim of this research is to examine the process of value creation in a social marketing context. As a core principle of service-dominant logic, value creation[5] (Vargo and Lusch, 2014) requires further efforts to better understand the processes and roles of different

[5]In this study the term value creation processes refers to value facilitation (by an actor to another actor), resource integration (to integrate operant and operand resources to create value-in-use/in context) and co-creation (a process based on interaction between actors) (Grönroos, 2012).

actors involved (Grönroos, 2012; Gummerus, 2013; Veloutsou et al., 2002). Previous research has concentrated on value outcomes (i.e. perceived value) and less attention has been given to value creation processes (i.e. value facilitation, resource integration and co-creation) (Arnould, 2008; Grönroos, 2012; Gummerus, 2013; Hibbert, Winklhofer and Temerak, 2012).

Despite the amount of literature on value creation, there is still a paucity of data about how customers co-create (McColl-Kennedy et al., 2012; Jaakkola and Hakanen, 2013; Payne, Storbacka and Frow, 2008; Woodruff and Flint, 2006), the roles of network actors during this process (Moeller et al., 2013) and the sub-processes and factors underlying value creation (Grönroos, 2012; Gummerus, 2013). More research is also required to learn about customer and stakeholder resource integration, the role of different types of resources for enhancing value for both the customer and the service provider (Grönroos, 2012) and how customers (Hibbert, Winklhofer and Temerak, 2012) and stakeholders (Frow et al., 2014) can use their operant resources in value creation (Arnould, 2008).

Social marketing research (Dibb and Carrigan, 2013; Gordon, 2013; Zainuddin, Russell-Bennett and Previte, 2013) has dedicated limited attention to collaborative processes of value creation (including facilitation, co-creation and resource integration) and research on the roles of different actors' involvement in facilitating behaviour and social change is emergent. As such, the study focuses on the process of value creation and actor engagement as central principles of SDL that may help to better explain the processes of change and the interplay between context and individual in a behaviour/social change context. Particular attention is dedicated to the challenges of applying SDL principles in a social change context and the necessary adaptations. Examining the barriers and challenges of adopting a collaborative approach provides a critical view on whether and how actor engagement and co-creation practices can contribute to building capacities to address external factors of behaviour change in a health social marketing programme.

Traditionally, social marketing research has focused on applications of behaviour change interventions at the final user level. A shift towards service-informed thinking is considered to facilitate transition from downstream to midstream and upstream-focused action (Russell-Bennett, Wood and Previte, 2013). The importance of partnerships and the engagement of various stakeholders in the social marketing process have been

acknowledged as key to a more holistic and sustainable approach that reflects the need to develop capacity for change (Bryant et al., 2001; Hastings 2003; Andreasen, 2006; Lefebvre, 2011). Yet, in practice less attention has been given to building capacity (Whitelaw et al., 2010) and assessing the existing capacity to support programmes (Faulkner et al., 2009). This study focuses on social marketing application at the community level by investigating the implications of engagement of both, members of the public[6] (as users and volunteers) and collaborating staff (as intermediaries and partners of the organisation initiating the social marketing programme) for building capacity, thus adding to the literature on midstream social marketing.

Although community participation and co-production are increasingly advocated as approaches to developing and implementing health initiatives there is a dearth of research uncovering the realities of actor engagement in tackling behaviour change (Butterfoss, 2006; Davies, Wetherell and Barnett, 2006; Morris et al., 2007). A co-creation approach challenges the traditional expert-based health system giving voice to non-experts and it requires socio-cultural and organisational change (Dunston et al., 2008). Given the challenges of participatory approaches in health contexts and the dearth of research on co-creation and engagement in social marketing, more research is needed to learn how individuals experience engagement in social marketing programmes and if and how social marketing operating on SDL principles can contribute to the creation of capacities to address external factors of behaviour. Few studies focus on the experiences and motivations of individuals that engage and are engaged in these programmes (Baker et al., 2011; Fotaki, 2011).

The study seeks to develop an improved understanding of how a collaborative interactional approach is supported and experienced in a social marketing context. By examining co-creation practices in a health social marketing programme and providing insight from the actors involved, this study adds to the efforts to address the dearth of research on the network actor perspective on engagement and co-creation in public health and marketing. In addition to examining the processes of value creation this research aims to explore actor (member of the public and collaborator) motivation for engaging with a health social marketing programme. Given the variety of actors involved

[6] The term ‘member of the public' is used throughout the thesis as a generic term that includes service users and volunteers in Children’s Centres.

in the social marketing programme under-analysis, examining their motivation provides insight into various contextual factors underlying their engagement.

Another study aim is to examine member of the public (as service user and/or volunteer) and staff (as collaborator and stakeholder) perceived value in a smokefree social marketing programme. Understanding people's experiences with social marketing and their perceived value is necessary to design context sensitive programmes that take into account the socio-cultural factors that influence behaviour. The limited existing value research in social marketing focused on functional and emotional customer value in a social marketing health service (Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previte, 2013; Zainuddin, 2013). This study examines value-in-context seeking to unveil other dimensions of actor value in a social marketing smokefree programme.

Drawing on different streams of literature including social marketing, SDL and public health, this study aims to improve our understanding of network actor engagement (stakeholders as partners and collaborators and members of the public as service users and volunteers) and value creation in a health social marketing context. In doing so, this study proposes to contribute to the efforts to integrate new theory in social marketing in order to improve its framework for behaviour and social change. A better understanding of actor engagement, participants' motivations and perspectives on value in social marketing is important for practitioners in the attempts to build relationships with their publics, facilitate capacity building and develop more sustainable interventions.

1. 2. 2 Research questions

In order to accomplish these aims the study proposes the following research questions:

Overarching research question:

1. What are the theoretical and practical implications of adopting a service-dominant logic lens to value creation and actor engagement in social marketing?

Underlying research questions:

1. What factors influence actor (stakeholder and service user) engagement in a health social marketing context?
2. How do actors integrate resources to facilitate and (co-)create value in a health social marketing context?
3. What motivates network actors (stakeholder and service user) to engage in a health social marketing programme?
4. What value dimensions are present in a health social marketing context?
5. What are the barriers and challenges of a collaborative approach to value creation in a health social marketing context?

1. 3 Methodology

The study adopts an 'inductive top-down' (Shepherd and Sutcliffe, 2011) case study approach to examine actor engagement and value creation in a health social marketing context. An inductive top-down approach approaches the literature as 'data' seeking to identify perspectives, tensions, oppositions and contradictions that will inform the questions of the research (Shepherd and Sutcliffe, 2011). These questions guide data collection and analysis. Although the approach to data analysis is inductive, seeking emerging patterns and themes, the analysis is affected by the literature review, fieldwork experiences, and research questions (Ziebland and McPherson, 2006). The diversity of actors involved in a health social marketing programme and the focus on engagement and value creation require a qualitative approach to facilitate an exploration of stakeholders' experiences of engagement and factors that influence it. A qualitative approach is relevant for this study because it provides a holistic view of engagement and value creation, focusing on participants' experiences while taking into account the importance of the context, interactions, roles and resources as structures that may inhibit or facilitate action (Strauss and Corbin, 1990).

The study adopts a case study approach to examine actor (member of the public as user and/or volunteer and collaborating staff as stakeholder) engagement and value creation in a community health programme setting. A case study is appropriate when the aim is to understand the context, reveal factors and mechanisms for action and explore

participants' meanings and understandings of an issue (Yin, 2003). The aim of the study is to generate a deep understanding of phenomena (i.e. value creation and engagement) (Easton, 2010). The selection of a single case study of a smokefree homes and cars programme is justified by the features of the programme which engages a wide range of collaborators and operates a pledge model. The Smokefree programme is an illustrative example of a smokefree initiative in the approach employed, being selected as an 'instrumental case study' to improve our understanding of engagement and value creation in social marketing (Stake, 2005).

The Smokefree programme engaged a wide range of staff of community based services and invited them to have a conversation about smokefree environments with their users. They were also asked to encourage people to sign a pledge committing to keep their homes and cars smokefree. The number of stakeholders involved and the community approach make smokefree homes programmes complex phenomena that are changing and evolving with the contributions from the participants. The diversity of actors involved in the programme makes it a relevant context to explore the implications of structures on engagement and value creation processes. The research sites are geographically defined in terms of two NHS Trusts boundaries to include the partners of the Smokefree programme.

The study uses interviews, observation and document analysis to generate data related to the case. The study included 47 semi-structured interviews with the main actors involved in the programme (staff from Children's Centres, Community Health Development Coordinators and their volunteers, Children's Hospital nurses, health visitors, midwives and members of the public as their service users and volunteers and STOP Smoking Services as programme organisers) and 43 informal interviews conducted during the observation sessions. Interviews were used to gain insight into participants' experiences and elicit their stories on their engagement with the social marketing programme. The interviews asked the participants to share their narratives regarding their everyday practices and their interactions with Smokefree. In addition, approximately 30 hours of observation were conducted at 5 Children's Centres and at the Children's Hospital. Observation was used to examine how participants communicate and interact with each other and events that informants may be unable to share (Marshall and Rossman, 2011). Observation also provided the opportunity to analyse any discrepancies between the data

obtained within interviews. Document analysis, including reports of formative and process evaluation, communication materials (leaflets, posters, information materials and training DVD) provided by Stop Smoking Services, is used to understand the contextual factors and structures that shape the programme. The data are analysed using a thematic analysis approach (Miles and Huberman, 1994). Data are coded and recoded in a systematic and iterative manner to accommodate emerging themes (Miles and Huberman, 1994; Strauss and Corbin, 1994).

1. 4 Overview of the thesis

The thesis is structured as follows: a first chapter introducing the research; a chapter presenting the literature review, a chapter dedicated to the methodology guiding the research. The empirical findings of the research are reported in three chapters. Each findings chapter includes an analysis and discussion of the findings covering also the challenges and barriers of a collaborative value creation model in social marketing. The final chapter of the thesis discusses the conclusions of the study.

The following chapter reviews the literature relevant to this study. Adopting a multi-disciplinary approach different literature streams are considered. The first section reviews the social marketing literature establishing the gaps and calls for research to further develop the field. The second section is dedicated to the service-dominant logic literature and its potential contribution to social marketing. A third section investigates the public health literature relevant to co-production and actor participation[7]. A fourth section summarises the research gaps to be addressed in this study.

Chapter 3 covers the methodology of this study and it includes a discussion of the ontology, epistemology, Smokefree case and methods adopted in this thesis. The study adopts an inductive qualitative case study approach to examine actor engagement and value creation in a health behaviour change context. The first section discusses the ontological and epistemological position adopted in this study. The research methodology and the rationale for a qualitative case study approach are described in

[7] Co-production and participation are the terms predominant in the health literature. As explained in the literature review, the marketing literature distinguishes between co-creation/co-production and engagement/participation.

section 3.2. Section 3.3 provides a rationale for the selection of the social marketing case. Section 3.4 describes the Smokefree case and sets the context of the research. The data generation methods utilised in this study and the analysis techniques are described in sections 3.5 and 3.6. Section 3.7 discusses the means used to ensure the quality of the research. The following sections describe research ethics and research limitations.

Chapter 4: 'Understanding actors in a collaborative value creation network' examines the actors involved in developing and implementing the Smokefree programme, their networks, roles, work practices and the relationships among them to provide a descriptive account as a basis for understanding and interpreting the phenomena examined in subsequent chapters.

Chapter 5: 'The process of value creation in a social marketing context' explores the process of collaborative value creation, including value facilitation, resource integration and co-creation. The chapter examines how members of the public (as service users) create value for themselves and their families and how other resource providers participate in the process of value creation.

Chapter 6: 'Value dimensions and motivation of actors in a social marketing programme' explores actor (staff and member of the public) motivation for engaging with the programme and their perceived value dimensions (i.e. social, altruistic, emotional, functional, epistemic) in this social marketing context. Exploring the concepts of motivation and value requires a focus on individual and agency, given their subjective dimensions. However, the study suggests that understanding actors' motivation and value in context also requires unpacking the concept of structure as a potential barrier or facilitator for engagement. The discussion also focuses on barriers and limitations of a collaborative approach reiterating the importance of structures to support/hinder engagement – a recurrent theme throughout the empirical section of this study.

The final chapter of the thesis (Chapter 7) summarises the discussion of the findings in the light of previous studies, the limitations of the study and implications for future research and practice. It also considers the theoretical, practical and policy contributions of this study to the three areas of literature, social marketing, service-dominant logic and public health.

Chapter 2: Literature Review

2. 1 Introduction

The purpose of this chapter is to introduce the key streams of literature relevant to this thesis and to identify the key concepts informing the theoretical framework for subsequent research. The chapter is split in three parts corresponding to the three streams of literature (i.e. social marketing, SDL and public health) informing this study.

The first part of the literature review chapter is dedicated to social marketing. The chapter starts by discussing different social marketing definitions and their implications for social marketing's life trajectory. A second section is dedicated to the main critiques that marked social marketing development. A final section reviews key contributions to revising and extending social marketing theory. This discussion is necessary in order to understand the arguments for exploring new concepts for social marketing theory.

The discussion on social marketing is followed by a part devoted to service-dominant logic (SDL) underpinning principles and their implications for social marketing. Separate sections explore principles and concepts such as: value creation as a network based process; co-creation and active consumers; resource integration; the nature of value; actor engagement (i.e. customer and stakeholder) and motivation. The chapter reviews the developments brought by SDL in marketing theory and highlights the research needed to complement the conceptual work.

The final part of the chapter reviews how principles of SDL are conceptualised in public sector and health literature to provide a rationale for a service orientation in public health. The first section reviews the principles underlying the shift towards a 'participatory co-production' approach in public health. Principles including participation, involvement, co-production of services, active citizens are discussed in the context of health services. A separate section focuses on empowerment as a key principle at the core of behaviour change and health improvement programmes. This final part of the literature review integrates concepts from the three stream of literature to provide clarity to the conceptual framework informing this thesis. The final section illustrates some of the challenges of collaborative approaches in health.

2. 2 An overview of social marketing

2. 2. 1 Defining social marketing

The emergence of social marketing has been explained by the broadening process of marketing and the shift from products, companies and selling towards customer needs and satisfaction (Webster, 1975). Broadening the areas of marketing application to include social contexts was seen as a response to the growing concern about the marketing's undesirable social effects such as driving a materialistic culture and its negative impact on the environment (Arnold and Fisher, 1996). The introduction of marketing rationalities and tools into the public sector to promote voluntary behaviour change is also linked with the governments' adoption of the market based approaches as the 'new public management' (Walsh, 1994). The main arguments for adopting market approaches in the public sector consisted of an increased efficiency and a desire to follow citizens' needs (Raftopoulu and Hogg, 2010). The variety of definitions employed to capture the main principles of social marketing reveals an evolving field of research with debates regarding the marketing and the multidisciplinary dimensions. Table 1 in the Appendices presents some of the influential definitions of social marketing.

Early definitions of social marketing emphasise that the core characteristic of social marketing was that it applied learning from the commercial sector to the social field (Kotler and Zaltman, 1971; Webster, 1975; Wiebe, 1951/1952). One of the most cited definitions of social marketing is provided by Kotler and Zaltman (1971) which emphasises the operational dimension and the focus on the marketing mix. The definition raised ethical issues, with words such as 'influence', 'acceptability', 'social ideas' which combined with commercial techniques of persuasion and manipulation added to the debate on the 'neutrality of marketing' (Morgan, 1992). The social marketing approach drew on transactional marketing (Grönroos, 2000). The dominant logic was product driven adopting an economics perspective on value and exchange (Domegan et al, 2013; Vargo and Lusch, 2004; 2008a). As such, the prevailing focus was on value as embedded in the offerings, tangible resources and dyadic transactions (Lefebvre, 2012; Vargo and Lusch, 2004; 2008a).

Lefebvre and Flora (1988) propose a definition for 'health marketing' and discuss the application of key principles of social marketing in health contexts. The authors (Lefebvre and Flora, 1988) emphasise that social marketing application in health programmes drives a change from the expert driven health education models to a consumer centred model. Social marketing key principles are defined as: 1) customer orientation, 2) voluntary exchange, 3) formative research, 4) audience analysis and segmentation, 5) channel analysis for distribution and promotion, 6) marketing mix, 7) process tracking and 8) a management process (Lefebvre and Flora, 1988). The authors suggest that the main contribution of social marketing to health programmes is a managerial framework based on analysis, planning, implementation, feedback and control that can lead to increased effectiveness, efficiency and customer satisfaction (Lefebvre and Flora, 1988).

Andreasen (1995) provides another dominant definition that marked the evolution of social marketing and its application in public health. Outlining the reliance on 'proven concepts and techniques drawn from the commercial sector' and the value of the desired behaviour change, the definition establishes social marketing as a behaviour change approach. In an attempt to define the theoretical foundations of social marketing and to increase the consistency of the approach, Andreasen (2002) introduced the concept of social marketing benchmarks criteria which built on the ones discussed earlier by Lefebvre and Flora (1988). According to these criteria, social marketing is (1) customer oriented, (2) has a clear behaviour change focus, (3) incorporates an exchange analysis, (4) takes into account competition (both internal and external), (5) uses segmentation and targeting to select the intervention target group and (6) develops a complete marketing mix (product, price, place and promotion) (Andreasen, 2002). The benchmarks are used by practitioners and funders as a framework to guide development of social marketing programmes (NSMC; ESMA). The benchmarks are also used in social marketing literature, to demonstrate that interventions have adhered to social marketing principles (Carins and Rundle-Thiele, 2013; Stead et al., 2007). Building on Andreasen's criteria and findings from reviews, the UK's National Social Marketing Centre (NSMC) added 'theory' and 'insight from the audience' to the benchmark criteria (French and Blair-Stevens, 2007). However, evidence indicates that in practice these benchmarks (the marketing mix in particular) are not always followed in designing

social marketing programmes and the field is still challenging some of the social marketing principles (Carrins and Rundle-Thiele, 2013; Stead et al., 2007).

The majority of definitions present social marketing as the application of commercial marketing techniques for social good. The definition proposed by French and Blair-Stevens (2007) emphasises the opening of social marketing to other approaches of behaviour change and a systematic approach. The 'systematic application' assumes a consistent approach that adopts a marketing mindset and takes action accordingly. Social marketing is not only an 'operational approach' used to plan an intervention but also a strategic one that can be used to support policy and strategy development on long-term (French, 2009b, p. 265).

Recent definitions acknowledge that social marketing requires 'the adaptation' of commercial marketing concepts to social marketing contexts (Dann, 2010) but they maintain the focus on downstream social marketing emphasising the strategic dimension and the exchange framework (Lee, Rothschild, and Smith, 2011). Professional social marketing associations such as ESMA, iSMA and AASM endorse a definition that highlights the 'integration' of marketing concepts with other approaches whilst maintaining the focus on behaviour.

Efforts to evaluate social marketing effectiveness - focused on interventions addressing nutrition (Carins and Rundle-Thiele, 2013), physical activity, substance misuse, tobacco (Stead et al., 2007), branding (Evans et al., 2008), marketing mix strategies (Luca and Suggs, 2010), theory (Luca and Suggs, 2013), mass-media strategies (Snyder et al., 2004; Grilli, Ramsay and Minozzi, 2002) and social marketing in general (Truong, 2014) - indicate that more efforts are needed to establish what strategies work better in areas such as: marketing mix development, behaviour/social change theories, upstream measures, stakeholder engagement and evaluation design. A review conducted in the UK to assess the potential of social marketing as a behaviour change framework, indicated that social marketing should build on the value of other traditional approaches and look to integrate those strategies that were successful in developing programmes of social change (National Consumer Council, 2006). Other studies (NSMC, 2009; 2010) indicated a certain resistance from practitioners to thoroughly adopt and apply the social marketing framework. The barriers identified were a negative perception of social

marketing due to association with sales based marketing, ethical concerns, the length of the process, and confusion regarding the social marketing domain which was often identified with health promotion or social advertising (NSCM, 2009). These findings support the evidence from other reviews (Stead et al., 2007; Luca and Suggs, 2010) that in practice social marketing has sometimes a narrow interpretation and that it requires further efforts to define its domain and endorse its application.

This section reviewed main definitions of social marketing in order to provide an understanding of how the field has evolved since its early years. Since Kotler and Zaltman (1971) coined the social marketing term, the various definitions used to capture the essence of social marketing have remained within the boundaries of transactional product oriented marketing. A change was brought by recent definitions which acknowledge the need to 'adapt' marketing theory and integrate it with other approaches to better apply to social contexts. Existing research reviewing social marketing practice highlights the focus on downstream (individual behaviour change), difficulties for practitioners in applying the benchmarks thoroughly and the need to further define and update the social marketing frameworks. The following section explores in more detail the main critiques associated with social marketing theory and practice.

2. 2. 2 Social Marketing Critiques

This section reviews the key critiques and debates that have marked the social marketing field to provide a comprehensive view on the trajectory of social marketing and to help understand the directions for further development of the field. These debates are connected with the social marketing benchmarks and include the relevance of exchange and marketing mix, the application of social marketing in health contexts, the downstream-upstream debate and ethical dilemmas.

2. 2. 2. 1 Dyadic exchanges and the marketing mix

The focus on individual behaviour change and exchange has been influenced by the predominance of a 'traditionalist' approach in social marketing (Gordon and Gurrieri, 2014). This approach drew on psychology and neoclassical economics theory in social

marketing and it led to the adoption of an interventionist - campaign oriented approach. This 'interventionist' approach has been criticised for neglecting the impact of external, environmental factors on behaviour change (Hoek and Jones, 2011; Lee and Garvin, 2003; Wymer 2011).

Social marketing definitions draw on transactional marketing theory (Andreasen, 2002; Bagozzi, 1975; Sheth and Parvatiyar, 2002). Transaction marketing focuses on creating purchases and exchanges operating on the 4P marketing mix model (Grönroos, 2000). The exchange framework was focused on transactions for need satisfaction (Sheth and Uslay, 2007) which has been challenged as oversimplifying and unable to explain all marketing realities (Grönroos 1994; Webster, 1992). Exchange has been identified as one of the core elements of the social marketing process (Andreasen 2002; Bagozzi, 1975; Hastings, 2003; Kotler and Lee, 2008; Laczniak, Lusch and Murphy, 1979). In social marketing, exchange theory suggests that an intervention involves a voluntary exchange of resources (Lefebvre and Flora, 1988). A key element in the process of exchange is providing an offer that is valued by the target audience (French, 2011). In order to influence the desired behaviour change in their target audience, social marketers have to provide them with information, tangible products and services, or other incentives that can be considered benefits in exchange. The exchange occurs when the target audience adopts the desired behaviour. French (2011, p. 156) distinguishes between positive exchanges (when people get a social or psychological reward), negative (when people face a form of penalty as a result of not adopting the promoted behaviour), 'passive' (when adopting the behaviour requires little cognitive engagement) and 'active' (when choice involves active cognitive engagement and decision making).

A number of authors (Buchanan et al., 1994; Luck, 1969; Ryan, 2001) argue that social marketing contexts do not allow for a real exchange and that often they involve a 'unidirectional transfer of value' from the social marketer (Peattie and Peattie, 2003). Social marketing typically confronts contexts that involve generalised and complex exchanges (Bagozzi, 1975; Webster, 1975) and often deals with market failures (Glenane-Antoniadis et al., 2003; Shultz, 2007). These issues question the traditional dyadic exchange model. The nature of the social product or service which is usually defined in terms of the 'greater social good' and determined by the government or other organisations challenges the principle of following customers' needs and desires. In

addition to this, the beneficiary of social marketing campaigns can be the general public or society at large (Glenane-Antoniadis et al., 2003; Brennan and Binney, 2008) which modifies the classic exchange mechanism from commercial marketing. Examples include anti-smoking campaigns, upstream initiatives to limit access to tobacco and change the social norm which would appear to adopt a position that contradicts the desires of individuals (i.e. to be able to smoke). Graham (1993) argues that, in fact social marketing denies the essence of marketing. Considering these criticisms and the changes in mainstream marketing, it has been argued that 'interaction' is a more appropriate concept for social marketing (Peattie and Peattie, 2003). This proposition will be covered in the section on social marketing revisions.

The criticisms of the transactional model in social marketing have also led some to question the appropriateness of the marketing mix since it is a commercial model, which makes it difficult to apply to social change contexts (Bloom and Novelli, 1981; Gordon, 2012; Peattie and Peattie, 2003; Tapp and Spotswood, 2013; Wood, 2008). The marketing mix is associated with a 'micro-marketing' perspective despite the 'macro-marketing' issues that social marketing generally aims to tackle such as public health crisis, environment protection, poverty etc. (Shultz, 2007). The marketing mix has been considered one of the core tenets of social marketing as it provided a framework for developing behaviour/social change programmes. However, evidence from practice indicates that social marketing situations require complex exchange relationships that involve more than the dyadic relationship, seller-buyer, from commercial marketing (Wood, 2008).

In addition, the concept of product platform has generated confusion among practitioners who found it difficult to apply in a social marketing context (NSMC, 2009; 2010). According to Kotler and Lee (2008), the social marketing product or offering includes three levels. The 'core product/offering' level comprises the benefits of the desired behaviour. The 'actual product' is the behaviour itself, and the 'augmented product' contains any objects or services created to support behaviour change (Kotler and Lee, 2008). Other scholars (Rothschild, 2009; Smith, 2009) argue that behaviours should be separated from products in social marketing. Smith (2009, p. 99) defines the product as 'a unique tool used by marketing to achieve the goal of behaviour change'. Peattie and Peattie (2003) argue that both perspectives fail to capture the nature of the social

marketing context. Peattie and Peattie (2003) point out that behaviour is not 'produced' or owned by the social marketer to be able to frame products as behaviours. Further, it is the final user/target customer who 'produces' the behaviour (Peattie and Peattie, 2003). This feature of social marketing 'products' points to the co-producer role of the customer in social marketing which will be discussed in more detail in the following chapters. Peattie and Peattie (2003) also argue that adopting the perspective that social marketing products are 'tools' is too simplistic, as the benefits for the final user are generally a result of their behaviour and not of the components of the social marketing programme. In their argument for a new vocabulary for social marketing Peattie and Peattie (2003) propose that the concept 'social proposition' is more appropriate than 'product', as an umbrella term to include behaviours and tools to support change. Defining the product as a 'bundle of benefits' (Rothschild, 2009) does not exclude behaviours. Further, the concept of augmented product, as any products/services used to support behaviour change (Kotler and Lee, 2008) includes the idea of product as a 'tool'. The study supports Smith's (2009) argument that social marketing products should include more than ideas and behaviours to provide strong alternatives to competing 'unhealthy' products and clear benefits. It also aligns to the argument that a change of vocabulary to reflect the intangible nature of social marketing products is needed (Peattie and Peattie, 2003). Thus, in this study the SDL term 'offering' is preferred as a generic term that includes social marketing products/services.

Adding to this debate, research indicates that interventions that could be described as social marketing used other strategies such as actor engagement, building partnerships and policy (Beall et al., 2012; Gordon, 2012; Luca and Suggs, 2010; Stead et al., 2007). A recent global online survey conducted among social marketing professionals who were invitees and pre-registrants attending the Second World Non-Profit and Social Marketing Conference in Dublin indicates that community based initiatives and engagement, peer groups and networks, digital influence and inter-organisational collaborations are the most successful tools in social marketing (Beall et al., 2012).

Criticisms of the 4Ps marketing mix are also noted in the commercial marketing literature. In particular, the literature notes the focus on the firm (rather than on the consumer) (Constantinides, 2006), the preference for short term and transactions, the underestimation of long term relational thinking and the inability to cover the integrated

marketing communication and new media (Rafiq and Ahmed, 1995). Dev and Schultz (2005) argue that current market realities where the customer has the ultimate power require a re-conceptualization of the 4Ps marketing mix and a shift from the supply, manager-driven to a customer-focused approach to the marketplace. Gummesson (2008) contends that more than a customer focus, contemporary marketing moves to a stakeholder approach which requires an update of the marketing mix. Lusch and Vargo (2006b) propose a framework centred on co-creation as an SDL alternative to the 4Ps. In this framework, product is replaced by a focus on co-creating services; price is conceptualised in terms of co-creating value propositions; co-creating conversations and dialogue would address promotion and value processes and networks would be a new way of understanding place (Lusch and Vargo, 2006b, p. 408).

This subsection reviewed the criticisms associated with exchange and the marketing mix in social marketing. The following subsection centres on another key area for debate in social marketing: the focus on individual and behaviour change.

2. 2. 2. 2 Individual behaviour change and a customer orientation

A prominent critique of social marketing (particularly in the health context) is its 'downstream' orientation. Traditionally, social marketing adopted a 'downstream' approach (Andreasen 1995; Kotler and Lee, 2008) focusing on changing the behaviour of people who are at risk through decisions at the individual level (Maio et al., 2007). Many social marketing programmes and interventions are based on self-efficacy cognitive models such as Theory of Planned Behaviour, Health Belief Model, Social Cognitive Theory, Protection Motivation Theory (Lefebvre, 2000; Lee and Garvin, 2003; Luca and Suggs, 2013). However this interventionist approach based on cognitive models has been criticised for neglecting the impact of external, environmental factors on behaviour change (Adshead and Thorpe, 2006; Bentz et al., 2005; Hoek and Jones, 2011; Lee and Garvin, 2003; Wymer 2011). These traditional cognitive models, have also been criticised as providing a limited perspective on behaviour whilst neglecting 'irrational' aspects such as 'automatic processes, habits, contexts, visceral states and bias' (Carvalho and Mazzon, 2013, p. 166).

The downstream focus is one of the main arguments against social marketing application in health contexts (Brenkert, 2002; Crawshaw, 2012; 2013; Wallack, 2002; Wymer, 2010; 2011). Crawshaw (2012) contends that social marketing can be seen as a form of what Foucault calls bio-politics (Foucault, 2009). According to this view, social marketing is associated with a neo-liberal approach promoted by new forms of governmentality that aim to responsibilise individuals into self-management of their own wellbeing (Crawshaw and Newlove, 2011; Crawshaw, 2012; Gurrieri, Previte and Brace-Govan, 2013; Jones, Pykett and Whitehead, 2011).

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Recent scholarship has questioned the application of the 'homo economicus' model in health contexts which assumes that exchange takes place between rational agents (Carvalho and Mazzon, 2013; Glenane-Antoniadis et al., 2003; Peattie and Peattie, 2003; Spotswood and Tapp, 2013). However, evidence indicates that social determinants of health are a key in influencing not only individuals' health but also their dispositions, beliefs and behaviours (Crawshaw, 2012; Marmot, 2010). As a result, given its individual (downstream) focus, social marketing's effectiveness and relevance to impact on wider social determinants of health is questioned (Crawshaw, 2012). Other scholars rejected this deterministic perspective and argued that to view social marketing as a purely neo-liberal approach is too simplistic and poses the danger of ignoring individual's agency and self-responsibility (Gould and Semaan, 2014).

Despite these critiques from the health field, social marketing brought a change in the way public health campaigns are carried out. As Hastings (2003) emphasises, pretesting communication materials with the target audience and ethnographic research were not a common practice before the ideas of social marketing started to be embraced by public health professionals. Social marketing is also credited for adopting a managerial planning approach and a focus on profitability (e.g. cost effective strategies) to develop behaviour change campaigns (Hastings and Haywood 1991). Further, social marketing made an important contribution to critical approaches to behaviour and social change by exposing how commercial marketing is shaping the environments that influence behaviour (Gordon, Carrigan and Hastings, 2011; Gordon, 2013; Hastings and Saren, 2003).

Other authors (Buchanan, Reddy and Hossain, 1994) argued against the novelty and advantages of social marketing pointing out that even the distinctive features of this approach such as customer orientation and integrated approach were not new to public health. As for 'profitability', this was considered inappropriate for a field where social justice and equity are the guiding principles. Buchannan and colleagues (1994) adopt a rather extreme position arguing that adopting a marketing frame of reference in health promotion would mean a shift from the altruism that characterises the health field towards 'antagonism' and professionals motivated by self-gain.

The downstream focus of social marketing has received criticisms also in other areas of social change (Brennan and Binney, 2008) such as the areas of environmental protection and sustainable consumption (Peattie and Peattie, 2009). The individual focus was acknowledged as a barrier to adopting a broader view on what might be needed for sustainable change (Brennan and Binney, 2008). Regarding environment and sustainability issues, scholars have highlighted that the behaviour promoted in social marketing campaigns primarily provides altruistic value to the individual (e.g. saving resources and energy for the benefit of future generations), which is difficult to market when the dominant discourse is consumption oriented (Kilbourne, McDonagh and Prothero, 1997; Peattie and Crane, 2005; Peattie and Peattie, 2009). The focus on individual behaviour change in the absence of institutional support for consumption reduction is suggested to be a fundamental limitation of environmental social marketing campaigns (Peattie and Peattie, 2009). There is growing acceptance that upstream social marketing strategies are required to support sustainable practices (Brennan and Binney, 2008). However, some scholars question whether social marketing is the right approach for any social problem (Andreasen, 2002; Brennan and Binney, 2008). For instance, ecological problems such as climate change require interdisciplinary approaches and integrating a variety of perspectives and action at micro, meso and macro levels (Brennan and Binney, 2008).

It is important to specify that despite these criticisms and the limitations of downstream approaches, individual behaviour change is needed as part of the broader social change aim (Brennan and Binney, 2008; Dibb, 2014; Gordon, 2013). Sustainable change requires voluntary behaviour change and individuals assuming that change (Hastings and Saren 2003; Stead, Arnott and Dempsey, 2013). A similar argument is made in

commercial marketing where both micro and macro marketing perspectives are required for constructive engagement with the society (Shultz, 2007). However, the growing agreement is that social change programmes require action at different levels which means understanding both individual and structural factors (Andreasen, 2012; Brennan and Binney, 2008; Brennan and Parker, 2014; Cherrier and Gurrieri, 2014; Dibb, 2014; French et al., 2010; French, 2011; Fry, 2014; Goldberg, 1995; Gordon, 2013; Gordon and Gurrieri, 2014; Hastings, 2003; Russell-Bennett, Wood and Previte, 2013; Spotswood et al., 2012; Szmigin et al., 2011).

This subsection reviewed social marketing critiques associated with behaviour change and the individual focus. The review highlighted the importance of concentrating action at the midstream and upstream levels to tackle external factors of behaviour. The discussion leads to how targeting and segmentation are implemented in social marketing to reinforce the focus on individuals.

2. 2. 2. 3 Targeting and segmentation

Segmentation and targeting were introduced as a way to efficiently use resources and increase impact (Andreasen, 2002). Using segmentation to select target groups for an intervention and to tailor the offering contrasts with traditional approaches that promoted generalised offerings to all audiences (Hastings, 2003). However, the application of segmentation and targeting via the 4Ps has been criticised for promoting a view which emphasised the role of the organisation in determining value propositions transmitted through unidirectional messages (social marketer – audience) (Luca, Hibbert and McDonald, 2015).

The application of segmentation to social marketing has aroused the criticism that it reinforces the concentration on individuals, neglecting broader structural factors that influence social problems (Brenkert, 2002; Dibb and Carrigan, 2013). Concerns have been raised about the use of segmentation as a means to select those individuals ready for change but excluding vulnerable or hard to reach populations (Brenkert, 2002; Newton et al., 2013). As such, segmentation in social marketing raises the issue of rationing: why should some individuals benefit from an intervention and not others? This ‘preferential treatment’ is often justified by limited access to resources and capabilities of the

organisations implementing the social marketing programmes (Newton et al., 2013). Yet, it risks increasing inequalities where low-income groups engage less with general social marketing offerings compared to more affluent groups (Frohlich et al., 2012; Stead, Hastings and McDermott, 2007).

The traditional marketing management approach and the 4Ps model led to an over-emphasis on promotion of messages to segments of the population which have attracted criticisms from practitioners that social marketing is manipulative, sales and advertising based (Andreasen, 2002; Brenkert, 2002; Stead et al., 2007). Concerns were raised that targeting people with social marketing messages assumes a paternalistic and interventionist mindset (Lee and Garvin 2003) which limits community involvement in the process of change (Andreasen, 2002; Brenkert, 2002).

It is important to note that these criticisms relate to implementation of segmentation and targeting. The literature highlights that one of the barriers to social marketing's growth has been the fragmented application of social marketing, which led to poor implementation of its concepts (Andreasen, 2002; 2003; Dibb and Carrigan, 2013). Recent work highlights the need for contemporary approaches to segmentation, moving from simple demographics towards psychographic segmentation strategies (Dibb, 2014; Zainuddin, Previte and Russell-Bennett 2011; Zainuddin, 2013). Service and relationship marketing literatures emphasise the potential of moving away from segment-based marketing towards approaches that favour 'individuated interaction' (Karpen, Bove and Lukas, 2012, p. 26) and the 'experience of one' (Prahalad and Ramaswamy, 2004, p. 8). Data capture technologies were identified as showing potential in gathering behavioural data, customising offerings and facilitating interactive programmes (Dibb, 2014). Technologies such as GPS tracking, smart phone apps and wearable sensors provide data that allow for a contextualised view of individuals' 'everyday activities' (Dibb, 2014, p. 1176; Sellen and Whittaker, 2010) promising potential for social marketing initiatives. Careful segmentation and high customisation to target more 'at risk' groups may help to address health inequalities and the exclusion of difficult to reach groups (Stead, Hastings and McDermott, 2007) whilst targeting stakeholder segments may support the efforts to tackle social issues at midstream and upstream levels (Gordon, 2013).

The review suggests that some of the challenges (e.g. inequality and reach of vulnerable populations) of segmentation and targeting in social marketing are due to poor implementation of these concepts. The literature indicates that contemporary approaches to segmentation and targeting inspired by relationships and service marketing show potential in customising offerings and contextualising programmes. The next section centres the discussion on ethical issues in social marketing.

2. 2. 2. 4 Ethical responsibility in social marketing

Several marketing scholars raised concerns regarding the ethical aspects of social marketing (Brenkert, 2002; Dholakia and Dholakia, 2001; Laczniak, Lusch and Murphy, 1979; Witkowski, 2005). In this view, social marketing is being accused of paternalism (Gordon and Gurrieri, 2014) and bias (Witkowski, 2005). Although, the social marketing agenda appears to be a noble one, there are still questions relating to who the agent of social change might be (Brenkert, 2002), who decides what the 'greater good' is (Andreasen, 1994; Andreasen, 2006; Spotswood et al., 2012) and what 'change' might mean for the target audience (Dholakia and Dholakia, 2001; MacFadyen and Hastings, 2000). For example, Brennan and Binney (2008) examine ethical dilemmas in social marketing when sustainability, health and well-being goals clash. Achieving sustainability is conditioned by aligning individual social, economic and environmental values (Brennan and Binney, 2008). Thus, social marketers are facing the challenge to negotiate values and goals from different perspectives and find a solution that is ethical and responds to all stakeholders needs (Brennan and Binney, 2008; Dibb, 2014). Other authors argue that social marketing has a political function since its goal is social welfare (Lazer and Kelley, 1973; Brenkert, 2002), which is also the primary concern of politics (Walsh, 1994) and social marketing programmes are often initiated by governmental agencies (Raftopoulou, and Hogg, 2010).

Further, the association of social marketing with neo-liberalism raised concerns of privileging a choice focus which poses the danger of contributing to stigma and exclusion of certain groups (Gurrieri, Previte and Brace-Govan, 2013). Gurrieri and colleagues (2013) examine breastfeeding, weight management and physical activity social marketing campaigns and contend that an inadvertent effect of such campaigns is the position of certain bodies as 'less acceptable' and the stigmatisation of women who

do not fit the 'healthy profile'. In a further commentary to their initial work, Gurierri, Brace-Govan and Previte (2014, p. 532) reinforce the call for greater ethical responsibility in social marketing research and practice to address the side effects of 'overly simplified campaign messages and images' practiced through neo-liberalist approaches. Other scholars raised concerns about the smokers' portrayal as individuals who cannot exert self-control and the discourse emphasising rational choice which may lead to stigma and marginalisation of smokers living in low-income areas (Frohlich et al., 2012; Poland et al., 2006). Greater ethical responsibility is indeed needed in all social marketing programmes (Andreasen, 2006; Brenkert, 2002).

This subsection reviewed the ethical debates in social marketing. Debates centre on the applicability of social marketing to social issues, the 'neutrality' of marketing tools, asymmetric power relations (social marketer/consumer) and the role of social marketing in shaping society. Critical reflection, ethical responsibility and a 'democratisation' of the social change process are needed in order to address ethical issues in social marketing. The next subsection covers the calls for midstream and upstream action in social marketing.

2. 2. 2. 5 Calls for midstream and upstream action

One of the key criticisms of behaviour change interventions is that they tend to ignore the social context that shapes behaviours (McKinlay and Marceau, 2000) as well as the physiological consequences of behaviour change and the biological factors (Sheps, Freedland, Golden, and McMahon, 2003). Increased awareness of the interdependence relationships between environmental and behavioural determinants of health (Alcalay and Bell, 2001) led to calls for the adoption of upstream (Gordon, 2013; Brennan and Binney, 2008; Wallack, 2002; Wymer, 2010) and midstream (Gordon, 2013; Russell-Bennett, Wood and Previte, 2013) approaches to change. Such approaches require a system view to understand and tackle the factors that might constrain behaviour at the interpersonal, community, organisational, and societal levels (Hoek and Jones, 2011; McLeroy et al., 1988; Wymer, 2010; 2011).

The literature notes an emerging orientation to 'upstream' social marketing (Dibb, 2014; Gordon, 2013; Hastings and Domegan, 2013). Calls were made for more 'strategic' social marketing that adopt a broader view of the processes required in social change programmes (French and Blair- Stevens, 2010; French, 2011; Gordon, 2013). More recently the term 'midstream' (meso) has been advanced to distinguish between action taken at the community level involving collaborations with public services and other community actors (Russell-Bennett, Wood and Previte, 2013) and personal networks such as family and friends (Dibb, 2014). 'Upstream' generally refers to initiatives at the policy and legislation level. However, the literature often uses the term upstream to refer to initiatives that focus on changing the environment by using a combination of legislation, enforcement, community approaches, education, and structural measures to support healthy behaviours (Andreasen, 2006; Bentz et al., 2005; Niblett, 2005; Rothschild, 1999; Wallack, 2002). An upstream approach can include advocacy (Kotler and Lee, 2008) and 'critical social marketing' to investigate the impact of commercial marketing on society and use the findings to influence policy makers and the industry (Gordon, 2011; Hastings and Saren, 2003). Other authors use the term 'upstream social marketing' to refer to strategies to influence and change the behaviour of policy makers and government officials (Andreasen, 2002; Brennan and Binney, 2008) to change the structural environment and have a positive influence on social issues (Gordon, 2013).

The literature indicates that upstream social marketing can involve local entities and community action to inform and influence changes at a higher level. Examples include campaigns engaging communities to support sustainable change in tweens' physical activity levels (Wong et al., 2004), nutrition (Piggin and Lee, 2011) and improve service to local supermarkets in low-income neighbourhoods (Gregson et al., 2011); partnerships at different levels to increase awareness of heart disease among women (Long et al., 2008) and osteoporosis prevention (Lefebvre, 2006); community engagement for male sexual health (Montoya et al., 2005) and advocacy projects that worked with the public to identify needs and solutions to increase healthy food availability (Goldstein, 2000; Walter and Agron, 2002; McDermott et al., 2005) and include nutrition education in state training programmes (Hersey and Daugherty, 1999). Other programmes involving regulatory and legislative action aimed to address alcohol consumption (Hastings et al., 2005; Meier, Brennan and Purshouse, 2010).

A systematic review of obesity prevention community wide interventions found that interventions focused on policy and environment are more sustainable than information, social marketing or events only (King et al., 2011). In addition, the review indicated the importance of engagement and development of partner groups in assisting sustainability (King et al., 2011). However, the evidence base for structural approaches and upstream interventions and the application of social marketing in practice to address the context of behaviour still requires sustained efforts (Carins and Rundle-Thiele, 2013; Truong, 2014; Whitelaw et al., 2010) as a downstream orientation tends to predominate in research and practice (Lieberman, Golden and Earp, 2013). Scholars emphasise the need to develop social marketing expertise of working with the variety of stakeholders operating at the midstream and upstream levels (Dibb, 2014; Gordon, 2013).

In a recent paper examining the potential of upstream social marketing, Gordon (2013) highlights the lack of 'key principles and guidelines for utilising upstream social marketing'. Calls were launched for developing approaches to better understand the mechanisms of collaboration and working with multiple stakeholders in social marketing (Dibb, 2014; Domegan et al., 2013; Gordon, 2013; Gordon and Gurrieri, 2014). Further, the context of social change programmes often requires collaboration with stakeholders from the commercial sector (e.g. food companies, alcohol industry) with conflicting views and values (Brennan and Binney, 2008; Dibb, 2014). Coordination of those views and values is a challenge of social marketing programmes aiming for structural change (Dibb, 2014; Polonsky, Carlson and Fry, 2003). Recent work suggests that learning from the stakeholder management literature (Dibb, 2014) and service marketing (Russell-Bennett, Wood and Previte, 2013) could help develop the social marketing expertise of stakeholder coordination and collaboration.

This section reviewed some of the critiques of social marketing to provide a view of the problematic areas which require further efforts for improvement. Key critiques highlight the neo-classical perspective of the exchange (Domegan et al., 2013) and challenges of applying specific commercial models such as the marketing mix (Wood, 2008) to social change contexts. The behavioural orientation of social marketing has been questioned for framing social problems only at the individual level, posing serious limitations to addressing health inequalities and structural change (Crawshaw, 2012). The transactional model adopted by classical social marketing translated into a managerial orientation that

was challenged for limiting community involvement in social change programmes (Brenkert, 2002). Finally ethical issues connected with the 'who' and the 'how' of social marketing in terms of defining what 'social good is' and the mechanisms used to achieve it (Brenkert, 2002; Raftopoulou, and Hogg, 2010) were discussed. The review noted the calls made for midstream and upstream action to address the context of behaviour change (Gordon, 2013). The following section explores the key contributions to revisiting and extending social marketing theory in order to outline the research priorities of the field.

2. 2. 3 Contributions to revising social marketing theory

The debates at the conceptual level continue to dominate the social marketing field which is still searching for a stronger identity 50 years after its birth (Andreasen, 2002; 2012; French, 2011; Dibb, 2014; Tapp and Spotswood, 2013). Andreasen (2012) advocates for viewing social marketing as another application of mainstream marketing rather than a 'special case'. However, despite the growing acceptance of social marketing as an approach to behaviour and social change (Dibb, 2014; Hastings and Domegan, 2013), the field has been dominated by a traditionalist marketing management perspective and even seemed to resist to the changes in mainstream marketing (Dibb, 2014; Gordon, 2012; Gordon and Gurrieri, 2014). Further, this transfer of classical marketing management models to social marketing and heath contexts favoured a focus on individuals while neglecting the context and the process of change.

Social change programmes are increasingly seen as complex open systems blending individual and structural factors (Cherrier and Gurrieri, 2014; Domegan et al., 2013). Fostering change within open systems requires a system view to understand and tackle the factors that might constrain behaviour at the interpersonal, community, organisational, and societal levels (Brennan and Binney, 2008; Dibb, 2014; Domegan et al., 2013; French, 2011; Gordon, 2013; Hastings, 2003; Luca, Hibbert and McDonald, 2015; Russell-Bennett, Wood and Previte, 2013). The field has also witnessed a move towards strategic social marketing that adopts a broader view of the processes required in social change programmes (French and Blair-Stevens, 2010; French, 2011; Gordon, 2013).

It has been argued that for social marketing to evolve and enhance its capacity, particularly at the midstream and upstream level, it needs to move beyond the simple application of commercial techniques and adopt a multidisciplinary approach to integrate concepts from other fields such as sociology and political science (Bryant et al., 2007; Donovan, 2011; Grier and Bryant, 2005; Lagarde et al., 2007; Spotswood et al., 2012; Stead, Hastings, and McDermott, 2007; National Consumer Council, 2006; Wymer, 2011). Learning from other disciplines is encouraged as a way to innovate and develop new theory so that social marketing could 'break free' from its traditional restraints (Dibb, 2014). Other scholars (Blair-Stevens, 2011; Desai, 2009; Dibb, 2014; Domegan, 2008; Fourali 2009; Gordon, 2012; Hastings, 2003; Lefebvre, 2012; Peattie and Peattie, 2003; Wood, 2008) argue that the source for social marketing development and evolution can be found in new marketing developments driven by the growth of relationship marketing, the service-dominant logic and co-creation of value (Russell-Bennett, Wood and Previte, 2013; Vargo and Lusch, 2006; 2008a). This section reviews contributions to integrate new theory in social marketing in order to identify areas for further development.

2. 2. 3. 1 New behaviour change models

As previously discussed, many social marketing programmes draw on early models of behaviour change theories which promote a view of individuals as rational agents (Carvalho and Mazzon, 2013; Crawshaw, 2012; Dibb, 2014; French, 2011; Luca and Suggs, 2013; Spotswood et al., 2012). These models have been criticised for providing a limiting view of behaviour change and not accounting for the 'irrationality' of human actions (Carvalho and Mazzon, 2013; Chuah and Devlin, 2011) and the external influences on behaviour (Crawshaw, 2012; 2013). Recent contributions from behavioural economics and socio-psychological theories have challenged the assumption that human beings are rational decision makers (Ariely, 2010; Shove, 2010; Thaler and Sunstein, 2008). As an approach that brings together psychology and economics, 'behavioural economics' is considered to lead to predictions of human behaviour that can inform policy to support individuals to make better decisions (Camerer, 1999). A core principle of behavioural economics stresses that non-cognitive biases influence behaviour and

decision making (Ariely, 2010; Kahneman, 2003). Behavioural economics suggest that in many instances it is more effective to change some aspect of place, and create 'choice architecture' that would 'nudge' people to make better choices rather than rely on individuals to make rational choices (Thaler and Sustein, 2008).

A number of scholars have proposed that social marketing integrates models inspired by behavioural economics (Adshead and Thorpe, 2006; Carvalho and Mazzon, 2013; French, 2011; Spotswood et al., 2012; Tapp and Spotswood, 2013). Behavioural economics is seen as an opportunity for social marketers to explore other approaches to behaviour (Dibb, 2014; Spotswood et al., 2012). In particular, insight from behavioural economics could help to shape the environment and change defaults to favour healthier choices (Carvalho and Mazzon, 2013; French, 2011; Spotswood et al., 2012). In so doing, it could provide individuals with the support needed in order to address institutional, social, and psychological barriers to healthy choices (Bertrand, Mullainathan, and Shafir, 2006). However, the application of behavioural economics to social change programmes is challenged by ethical issues of transparency and social marketers' accountability for shaping the environment. 'Nudging' people, 'non-cognitive exchanges' and hidden persuasion strategies (Spotswood et al., 2012) challenge the concept of voluntary exchanges in social marketing (Andreasen, 2003). Behavioural economics theory provides indeed an opportunity to explore new tools for social marketing, but research needs to constructively engage with the ethical issues that such applications might raise in the field of social marketing (Dibb, 2014; Gordon, 2013). Furthermore, behavioural economics models are centred on how to influence the final user, with less consideration given to the collaborations required in social change contexts. The next subsection reviews the contributions of critical approaches to broadening and developing the social marketing scope.

2. 2. 3. 2 Critical approaches in social marketing

In recent years, several scholars, have started to adopt a critical lens to the social marketing field (Gordon, 2011; Gurrieri, Previte and Brace-Govan, 2013; Hastings, 2009). Critical marketing approaches acknowledge the role that marketing has as a 'social force with moral responsibilities and the potential to influence the welfare of

society' (Bhattacharya and Korschun, 2008, p. 114). From a critical perspective marketing is not a neutral instrument but one that carries meanings, principles and practices that shape society (Arnold and Fisher, 1996; Murray and Ozanne, 1991; Tadajewski and Brownlie, 2008). Critical marketing draws on Critical theory[8] and adopts various approaches, such as sustainability, ethics, feminism, discourse analysis, consumer culture and postmodernism (Tadajewski and Brownlie 2008).

Critical social marketing scholars build on an early definition of social marketing which positioned social marketing also as an approach concerned with the consequences of marketing practices on society (Lazer and Kelley, 1973). Yet, the critical dimension of social marketing has been neglected in favour of downstream approaches centred on behaviour change (Gordon, 2011; Hastings and Saren, 2003). The emergent stream of critical research in social marketing has been instrumental in articulating the 'complex, conflicted and increasingly interdependent world' (Shultz 2007, p. 293) where social marketers operate. Critical social marketing research has reaffirmed the need to understand the structures around individuals and the complex relationships between individual and environment. The term 'critical social marketing' has been proposed (Gordon, Carrigan and Hastings, 2011; Gordon, 2011) to define a branch of social marketing that 'involves critically investigating the impact of commercial marketing on society from a (social) marketing perspective' (Gordon, 2011, p. 85). This information is then used to inform upstream social marketing activities such as advocacy, lobbying, policy and regulation; as well as downstream social marketing interventions. Hastings and Saren (2003) build on the Tobacco industry case to illustrate how findings of critical marketing research can be used to design social marketing programmes that aim to counter the efforts of commercial sector (i.e. smoking) but also influence policy makers and industry.

The previous examples focus on adopting a critical approach to commercial marketing practices. Several scholars argue for the use of critical theories to challenge ingrained understandings and constructs and encourage more reflexive practice in social marketing (Gurrieri, Previte and Brace-Govan, 2013; Gordon and Gurrieri, 2014). For instance,

[8] Critical theory is a social theory drawing on structuralism, post-structuralism, deconstruction, Marxist theory and other systems of thought oriented towards critiquing and changing society as a whole (Held, 2004). Critical theory investigates the contemporary society through reflection and critique, to reveal the limitations and ways for future development (Horkheimer, 1972 [1937])

Gurrieri, Previte and Brace-Govan (2013) make a contribution to the emerging critical social marketing stream of research by examining social marketing campaigns through feminist theory lens. The authors (Gurrieri, Previte and Brace-Govan, 2013) examine how social marketing activities can marginalise and render women vulnerable when they promote an idealised image of the body. Their research provides a critical view of the exchange between social marketers and target consumers which is marked by power and resistance.

Other scholars (Brennan and Binney, 2008) adopt a similar position suggesting that social marketing programmes aimed to improve the well-being of societies, may be in fact contributing to unsustainable practices (e.g. promoting increased access to an improved standard of living can increase consumption levels). Thus, more engagement with critical approaches is required to understand the role of social marketers in creating social change. Although upstream approaches are highly needed to address structural factors, Brennan and Binney (2008) point to the need to understand the social marketer role and their responsibility in adopting sustainable marketing practices.

Gordon and Gurrieri (2014) adopt a critical lens to argue for multi-actor reflexivity in social marketing. They draw on Actor Network Theory[9] (Latour, 2005) to examine researcher, participant and other stakeholder reflexivity in the case of tobacco control. The authors (Gordon and Gurrieri, 2014) identify little evidence regarding the researchers, participants and other stakeholder reflexivity on their role in shaping the research process, issues related to power relationships and problems experienced when delivering programmes in social marketing. In line with recent scholarship (Brennan and Binney, 2008; Lefebvre, 2011; Hastings and Domegan, 2013; Polonsky, Carlson and Fry, 2003; Stead, Arnott and Dempsey, 2013) the authors (Gordon and Gurrieri, 2014, p. 267) acknowledge the 'interconnectedness' of actors and suggest that 'collaborative research, co-creation, co-participation and co-interpretation of meanings' are highly relevant in order to empower participants and address the ethical dilemmas that might arise in social change contexts. Gordon and Gurrieri's (2014) work contributes a macro-

[9] Actor Network Theory - describes how human and non-human actors from different structures that share an interest form temporary and dynamic networks (Latour, 2005). These networks create assemblages of relationships specific to an action or an event and become 'actants' (Latour, 2005). Actor Network Theory provides a framework for explaining how actors with aligned interests in a certain problem support cooperative, inclusive and innovative solutions to a problem (Latour 2005).

marketing perspective to an emerging stream of research in social marketing and calls for reflexivity and network approaches to better understand how processes are negotiated and performed in open systems such as social change programmes.

A Socio-cultural perspective

Supporters of multidisciplinary social marketing have examined the potential of theories of social capital (Glenane-Antoniadis et al., 2003; Spotswood and Tapp, 2013) and structuration (Cherrier and Gurrieri, 2014) to provide additional concepts to social marketing theoretical frameworks.

Glenane-Antoniadis and colleagues (2003) argue for the interdisciplinarity of social marketing and examine the potential of social capital to extend social marketing theory. The authors contend that social capital theory provides a rich area for insight for extending social marketing theory because it acknowledges the nature of exchange and the importance of behavioural and social issues. From a social capital theory (Adler and Kwon, 2002) perspective, individuals may be incentivised to participate in exchanges by providing them with network benefits (peer approval, social identity). Thus social capital theory would help understand the role of networks and norms in shaping action for change (Glenane-Antoniadis et al., 2003). Drawing on Bourdieu (1990), Spotswood and Tapp (2013) suggest that a cultural lens may provide an alternative to the classical psychological and cognitive models for understanding behaviours. Their ethnographic study of physical activity behaviour in a deprived community indicated that cultural mechanisms play a key role in influencing taste and attitudes around healthy behaviours (Spotswood and Tapp, 2013). A 'culture change logic' (Spotswood and Tapp, 2013) was proposed as more comprehensive than narrow social marketing models operating on the 4Ps.

Cherrier and Gurrieri (2014) draw on structuration theory (Giddens, 1984)[10] to examine alcohol consumption as influenced by upstream actions (e.g. policy and industry) and symbolic representations and social norms at the midstream level (e.g. family and friends). Cherrier and Gurrieri (2014) propose a framework for understanding individual

[10] Giddens' structuration theory draws on the principle that institutions are created by actions but at the same time, once created these institutions can constrain action (Giddens, 1984). As such, individual practices are enabled and constrained by institutional orders (Barley and Tolbert, 1997; Giddens, 1984).

consumption as a system of interaction with structural elements at the downstream, midstream and upstream levels. Cherrier and Gurrieri (2014) contribute a neo-institutional perspective to the social marketing 'researchscape' (Dholakia, 2012) and turn attention to the roles of 'institutions' as part of the social system (Giddens, 1984) in normalising behaviours and creating culture. An important finding of Cherrier and Gurrieri's (2014) study suggests the role of individual agency in resisting institutions and enacting change. Their empirical account adds to the emerging stream of alcohol consumption studies (Fry, 2010; Fry et al., 2014; Piacentini and Banister, 2009; Spotswood and Tapp, 2013; Szmigin et al., 2011) which emphasises the need for broadening the scope of social marketing approaches beyond micro (individual) to meso (midstream) and macro (upstream) levels.

These recent contributions articulate the need for new theoretical angles in social marketing and understanding of social and behaviour change as complex processes unfolding in an open system where individuals interact through institutions, norms and culture. The next subsection discusses applications of social marketing as a community based approach.

2. 2. 3. 3 Community based models of social marketing

Other scholars explored learning from community development and action research models to extend social marketing action beyond the individual (Bryant et al., 2007; McKenzie-Mohr, 2000; Kelly et al., 2003). Building on community development and participatory models, 'community centred social marketing' (McKenzie-Mohr, 2000) or 'community based prevention marketing' (Bryant et al., 1999; 2014) provide examples of how social marketing has adapted to other frameworks of social change to move the action midstream and upstream and engage stakeholders. These community based models of social marketing emphasise the importance of process and knowledge sharing in fostering change. McKenzie-Mohr (2000) proposed a community based social marketing model for environmental change whereas Bryant and colleagues (1999) suggested a community model for health social marketing programmes. Kelly and colleagues (2003) propose a 'community readiness model' as a complementary approach to social marketing. This model differs from other community based approaches in that it examines the community stage of readiness to deal with the problem (Kelly et al., 2003).

These approaches are similar in blending social marketing principles with community development models to build capacities and create the infrastructure for behaviour change. Community development programmes operate a 'bottom up' approach (Oakley, 1989) aiming to build local capacity (Wilkinson, 1989) and are considered to have the advantage over other approaches of health promotion of addressing structural determinants of health and more potential in reaching disadvantaged populations (Shiell and Hawe, 1996). Community development approaches became particularly popular in public health in the 1960s and 1970s, influenced by the work of grass-roots political activists and educators (Freire, 1983). These participatory approaches are animated by principles of action research (Ozanne and Anderson, 2010), co-production (Ottman et al., 2011), empowerment (Wallerstein, 1992) and capacity building (Wilkinson, 1989). Within the community based social marketing framework, community members are trained in social marketing principles to be able to co-produce, plan strategically and design community activities (Bryant et al., 2007). Involving the community during all the steps of the programmes contributes to the creation of necessary structures for sustainable behaviour change (Middlestadt et al., 1997).

Evidence indicates that the integration of social marketing principles within a community approach has been applied to pro-environmental behaviour change projects (McKenzie-Mohr and Smith, 1999); physical activity (Rissell et al., 2010; Alfonso et al., 2011), nutrition (California Department of Health Services, 2004; Stead, Arnott and Dempsey, 2013), men's health (O'Brien and Forrest, 2008) and smoking (Hacker and Wigg, 2010). However, these community driven models of social marketing focus on the process of developing the programme while remain based on psychological knowledge (McKenzie-Mohr, 2000). More research is required to determine how marketing concepts can be integrated within a participatory approach and the potential of social context oriented theories to develop social marketing theory.

A number of authors argue for redefining the marketing core of social marketing and integrating new developments from mainstream marketing. The following section reviews work which argues for the integration of concepts from other marketing disciplines and development of new social marketing theory. Particular attention is dedicated to work that explored the application of new concepts inspired from

relationships (Hastings, 2003; Gordon, 2013; Peattie and Peattie, 2003) service marketing (Russell-Bennett, Wood and Previte, 2013) and value creation (Desai, 2009; Domegan et al., 2013; Russell-Bennett, Previte and Zainuddin, 2009; Zainuddin, Previte and Russell-Bennett, 2011) in social marketing. This is justified by the connection of these works with the service dominant perspective which is the object of this research.

2. 2. 3. 4 A relational perspective

From exchange to interaction

Peattie and Peattie (2003) provide a critique of the traditional social marketing theoretical concepts supporting the argument that adapting concepts from other marketing sub-disciplines such as relationship marketing, service marketing, nonprofit marketing and political marketing may be more appropriate for the field's development. These authors (2003, p. 282) propose a revision of the marketing mix and adopting a new language relevant for social contexts. As such, 'social propositions' would replace 'products', 'cost of involvement' would be used instead of 'price', 'accessibility' instead of 'place' and 'social communication' to replace 'promotion'. In the new vocabulary, competition would be framed as 'competing ideas' as this is more specific about the object of competition. The authors do not disregard the utility of the exchange principle but they argue that interaction tends to dominate social marketing activities as a key operating principle (Peattie and Peattie, 2003). These arguments for a more 'socially oriented' vocabulary for social marketing highlight the importance of articulating new theory in social marketing within the efforts to move the field forward and improve its tools for supporting behaviour and social change.

As previously illustrated in this chapter, the focus on behaviour change has been one of the central criticisms of social marketing applications (Andreasen, 2006; Wymer, 2010). Spotswood and colleagues (2012) make the point that moving away from the focus on behaviour would enlarge the scope of social marketing to consider promoting ideas. In doing that, Spotswood and colleagues (2012) make a similar case to Peattie and Peattie (2003) in arguing that the language employed in social marketing might need updating. Their argument builds on early definitions which proposed that social marketing was focused on the promotion of new ideas (Kotler and Zaltman, 1971; Wiebe, 1951/1952). However, the proposition of extending the scope of social marketing from behaviour to

ideas falls under the ethical debate regarding the lines between social marketing and social engineering (Kennedy and Parsons, 2014).

Relationship marketing

Hastings (2003) argues that a relational paradigm is more suitable for social marketing than the transactional one because it favours a different way of thinking wherein marketing is done *with* and not *to* customers. Hastings (2003) proposes a revision of social marketing based on three propositions: (1) a change from transactions to relationships; (2) a stakeholder approach and (3) equal emphasis on satisfaction and sales. A focus on relationships requires constant interaction with the audience, at each stage of the change process while customising the offering to fit their needs. A stakeholder approach means going beyond the customer to address the social context and target upstream change. Equal satisfaction and sales mean targeting behaviour change while building relationships and creating the setting for further change actions (Hastings, 2003). Hastings makes an important contribution in acknowledging the role of relationships and the importance of a stakeholder approach in social marketing. However, the perspective proposed is still 'provider' dominant (O'Malley and Prothero, 2004; Gummesson, 2008; Prahalad and Ramaswamy, 2004) operating within the framework of exchange. Limited attention is dedicated to the dynamics of those relationships and the nature of value in a social marketing context.

2. 2. 3. 5 A new social marketing mix

The challenges of the 4Ps marketing mix stimulated efforts to design new models, which are more appropriate for social change contexts. For example, French and Blair-Stevens (2007) proposed using a 'methods mix' for strategic social marketing which adds to the marketing mix other elements such as engagement, partnerships and publics. Gordon (2012) draws on Shizumu (2003), (as quoted in Gordon, 2012) 7C's model, relational thinking and consumer focus ideas from Dev and Schultz (2005), Lauterborn (1990) (as quoted in Gordon, 2012) and Grönroos (1994), to propose a 're-tooling' of the social marketing to include 'circumstances', 'organisation and competition', 'cost', 'process' and 'channels/strategies' indicating the field's tendency to address both, the downstream-individual and the upstream-context dimensions.

Tapp and Spotswood (2013) argue that the 4Ps model has little to offer to social marketing programmes that operate in a service mode, aim to change values and culture, and build on behavioural economics and psychology models. The authors (Tapp and Spotswood, 2013) argue that the complex mechanisms of change required by such programmes are difficult to fit within the narrow 4Ps framework. The authors build on Michie and colleagues' (2011) model to propose the COM-SM framework as an alternative to the 4Ps. The framework connects social marketing with the 'capability, opportunity, motivation' model of behaviour. Tapp and Spotswood's (2013) framework takes a step further in proposing a model for social marketing that accommodates strategies such as nudges, rewards and exchanges (motivation), service and support (capability) and relationships and community (opportunity). However, the model is still predominantly grounded in psychology, targeting behaviour change. In addition, the authors propose a hierarchy of COM-SM strategies where relationships and community and service support are considered necessary only when social marketing objectives are not being met by promotion and education at the motivation level.

2. 2. 3. 6 Service thinking and value (co-)creation

Despite social marketers' growing interest for new developments in marketing, there are few contributions that interrogate the application of service thinking to social marketing contexts. Scholars have started to examine core ideas such as - value creation (Russell-Bennett, Previte and Zainuddin, 2009; Zainuddin, Previte and Russell-Bennett, 2011) co-creation (Desai, 2009; Domegan et al., 2013) and service thinking in social marketing (Lefebvre, 2012; Russell-Bennett, Wood and Previte, 2013). This scholarship builds on the argument for broadening and deepening the social marketing discipline in order to effectively engage with complex social problems (Dibb, 2014; Gordon, 2013; Hastings and Domegan, 2013). Whilst making important steps towards exploring new concepts and theories already established in mainstream marketing, this body of work is mainly conceptual (excepting Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previte, 2013; Zainuddin, 2013) launching the call for exploring these new developments in social marketing. Further, these works draw mainly on service and relationship marketing as broad disciplines with less focus on the implications of SDL as a paradigm for social marketing theory and practice. In this section we review the recent

work in social marketing drawing on service thinking to better understand the areas that need further development and refining.

Desai (2009) builds on Hastings' (2003) argument for relationship marketing and argues that customer relationship management 2.0 and service logic are more appropriate for social marketing than goods marketing given their ability to accommodate the marketing of intangibles and the active role of customers. In their argument for learning from service thinking to co-create in social marketing, Desai (2009) suggests that the DART (dialogue, access, risk-benefits and transparency) co-creation model proposed by Prahalad and Ramswamy (2004) would be a valuable framework for social marketers in their attempts to target change both downstream and upstream. The author (Desai, 2009) focuses on one aspect of service logic, mainly customer co-creation of value-in-use and provides examples of social marketing programmes that applied co-creation principles. The work emphasises the active role of consumers in social marketing contexts but allocates limited attention to the challenges that co-creation might pose in such contexts. For example, the paper adopts the view that social marketing customers are empowered and networked, neglecting the implications of a co-creation perspective when dealing with vulnerable and marginalised groups. Although the author highlights that exchanges take place in network contexts, the paper concentrates little attention to the network, systems view of SDL and its implications for social marketing.

Russell-Bennett and colleagues (2009) build on service thinking to propose a model for value creation in service based social marketing programmes. Adopting a value creation view is seen as a potential solution to support individual processes and address long term behaviour change. As Desai (2009) these authors suggest that social marketing is service oriented which makes the product logic difficult to apply. Building on previous work from Holbrook (2006), Sheth and Uslay (2007), Sweeney (2003) (as quoted in Bennett, Previte and Zainuddin, 2009) and Smith and Colgate (2007) the authors adopt an experiential view to suggest six sources of customer value creation for social marketing services: information, service, interaction, environment, customer co-creation and social mandate (Russell-Bennett, Previte and Zainuddin, 2009, p. 213). The paper provides a first attempt to conceptualise customer value creation in social marketing. In later work, the authors, (Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, 2013) added empirical examples to this emerging stream of research by investigating value

dimensions in social marketing from an experiential perspective in the context of breastfeeding services. Whilst this body of work makes an important contribution by applying an experiential view on value in social marketing, more research is needed to investigate the inextricable implications of value creation at different levels (i.e. downstream, midstream, upstream) in social marketing. Further, as these scholars point out, their work centres on customer value-in-exchange. As SDL scholarship proposes, value creation can occur at different stages of interaction with an offering, and outside the 'exchange' (e.g. value-in-context, value-in-use) (Chandler and Vargo, 2011; Sheth and Uslay, 2007; Vargo and Lusch, 2008a). Other scholars supporting the integration of SDL concepts in social marketing draw attention to the need to consider the multiple stakeholders and their perception of value in social change programmes (Dibb, 2014; Gordon and Gurrieri, 2014; Lefebvre, 2012). Thus, further research should be conducted on the value creation process in social marketing as a network based process (Domegan et al., 2013) and beyond exchange thinking (Russell-Bennett, Previte and Zainuddin, 2009).

Domegan and colleagues' (2013) also build on co-creation as one fundamental principle of SDL (Vargo and Lusch, 2008a; 2008b). Their contribution notes conceptual, ethical and practical barriers to adopting a value co-creation perspective in social marketing particular in connection with citizen participation, the expert-citizen dynamic, customer value and the experiential co-creation process. In their paper, Domegan and colleagues (2013) note that co-creation is an appealing alternative to the goods-dominant logic in social marketing but that it poses the risk of narrow conceptualisations confined at the individual level. However the authors (Domegan et al., 2013) emphasise that adopting a collaborative view on value creation shows potential in explaining the governance processes (including power related issues) and defining value from different stakeholder perspectives. Their work (Domegan et al., 2013, p. 250) acknowledges the risk of adopting commercial marketing theory without careful analysis in social marketing and launches a call for further theoretical and empirical work investigating value creation and its implications as a 'network of networks approach' in social marketing. Whilst contributing a critical review of value co-creation application in social marketing Domegan and colleagues' (2013) point to the importance of investigating the potential of the systems perspective brought by SDL for social marketing.

Lefebvre (2012) draws on ideas from transformative consumer research, online technologies, SDL, design thinking, relationship marketing and public health to suggest a model for transformative social marketing based on three dimensions: scope, design and value space. The author argues for extending the scope of social marketing from changing individual behaviour to changing the marketplace. The design dimension includes honouring people, radiating value, engaging service and enhancing experiences as key principles. Finally, the value space emphasises that social marketing should be driven by trust, love, hope and dignity as key value principles (Lefebvre, 2012). The model proposed in Lefebvre's (2012) essay suggests moving beyond behaviour change to conceptualising social marketing as an approach to improve people's well-being and social welfare. As other attempts examined in this chapter (Desai, 2009; Domegan et al., 2013) to explore the applicability of commercial approaches grounded in SDL to social marketing, Lefebvre's (2012) paper concentrates on the principle of co-creation and co-design. He argues for adopting a customer-dominant view in social marketing in response to the critiques raised by the managerial driven model of social marketing. The author joins the call (Brennan and Binney, 2008; Dibb and Carrigan, 2013; Dibb, 2014; Gordon and Gurrieri, 2014; Hastings and Domegan, 2013) for a broader view of the marketing system where multiple stakeholders and factors influence individual actions. Lefebvre's (2012) work is positioned as a starting point for changing the conversation in social marketing. His 'aspirational' ideas (Lefebvre, 2012, p. 127) for 'transforming' social marketing are grounded in contemporary strands of research and disciplines that are thought to show potential for social marketing.

Russell-Bennett, Wood and Previte (2013) propose that a shift towards service-informed thinking may facilitate transition from downstream to midstream focused action. In their view, midstream social marketing should provide an understanding of how services and service employees' influence and support individual behaviour change. Russell-Bennett and colleagues (2013, p. 227) suggest four key service principles for social marketing including: the service experience, the service employee, service quality/customer value and the active role of the customer in value creation. The service informed framework is proposed for those social marketing programmes that use 'service' as part of their 'social product' (e.g. health services such as mammography testing, breastfeeding support etc.). Russell-Bennett and colleagues (2013) draw on the services marketing literature and link SDL with co-creation and active customer involvement. Their analysis also identifies

key challenges in implementing service thinking in social marketing, in particular the medical/technical view of services in the health context, the poor reputation of marketing in public sector organisations, job roles and identity, regulatory and institutional frameworks and power and control. Their work provides an initial review of service thinking propositions that show potential for developing midstream social marketing

This body of literature indicates that there is a growing interest in articulating new concepts in social marketing within the effort to evolve the field into a discipline. The shift of paradigm proposed by SDL brings a systems approach emphasising the importance of processes and context for value creation showing potential for updating social marketing theory. Despite this interest, there has been little focus on the empirical aspects of SDL and value creation in a social marketing context (Domegan et al., 2013; Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previte, 2013; Zainuddin, 2013).

This study extends the above mentioned work by examining the theoretical principles that underpin SDL and their implications for social marketing theory and practice. A systematic analysis of the core principles of these perspectives is necessary to examine their synergy with social marketing logic in order to avoid simply transferring models from commercial marketing. The review of recent work exploring service thinking and value creation in social marketing (Domegan et al., 2013; Lefebvre, 2012; Russell-Bennett, Wood and Previte, 2013) indicates an emerging interest in the collaborative processes of value creation (including facilitation, co-creation and resource integration) and the roles of different actors' involvement in facilitating behaviour and social change. As such, the study focuses on the process of value creation and actor engagement as central principles of SDL that may help to better explain the complex processes in a social change context. Efforts to examine the 'multiplicity of views' and 'the process' are highly needed to support social marketers' constructive engagement with social issues (Brennan and Binney, 2008; Gurrieri, Previte and Brace-Govan, 2013; Gordon and Gurrieri, 2014; Lefebvre, 2012; Shultz, 2007). Exploring value from multiple perspectives moves away from the 'paternalistic' model of expert driven programmes and indicates potential for democratising the process of change (Ind and Coates, 2013; Lefebvre, 2012). In a comprehensive review of social marketing development, Dibb (2014, p. 1178) concludes that 'borrowing theoretical concepts from other fields with a

more advanced understanding of stakeholder management is essential' to ensure that the challenges of such collaborations are well managed. Further, the study identifies the challenges of applying SDL principles in a social change context and the necessary adaptations. In doing so the study provides a critical view on whether and how a service perspective centred on actor engagement and value creation can support collaborative approaches and address external factors of behaviour change in a health social marketing programme. The next part of the chapter reviews SDL underlying principles and the conceptual developments brought in marketing.

2. 3 Updating the marketing core: Service-dominant logic underpinning principles

The definition proposed by Kotler and Zaltman (1971) has grounded social marketing in transactional marketing operating on goods-dominant logic. Exchange has been considered the fundamental construct in marketing for decades (Bagozzi, 1975; Vargo and Lusch, 2008a). During the last decades, in the context of service and relationship marketing, the appropriateness of exchange as the key marketing concept has been challenged and the concepts of 'interaction', 'relationships' and 'value creation' have been proposed as fundamentals of marketing (Webster, 1992; Gummesson, 2002; Grönroos, 2006; Sheth and Uslay, 2007).

The emergence of relationship marketing in the 1970's as a systems oriented approach has marked a shift in marketing discipline (Kotler, 1992; Brodie et al, 1997) which moved towards a value creation paradigm that required revisiting the exchange mechanism to accommodate active customer involvement and a stakeholder orientation (Janic and Zabkar, 2002; McKenna, 1991; Sheth and Uslay, 2007). Building, enhancing and maintaining long-term customer relationships replace the focus on sales and transactions (Gummesson, 2008) while building relationships with different publics (i.e. suppliers, competitors and employees) creates competitive advantage (Morgan and Hunt, 1994).

Following these trends, service-dominant logic (SDL) has been positioned as a 'revised theory of economics and society' (Vargo and Lusch, 2008b, p. 30). However, the

authors admit that rather than a theory, SDL should be seen as a 'mindset', a 'lens' through which to examine social and economic processes (Vargo and Lusch, 2008a). As previously stated, SDL builds upon scholarship on service management, relationship marketing, and the connectivity that emerged from developments in the on-line infrastructure (Gummesson, Vargo and Lusch, 2010). Indeed, one of the criticisms of SDL builds on the premise that Vargo and Lusch's work is mainly a 'retrospective' of old marketing ideas across disciplines (Brown, 2007). However, as other scholars noted, it is precisely this historical perspective of SDL that provides value to marketing thought (Ballantyne and Varey, 2008; Gummesson, 2011). SDL's aim to provide an integrative view of diverse perspectives and concepts across diverse fields - that have started the shift from a marketing view grounded in transactions of tangible resources - is considered timely (Aitken et al., 2006; Ballantyne and Varey, 2008; Grönroos, 2006). As the authors themselves acknowledge, SDL constitutes a step towards building marketing theory that provides a general understanding of value creation and exchange (Vargo and Lusch, 2008a). 'SD logic represents an evolution, rather than a revolution' (Gummesson, Vargo and Lusch, 2010, p. 10). This argument is supported even by critics of SDL who admit that the ideas expressed in Vargo and Lusch's work 2004; 2006) stressing a systems view where all actors participate in value creation – although idyllic - were a response to the growing criticisms of previous paradigms and anti-marketing movements (Brown, 2007). The multi-disciplinary roots of SDL indicate potential to explain the value generation processes from various stakeholder perspectives and the service management issues across networks in social marketing.

SDL is underpinned by 10 fundamental principles (FP) (Vargo and Lusch, 2004) which were later revised to reflect the contributions of other scholars to refine and develop this logic (Archpru Akaka, Vargo and Lusch, 2012; Chandler and Vargo, 2011; Vargo and Lusch, 2006; 2008a; 2014). In a later paper, Vargo and Lusch (2014) condensed the 10 propositions in 4 axioms from which the other six propositions could be derived. Table 2 provides a brief summary of these propositions and axioms. The following sections will concentrate on the SDL principles. Although the discussion is initiated by the SDL fundamental principles as defined by Vargo and Lusch (2004; 2008a), the contributions from other scholars to refine SDL are also considered. Although SDL has been received with enthusiasm by the marketing community (Peñaloza and Venkatesh, 2006) it also generated critiques regarding its philosophical and conceptual principles (Brown, 2007;

Campbell, O'Driscoll and Saren, 2013; Grönroos, 2008; 2012; Wright and Russell, 2012). These critiques will be discussed throughout the review of SDL in the following sections. As Vargo and Lusch (2008a) stressed, SDL is an emerging and still developing set of theories which are open for further elaboration and refinement.

2. 3. 1 From goods to service

The emergence of SDL (Vargo and Lusch, 2004; 2008a) has confirmed that marketing is experiencing important changes marked by a shift from product to service as a catalyst for exchange (Ballantyne et al., 2011; Bhattacharya and Korschun, 2008; Day and Montgomery, 1999; Gummesson, 1995; Rust, 1998). Three of the SDL fundamental propositions emphasise the ubiquity of service (FP1, FP2, FP5) (Vargo and Lusch, 2008a, p. 6). This logic recognises the essential role that relationships, value creation and intangibility have in the marketing process (Vargo and Lusch, 2004). In this logic, service is viewed as 'a perspective on value creation rather than a category of market offerings' (Edvardsson, Gustafsson and Roos, 2005, p.118). The focus on services means a shift from 'the means and the producer perspective to the utilisation of the customer perspective' (Gummesson, 1995, p. 251).

The classical output orientation of goods-dominant marketing is centred on how actors exchange output units while SDL is process and network oriented (Gummerus, 2013; Lusch, Vargo and Tanniru, 2010) and based on how actors exchange service (Chandler and Vargo, 2011, p. 36). As such, goods are considered distribution mechanisms for service (FP3) (Vargo and Lusch, 2004). Service based marketing challenges the traditional unidirectional transfer of value of goods based marketing concentrating on dialogue and interaction (Ballantyne and Varey, 2006). Marketing exchange is no longer driven by transactions, but is replaced by an 'open-ended process' generated by interactions 'with' customers (Ballantyne, 2004) in contrast to the conventional view of marketing 'to' customers (Ballantyne and Varey, 2006; Grönroos, 2006). Thus value creation is conceptualised as a dynamic network process where various actors interact to share and integrate resource (Archpru Akaka, Vargo and Lusch, 2012; Frow et al., 2014).

Several scholars questioned the explanation power of SDL for all marketing contexts (Brodie, Sels and Saren, 2006; Wright and Russell, 2012). In a critical account of SDL, Wright and Russell (2012) reflect on the general application of SDL and suggest that something that is said to be applicable to all contexts might lose its explanatory power. Evidence from practice indicates that some marketing contexts resonate better with other perspectives (such as goods-dominant logic) (Ambler, 2006; Brodie, Sels and Saren, 2006; Sweeney, 2007; Wright and Russell, 2012). In contributions following the seminal 2004 article, Vargo and Lusch (2014, p. 247) provide a more nuanced view of the relationship between the two paradigms emphasising that goods logic is 'nested in SDL rather than replaced by it.' Further research is required to investigate SDL concepts in different contexts in order to enhance our understanding of how and when this new perspective might be more useful.

2. 3. 2 Value creation

This section explores the concepts associated with value creation processes. Particular attention is dedicated to research (conceptual and empirical) on value networks and propositions, facilitation, co-creation and resource integration. The literature stemming from SDL has allocated a considerable interest to conceptualising co-creation of value (Ind and Coates, 2013; McColl-Kennedy et al., 2012; Payne, Storbacka and Frow, 2008; Vargo and Lusch, 2008a). However a distinction needs to be made between the processes of value creation. Sheth and Uslay (2007, p. 305) distinguish between value creation (created in the firm and then exchanged with the customer) and co-creation (created by both the firm and the customer). Other authors emphasise that the firm cannot create value by itself (Vargo and Lusch, 2008a), and that other actors than the firm participate in value co-creation. Grönroos (2012) argues that the metaphorical perspective on co-creation led to a certain confusion of which actions represent co-creation. To avoid the confusions between value creation and value co-creation, Grönroos (2012) proposes the concept of 'value formation'. The process of value formation includes *value facilitation* (when the firm/other actor acts alone to facilitate customer's creation of value-in-use), *resource integration* (by the actor who creates value-in-use for themselves) and *co-creation of value* (when the firm and the customer act together in a dialogical and interactive process that creates value for both actors involved) (Grönroos, 2011a; 2012).

Drawing on these conceptualisations, this study views value creation as a process that includes *value facilitation* (when the firm/other actor acts to facilitate customer's creation of value-in-use), *resource integration* by the customer (who creates value-in-use for themselves) and other network actors (Lusch, Vargo and Tanniru, 2010) and *co-creation of value* (when the supplier/other actors and the customer act together in a dialogical and interactive process that creates value for the actors involved (Grönroos, 2011b; 2012).

2. 3. 2. 1 A network perspective on value creation

A prominent view in the SDL literature draws on Network Theory (Archpru Akaka, Vargo and Lusch, 2012; Ballantyne et al., 2011; Frow et al., 2014; Gummesson, 2008; McColl-Kennedy et al., 2012; Vargo and Lusch 2008a) to conceptualise value creation as a network based process which includes contributions from customers, suppliers and other stakeholders in a network. Thus, value is created through a relational process and interactive experiences (Berthon and John 2006; Gummesson 2008; Gummesson and Mele, 2010). Chandler and Vargo (2011, p. 35) provide a broad perspective where value creation is 'joint integration of resources by multiple actors associated with an exchange'.

The SDL approach to value creation assumes the interplay of actors, resources and processes taking place within a network. Lusch, Vargo and Tanniru (2010, p. 20) define a value network as 'a spontaneously sensing and responding spatial and temporal structure of largely loosely coupled value proposing social and economic actors interacting through institutions and technology, to: (1) co-produce service offerings, (2) exchange service offerings, and (3) co-create value.' (p. 20). The focus on value networks has also translated into developments in the value proposition literature which marks a change from a narrow dyadic, customer-supplier perspective, to a complex view that includes multiple stakeholders or 'actors' within a service ecosystem (Ballantyne et al., 2011; Frow et al., 2014; Frow and Payne, 2011). The term value proposition used to refer to the offering crafted by the focal firm/organisation (Ballantyne et al., 2011). Ballantyne and colleagues (2011) suggest that in a service-dominant view, the meaning

of the value proposition term has extended to incorporate offerings co-created with customers and other stakeholders. These authors (Ballantyne et al., 2011) propose the term 'reciprocal value propositions' to illustrate the collaborative aspect of value creation. The literature on value propositions includes conceptual work on the role of knowledge sharing and dialogue in shaping value propositions (Ballantyne and Varey, 2006b), the reciprocity of value propositions, and their role on stakeholder relationships (Frow and Payne, 2011) value co-creation within business (Lusch et al., 2008), service ecosystems (Vargo and Lusch, 2011) and empirical work on solution networks (Jaakkola and Hakanen, 2013).

Given the prominent role of networks in recent conceptualisations of value, clarifying some of the concepts associated with a network perspective is required in order to understand the theoretical roots of SDL. Network Theory has contributed an alternative relational approach to the dominant focus on the individual in researching social processes (Borgatti and Foster, 2003; Gulati, Nohria and Zaheer, 2000; Pescosolido, 1992). Network Theory has made consistent contributions to developing marketing theory based on relational thinking (Granovetter, 1985) and interactions (Gummesson, 2007). It is important to note that 'Network Theory' is not a single theory but rather a 'perspective' or a 'paradigm' that includes different applications. The network perspective draws on a number of theories such as rational self-interest and social capital, social exchange and dependency, theories of mutual interest and collective action and cognitive theories (for a comprehensive review see Katz et al., 2004). One of its applications, Social Network Analysis (Scott, 2000) has contributed to the understanding of how the social structure of relationships around a person, group, or organisation affects beliefs, perceptions attitudes and behaviours of both individuals and the system as a whole (Hawe and Ghali, 2008). In this sense, Social Network Analysis facilitates analysis at both the individual and group level while moving the focus on interactions and patterned relationships (Pescosolido, 1992).

Simply defined, a network is a set of actors ('nodes') connected by relations ('ties' or 'edges' (Wasserman and Faust, 1994). The actors ('nodes') can be individuals, groups, organisations, concepts and societies (Borgatti and Foster, 2003). A network is defined by the nature of interaction (dyad or group based, face-to-face, mediated, and anonymous), the degree of familiarity or friendship (ties) and the pressure to conform to

expectations (the position within the network) (Vassilev et al., 2011). Lusch and colleagues (2010) propose that a value network is shaped by interactions between actors which have different competences, relationships and information.

Interactions and ties

The overall focus on servicing experiences (Flint 2006; Prahalad and Ramaswamy 2004; Vargo and Lusch 2008a) of SDL translates into a focus on interaction processes which are central to resource integration (Karpen, Bove and Lukas, 2012). From a service perspective, interaction is understood as 'service interaction' which enables actors 'to enter the value creating processes of other parties, support them and benefit from them' (Gummesson and Mele, 2010, p. 191). Interactions are seen as enabling co-creation 'spaces' and 'generators of experience and value' for the network (Ballantyne and Varey, 2006). Interaction assumes also the form of dialogue. Dialogue is understood as 'an interactive process of learning together' (Ballantyne, 2004). Through dialogue actors not only exchange information but also share their operant resources (e.g. knowledge, skills, relationships etc.) with other actors (Gummesson and Mele, 2010). The centrality of dialogue is highlighted by the view that in a changing value network the organisation's interaction with the network does not always lead to profit but to feedback and learning (Lusch, Vargo and Tanniru, 2010).

In two seminal papers Granovetter (1973, 1983) distinguished between strong ties (family and friends) and weak ties (acquaintances). Granovetter (1973) proposed the concept of the strength of ties to show that society consists of connected clusters which are linked to each other by weak but important ties. His concept of embeddedness (Granovetter, 1985) suggests that everything is embedded in networks and thus connected. Weak ties are valuable particularly because they provide people with access to information and resources that might not be available in their immediate network (family, friends – strong ties) (Granovetter, 1983). Strong ties provide individuals with socio-emotional support but they require a high level of trust (Katz et al, 2004). Archpru Akaka and Chandler (2011) indicate that social roles are considered resources for change in value networks due to their embeddedness (Granovetter, 1985). Embeddeness assumes social norms, social positions and other relationships that can be drawn upon as resources in the process of value creation (Archpru Akaka and Chandler, 2011).

In the public sector, scholarship has started to engage with Network Theory within the efforts to explain organisational collaborative capacity and partnerships (Lai, 2012), community development approaches (Chiu and West, 2007; Durie and Wyat, 2007) and chronic illness self-management studies based on social networks and social capital (Vassilev et al., 2011). In social marketing there are very few studies that engaged with the 'network perspective'. For example, Barrutia and Echebarria (2013) studied the 'network effect' (Frels et al., 2003) as a social marketing tool to facilitate adoption of complex behaviours by target adopters.

This subsection introduced some of the concepts related to a value network. It discussed the concept of 'reciprocal value proposition' to illustrate the collaborative nature of value creation. It traced the roots of collaborative value creation within the network perspective and introduced the concept of weak and strong ties as relevant for describing the nature of relationships within a network. Granovetter's (1983; 1985) work provides useful concepts to understand the relationships between the various actors (in particular staff-member of the public) engaged with a health social marketing programme. The next section concentrates on value co-creation.

2. 3. 2. 2 Co-creation

Customers as co-creators of value

A fundamental change from the goods-dominant logic is the acknowledgement that customers create value (FP6) and that firms/organisations which act as suppliers cannot unilaterally deliver value but only offer value propositions (FP7) (Vargo and Lusch, 2008a). This principle has generated debates in the literature with different interpretations regarding the process of co-creation (Grönroos, 2011a; 2012; Hibbert, Winklhofer and Temerak, 2012) and the role of the customer in relation to other actors participating in the process (Ballantyne et al., 2011; McColl-Kennedy et al., 2012; Peñaloza and Venkatesh, 2006). Following SDL, firms/organisations are 'facilitators' for their customers' processes of value creation. Other scholars noted that in fact suppliers can create value when they engage in co-creation activities with other actors in their networks (Grönroos, 2012)

The traditional marketing view operates a 'goods-dominant logic based on the value-in-exchange meaning of value' whilst SDL, is centred on 'the value-in-use meaning of value' (Vargo and Lusch, 2004, p. 7) meaning that value is created at the consumption stage by the consumer (Gummesson, 1998; Grönroos, 2008). The idea that customers create value is not new (Grönroos, 2008; Gummerus, 2013; Wikstrom, 1996). The literature prior to SDL suggests that customers create value when they 'use' products or services ('value-in-use') or when they 'consume' (Wikstrom, 1996). The novelty of the value co-creation perspective resides in a change of the customer role as an integrator of the inputs provided by the firm and other value network partners (McColl-Kennedy et al., 2012; Vargo and Archpru Akaka, 2009).

One view, associated with the customer logic, suggests that value creation processes happen in the customer sphere in their daily activities where the firm 'offerings' are resources needed to perform those activities (Arnould et al., 2006; Cova and Dalli, 2009; Grönroos, 2006; 2008; Heinonen et al., 2010). The customer logic advances the view that customers live in their own world where firms can enter only if they are allowed to do so by customers (Gummerus, 2013). This view builds on Consumer Culture Theory (Arnould and Thompson, 2005) which emphasises that value resides in the experience of consumption. Although this suggests a rational instrumental orientation, the literature suggests customers seek different types of value and that customer processes are dynamic (Arnould, Price and Malshe, 2006; Payne, Storbacka and Frow, 2008). Payne and colleagues (2008) suggest customer value creation processes are sometimes 'non-linear and unconscious' where relationship experiences shape their perception of value. According to this view, firms need to 'support the customers' processes with a set of resources' (Grönroos, 2006, p. 360).

Co-creation as an interaction based perspective

Another dominant view on co-creation centres on the interaction with other actors in customer's network. McColl-Kennedy and colleagues (2012, p. 370) propose a definition of customer value co-creation which emphasises the network aspect: customer value co-creation is the 'benefit realised from integration of resources through activities and interactions with collaborators in the customer's service network'.

In order to further the conceptual clarity, it has been proposed that co-creation occurs when all parties involved benefit from it, they participate willingly in the activities, and all contributions are acknowledged (Gummerus, 2013). The stream of literature acknowledging the interaction element of co-creation indicates that usually both parties benefit from the co-creation activities (Nambisan, 2002; Grönroos, 2006; 2008) and that co-creation is collaborative (Vargo and Lusch, 2008a). Very few scholars engaged with the negative experience of co-creation or co-destruction (Echeverri and Skålén, 2011; Plé and Chumpitaz Cáceres, 2010; Smith, 2013). Echeverri and Skålén (2011) contend that co-creation is not only positive and that sometimes it can mean destruction of value when interactions between providers and customers result in little or no value.

Although, the marketing literature differentiates between 'co-production' and 'co-creation of value' (Bolton and Saxena-Iyer, 2009; Grönroos, 2011a) it is noted that the two are linked as 'nested concepts' with co-production being a subordinate concept to that of co-creation of value (Lusch and Vargo, 2006a, p. 284). Karpen, Bove and Lukas (2012) emphasise that a service dominant orientation can create the context for co-production empowering the customers to have an active role in developing a product or a service. Hilton, Hughes and Chalcraft (2012) even question the way SDL distinguishes co-creation from co-production. These authors propose that the notion of 'resource integration' is more appropriate than 'co-production' as the latter is associated with the goods-dominant logic (Hilton, Hughes and Chalcraft, 2012).

In service marketing literature, 'customer co-production' is defined as customer participation within established parameters by the organisation (e.g. self-service checkout) (Bowen, 1986) resulting in work being transferred from the organisation to the consumer (Bolton and Saxena-Iyer, 2009). Co-creation is the result of the customer participation but unlike co-production, it does not follow pre-determined options being creative, spontaneous (Bolton and Saxena-Iyer, 2009) and customising where the customer and the firm are equals defining and solving problems together through continuous dialogue (Prahalad and Ramaswamy, 2004, p. 8). Co-creation draws on the view that value is a function of experience that comes from interactions (Prahalad and Ramaswamy, 2004; Ramaswamy, 2009; Ramaswamy, 2011), from pursuing life goals or performing social roles (Arnould, Malshe and Price, 2006). As co-creators, customers are active, knowledgeable, networked and engaged (Prahalad and Ramaswamy, 2004;

Ramaswamy, 2009). From an organisational perspective co-creation of value is a process through which customers, organisations and other network actors interact providing valuable insight on customers' desires and needs (Lusch and Vargo, 2006a).

The literature indicates that there is still limited empirical evidence about value creation processes, particularly around co-creation across contexts and roles (Archpru Akaka et al., 2014; Gummerus, 2013; Jaakkola and Hakanen, 2013; McColl-Kennedy et al., 2012; Moeller et al., 2013; Payne, Storbacka and Frow, 2008; Frow et al., 2014; Woodruff and Flint, 2006; Zwick, Bonsu and Darmody, 2008). For example, McColl-Kennedy and colleagues (2012) make an important contribution by identifying co-creation practices in a healthcare context (e.g. patients suffering from cancer). Moeller and colleagues (2013) contribute a customer role typology and suggest that customers can play multiple roles when engaging in collaborative value creation. Another study which examined value co-creation in assessing higher education teaching quality highlighted the influence of all interacting actors in the process of value creation (Díaz-Méndez and Gummesson, 2012). Minkiewicz, Evans and Bridson (2014) build on an empirical study to suggest that through personalisation, engagement and co-production customers co-create experiences which lead to value.

This section explored the different conceptualisations of co-creation of value in marketing. The review noted the distinction between co-creation and co-production and the implications of adopting one term or another. Further, the different understandings of co-creation of value as a perspective centred on customers' activities (through consumption) and as interaction based have been also discussed. It is important to note that one perspective does not exclude the other as both understandings are customer centred. This study uses the term co-creation to refer to the perspective on value creation based on interactions between network actors (McColl-Kennedy et al., 2012). The following section covers the different conceptualisations of resource integration as a value creation process.

2. 3. 2. 3 Resource integration

The concept of resources is central in SDL as it advances several principles about different types of resources and actors (Vargo and Lusch, 2004; 2008a). SDL emphasises

the integration of resources as an essential function for both the organisation and the customer in the process of value creation (FP9) (Vargo and Lusch, 2004; 2008a). One of the interpretations of value co-creation is that the customer integrates resources in relation to a value proposition to obtain value-in-use (Vargo and Lusch, 2008a). This means that the organisation becomes a 'facilitator' for customers' value creation (Grönroos, 2006; 2008), providing co-creation opportunities for the other actors involved (Payne, Storbacka and Frow, 2008) and building relationships with the customer (Grönroos, 2011b) and other stakeholders (Gummesson, 2008).

The literature (Vargo and Lusch, 2004; Madhavaram and Hunt, 2008) distinguishes two broad categories of resources: operand resources which are typically physical (raw materials or physical products); and operant resources, which are typically human (skills and knowledge of customers and employees), organisational (routines, cultures, competencies), informational (knowledge about markets, competitors, and technology), and relational (relationships with competitors, suppliers, and customers). Arnould and colleagues (2006) define consumer operand resources as tangible resources (including economic resources, material objects and goods) over which the consumer has 'allocative' capabilities. Operant resources are intangible including social (family relationships, consumer communities, commercial relationships), cultural (specialised knowledge and skills, history, imagination) and physical resources (energy, strength, emotion) (Arnould, Price and Malshe, 2006).

One of the core principles of SDL is the focus on knowledge and skills of both providers and customers as key resources that are integrated in the process of value creation (Vargo and Lusch, 2004). In revised versions of SDL, the competitive advantage is created through operant resources, rather than through operand resources (FP4), with knowledge and skills being the fundamentals that operate on resources to produce a favourable customer experience (Vargo and Lusch 2008a; Normann and Ramirez, 1993). The roots of this distinction between operant and operand resources and the superiority of the former is associated with Western philosophy and traced back to Greek philosophy which has traditionally privileged 'mental life over material/physical objects' (Campbell, O'Driscoll and Saren, 2013, p. 307).

The SDL stated superiority of operant resources to operand resources has generated one of the prominent criticisms to SDL (Brown, 2007; Campbell, O'Driscoll and Saren, 2013; Wright and Russell, 2012). Indeed such emphasis on operant resources poses the danger of neglecting the role of operand resources as physical resources with implications for environment (Campbell, O'Driscoll and Saren, 2013; Wright and Russell, 2012). Given the challenges that our society faces in terms of resource depletion due to global issues such as globalisation, supra-population, environment protection, poverty and inequalities, a discussion about resources cannot diminish the importance of operand (tangible) resources for creating value (Campbell, O'Driscoll and Saren, 2013). Further, an overemphasis on operant resources and human agency might be interpreted as minimising the effect operand resources as structures might have on operant resources (Campbell, O'Driscoll and Saren, 2013).

Despite a growing body of research, the concept of resource integration - as central to the process of value creation - is still under-theorised in the literature (Peters et al., 2014). One definition conceptualises resource integration as the process through which multiple actors interact to draw on their own resources and others' to create value (Chandler and Vargo, 2011; Vargo and Lusch, 2008a). For example, Vargo and Lusch (2008a, p. 7) define resource integration as the process through which various actors (organisations, households, and/or individuals) 'integrate and transform micro-specialised competences into complex services that are demanded in the marketplace'. Grönroos (2011a; 2012) defines resource integration as the process through which actors create value-in-use (for themselves). Later developments of SDL recognise the centrality of networks to understand resource integration (Vargo, Maglio and Akaka, 2008; Vargo, 2008). In this view resource integration is a network-oriented process with 'all parties uniquely integrating multiple resources for their own benefit and for the benefit of others' (Vargo, 2008, p. 211).

In a service perspective resources are not static but changing, evolving and devolving when the context diminishes existing resources because of the lack of enabling resources (Vargo and Lusch, 2004; Chandler and Vargo, 2011). A key characteristic of the resource integration process is that the service context facilitates the creation of new potential resources through access to additional resources (Vargo and Lusch, 2011). As 'operant resources produce effects they enable humans both to multiply the value of

natural resources and to create additional operant resources' (Vargo and Lusch, 2004, p. 3). Resources can even lose their status as resources if they are no longer employed in the value creation process (i.e. their functionality is enabled by the disposition to serve a specific purpose) (Löbler, 2013).

Gummesson and Mele (2010) elaborate on the dynamics of the resource integration process and propose different forms of the process: complementarity (resources that complement each other to create a whole), redundancy (sharing similar resources contributes to creating knowledge) or mixing (different and similar resources) in which the actors are engaged in 'matching' resources, processes and outcomes in order to co-create value. Resource integration is not simply joining resources but the careful 'incorporation' of resources by an actor into another actor's process (Gummesson and Mele, 2010, p. 195). Peters and colleagues' (2014) conceptualise resource integration as emergence (i.e. creating new properties) and an interaction-based process. Despite the distinction advanced, the authors (Peters et al., 2014) admit that any social activity includes an element of interactivity which means that resource integration as emergence does involve interaction.

Resource integration is linked with the notion of agency and capabilities (Kleinaltenkamp et al., 2012; Peters et al., 2014). Resource integrators are seen as actors who have agency, integrating operant and operand resources (Kleinaltenkamp et al., 2012). Agency is defined as the ability of self-reflexive actors to act (Archer, 2000). Sewell (1992) defines resources as polysemous, 'embodying cultural schemas' (rules) in a specific context. Resources are 'sources of power' (Sewell, 1992) that may be mobilised to reshape the existing structures. Another definition indicates that resource integration is 'the ability of consumers to employ their resources individually, or collectively as co-consumers, to determine and enhance their own consumption experiences' (Baron and Harris, 2008, p. 115). The process of resource integration is seen as a socio-cultural process being shaped by actor expectations, goals, needs and capabilities (Arnould, Price and Malshe, 2006; Gummesson and Mele, 2010). Campbell and colleagues (2013) propose an alternative view of operant and operand resources as 'co-evolving interdependents' which accepts that actors can also be acted on by resources. This perspective points to the influence that operand resources (physical spaces, economic resources, material objects and goods) might have on enabling or

inhibiting action. Despite the emphasis on the dynamic creation effect and the focus on operant resources, the emerging empirical work on resource integration suggests the interplay between operant and operand resources (Piacentini, Hibbert and Hogg, 2014).

Despite the growing body of literature on SDL, there are very few empirical studies dedicated to resource integration (Baron and Harris, 2008; Jaakkola and Hakanen, 2013; Piacentini, Hibbert and Hogg, 2014). Piacentini and colleagues (2014) investigated resource integration in relation to vulnerable groups and consumers in a public service context. Baron and Harris (2008) provide an account of consumers and 'co-consumer' experiences with resource integration in the context of an experiential episode (i.e. a campaign to save a local cinema). Jaakkola and Hakanen (2013) examine how actors integrate resources to develop integrated solutions. Their study suggests that in value networks dominated by operant resources the processes of integration are difficult to plan (Jaakkola and Hakanen, 2013). The existing studies point to the dynamics of resources more broadly and the effect of operant resources to activate other resources and generate value as a still under-researched area (Baron and Harris, 2008; Piacentini, Hibbert and Hogg, 2014).

This section reviewed the various conceptualisations of resource integration in the SDL literature. This research draws on these conceptualisations to define resource integration as a socio-cultural process (Arnould, Price and Malshe, 2006; Gummesson and Mele, 2010) through which actors 'act' upon their own resources and resources from other actors in their own network (Chandler and Vargo, 2011) to incorporate and transform them according to their own expectations, goals, needs and capabilities. The review discussed resource integration as emergence and interaction noting the links with other definitions which highlight the dynamic, transformative effect of resource integration. This literature highlights the centrality of operant resources in the process of value creation. However, the review notes that emerging research suggests the interplay between operand and operant resources and the need for further research on actors' resource integration processes.

This segment concluded the section dedicated to the value creation processes. The Chapter continues with a discussion of the concept of value to provide an understanding of the recent developments stimulated by SDL. Understanding value in a social

marketing context is essential to be able to develop programmes that are sensitive to the context of their audiences and address potential barriers to change.

2. 3. 3 Defining value

2. 3. 3. 1 Value-in-use and value-in-context

SDL adopts the principle that value is not derived from acquisition - a principle enounced in the early marketing tradition (Alderson, 1957) - but it is co-created by consumers and other actors in their network through the integration of operant and operand resources (Vargo and Lusch, 2004; McColl-Kennedy et al., 2012). Sheth and Uslay (2007) emphasise marketing is moving towards a value creation paradigm that encourages marketers to move beyond value in exchange to other types of value (i.e. information, disposal) and involve stakeholders and networks (p. 303). The concept of 'value-in-use' is proposed to define consumer perceived and experienced value (Vargo and Lusch, 2004). Macdonald and colleagues (2011, p. 671) define value-in-use 'as a customer's outcome, purpose or objective that is achieved through service.'

Recent SDL informed work uses the terms value-in-context and value-in-use interchangeably (Chandler and Vargo, 2011; Vargo and Lusch, 2012). Although initially the term of value-in-use was proposed as an alternative to the term value-in-exchange (Vargo and Lusch, 2004; 2008a) scholars pointed out that it is focused on the end user actor neglecting the contextual nature of the process of value creation (Chandler and Vargo, 2011). Thus, later developments on SDL propose the term 'value-in-context' to emphasise the role the context dimension has in the process of value creation (Chandler and Vargo, 2011; Vargo and Lusch, 2012). In response to other scholars who raised the issue of distinguishing between different value creation processes (Grönroos, 2011a; 2012) value-in-context recognises that value is not always co-created and that it depends on the availability and integration of resources (Vargo et al., 2010). Other scholars (Campbell, O'Driscoll and Saren, 2013) who emphasise the importance of operand resources suggest the concept of 'value-in-underuse' for situations that require conservation of resources (e.g. forests, soil, fish, etc.).

The context dimension is important because it provides a frame which takes into account the uniqueness of each actor's perspective (Chandler and Vargo, 2011). Edvardsson, Tronvoll and Gruber (2011) propose that value should be seen as 'value-in-social-context' as the way resources are assessed depends on the social context where they operate. This means that customer's position, their role, their way of interacting, and the language used, are all resources that should be taken into account when making value propositions (Edvardsson, Tronvoll and Gruber, 2011). However, as Campbell and colleagues (2013) note, value-in-context also assumes a notion of 'affective' value - that there is a shared view of value within a certain network. One might argue that the complexity of networks makes it difficult to achieve this 'collective' view of value, in particular in social change contexts which gather actors who might have conflicting views (Domegan et al., 2013). As with other principles of SDL, the concept 'value-in-context' needs further exploration in empirical contexts to better understand how the variety of views and value perceptions are navigated.

2. 3. 3. 2 From functional to experiential value

Conceptual and empirical studies on value (Babin, Darden and Griffin, 1994; Sanchez-Fernandez and Iniesta-Bonillo, 2007; Sheth, Newman and Gross, 1991; Sweeney and Soutar, 2001) indicate that the concept of customer value is still ambiguous (Gummerus, 2013; Karababa and Kjeldgaard, 2014). Value has been generally researched and conceptualised in terms of outcomes, or what the customer receives in exchange (Echeverri, and Skålén, 2011; Gummerus, 2013). Other authors (Babin and James, 2010, p. 471) state that value is a concept 'that captures the result of service'.

SDL with its focus on co-creation has challenged the traditional economic perspective on value where value was an evaluation of costs versus benefits. The revised foundational propositions of SDL (FPs) suggest the phenomenological dimension of value. FP6 proposes that 'the customer is always a co-creator of value', and FP10 posits that 'Value is always uniquely and phenomenologically determined by the beneficiary (Vargo and Lusch, 2008a, p. 7). Although this proposition has been contested by scholars (Echeverri and Skålén, 2011; Grönroos, 2008; 2011a) as confusing, as 'co-creation' requires interaction, others suggested that the proposition refers to a customer centric perspective on value (Gummerus, 2013; Vargo and Lusch, 2012). According to this view,

determination of value by the customer is seen as phenomenological and relating to the experiential dimension of value (Gummerus, 2013). Although a co-creation perspective emphasises the experiential dimension of value (Prahalad and Ramaswamy, 2004; Ramaswamy, 2009; 2011) the phenomenological approach is seen as being more explicitly taking a step further in discovering 'the deeper meaning of the 'lived' experience in terms of the individual's relationship with time, space, and personal history' (Goulding, 2005, p. 303). Peñaloza and Venkatesh (2006) propose a value creation view that includes 'meanings'. As Khalifa (2004) notes, value as meaning moves beyond experience in the sense that it is connecting the experience with an individual's personal beliefs. The difference between experience and meaning is understood as the difference between 'living through' versus 'living for' (Khalifa, 2004, p. 657). However, Vargo and Lusch (2008a) admit that phenomenological and experiential can be used interchangeably.

Work stemming from SDL acknowledges that value is an 'elusive' concept (Echeverri and Skålén, 2011; Grönroos, 2012; Gummerus, 2013; Karababa and Kjeldgaard, 2014; Vargo et al., 2008; Woodall, 2003), based on an evaluative judgement (Hilton, Hughes and Chalcraft, 2012). Vargo and Lusch (2008a) present value as a phenomenon that is '…idiosyncratic, experiential, contextual and meaning laden' (p. 7). Holbrook (2006, p. 715) defines customer value as 'interactive, relativistic, preference experience.' Although value creation takes place at the network level (Gummerus, 2013; Vargo, 2009) value outcome determination takes place at the individual level (e.g. in customer's sphere). Thus, value is subjective, based on the personal judgement of the beneficiary and it emerges from the customer/user interaction with the object (Hilton, Hughes and Chalcraft, 2012) and interaction with other value network actors (McColl-Kennedy et al., 2012). The following section will explain these concepts in more detail whilst concentrating on the notion of perceived value and value as co-created as they are central to SDL and the objectives of this study.

2. 3. 3. 3 Multi-faceted value

The marketing literature indicates different conceptualisations of value into multiple dimensions (Babin, Darden and Babin, 1998; Gummerus, 2013; Holbrook, 2006; Sanchez-Fernandez and Iniesta-Bonillo, 2007; Sheth, Newman and Gross, 1991).

Previous reviews on value outcomes have focused on 'value as means–ends' (functionality), 'value as benefits/sacrifices' (solutions) and 'value as experience outcomes' (experience) (Karababa and Kjeldgaard, 2014; Sanchez-Fernandez and Iniesta-Bonillo, 2007; Woodall, 2003). Khalifa (2004) notes a fourth form of customer value as 'meaning' and Gummerus (2013) notes that from an SD perspective, value is conceptualised as phenomenological.

The 'means/ends' perspective is based on the idea of customer as a rational agent whose perception of value draws on a careful analysis of offering's utility (Khalifa, 2004). Similar to the means/ends, the view of 'value as benefits/sacrifices' envisages customer perceived value as utility (Bolton and Drew, 1991; Zeithaml, 1988) based on inputs (benefits) and outputs (sacrifices). Johnson and colleagues (2006, p. 123) note that value is a comparative judgment, in that it 'encompasses perceptions of quality given price and inputs versus outputs relative to the competition'. These conceptualisations have received criticisms because of their reliance on customer cognitive information processing (Payne, Storbacka and Frow, 2008) and rationality which assumes perfect access to information and neglects the impact of emotions on decision making (Hunt and Morgan, 1996).

The conceptualisations of value provided by Holbrook (1996; 1999; 2006), Babin, Darden and Babin (1998) and Sheth, Newman and Gross (1991) articulate the multi-dimensions of value that can range from functional/utilitarian to emotional/hedonic and epistemic. Holbrook (2006) distinguishes between *extrinsic value* (where value is instrumental and functional as a means-to-an-end derived from the consumption experience) and *intrinsic value* (where a consumption experience is an end-in-itself). According to Holbrook (2006) value can also be *self-oriented* (where value of the product or consumption experience is sought for its effects on the customer) and *other-oriented value* (where value of the product or consumption experience resides in how others respond to it, or what effect it has on them). Other authors (Babin, Darden and Babin, 1998) distinguish between utilitarian (task-related and rational) and hedonic (personal and emotional) value.

Sheth and colleagues (1991) identify five different types of consumption value including: functional, social, emotional, epistemic and conditional value. *Functional value* is

defined as the perceived utility acquired from performance and functionality (Sheth, Newman and Gross, 1991). Traditionally, in an economic exchange view, functional value was seen as the main type of value consumers sought when engaging in exchange (Sheth, Newman and Gross, 1991). Functional value is utilitarian (Babin, Darden and Babin, 1998) extrinsic and self-oriented, serving as a means to customer's objectives (Holbrook, 2006). *Social value* is extrinsic and other-oriented (Holbrook, 2006) resulting from an offering association with social groups (Sheth, Newman and Gross, 1991) and its ability to shape the behaviours of others (Holbrook, 2006). *Conditional value* (Sheth, Newman and Gross, 1991) is the result of a specific situation or context and enhances the functional or social value. *Emotional value* or *hedonic value* (Hobrook, 2006; Babin, Darden and Babin, 1998) is intrinsic and self-oriented and it derives from the offering capacity to arouse feelings or affective states (Sheth, Newman and Gross, 1991). Sheth and colleagues (1991) suggest value can be also *epistemic* if the offering arouses curiosity, provides novelty or satisfies the desire for knowledge. Value has also been defined by its altruistic dimension. *Altruistic value* is intrinsic and directed towards others (Holbrook, 2006) as a self-fulfilment or a sense of well-being (Zainuddin, Previte and Russell-Bennett, 2011). It resides in the individual's concern for how their consumption behaviour affects others (Holbrook, 2006), which is particularly relevant in social marketing (Zainuddin, Previte and Russell-Bennett, 2011).

The typology of value model proposed by Holbrook (1996; 1999) was identified as the most comprehensive in a systematic review of the literature on perceived value (Sánchez-Fernández and Iniesta-Bonillo, 2007). Holbrook's work opens the research avenues for value as experience outcomes. Unlike the other perspectives on value which envisage humans as rational agents, value as experience acknowledges the importance of emotions and sees humans as emotional sensation seekers (Gummerus, 2013).

Health behaviour change programmes have been traditionally promoting a utilitarian/functional value perspective where the audience is encouraged to act rationally based on the information provided and make the best decisions for their own health. More recently, health social marketing programmes such as Change 4 Life, Vitality and Verb, have started to use relational and experiential strategies to create value propositions that appeal to the emotional dimension of value. These programmes provided service-led initiatives, skills building sessions and fun activities to engage the

audience and give them the opportunity to have positive experiences of the behaviour promoted (ShowCase NSMC, no date; Wong et al. 2004). Despite these examples from practice, there is limited theorisation and empirical research on 'customer' value in social marketing (Fry, 2010; Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, 2013). A study examining customer value in a social marketing wellness service suggests that self-oriented emotional and functional dimensions of value appear to dominate this context (Zainuddin, Previte and Russell-Bennett, 2011). Emerging research has started to engage with the experiential aspect of value in social marketing contexts in relation to alcohol consumption (Fry, 2010; Fry et al., 2014; Piacentini and Banister, 2009; Spotswood and Tapp, 2013; Szmigin et al., 2011). These studies focus on understanding alcohol consumption from the 'customer's perspective' highlighting the limitations of social marketing programmes that focus on self-responsibility and a medical model whilst neglecting the environment and the context of 'an intoxication culture' (Szmigin et al., 2011, p. 759).

Having examined the various conceptualisations of value as outcome, the discussion continues with a review of the concept 'customer engagement'. The prominent role of customers as value creators requires unfolding the different stages of action, motivational state and processes involved (Brodie et al., 2011) when active actors engage in value creation.

2. 3. 4 Customer engagement

The relational perspective in marketing recognises customer engagement as a central concept in the process of value co-creation (Brodie et al., 2011; Grönroos, 2000). A service centred view is considered 'inherently customer oriented and relational' posits one of the fundamental principles of SDL (FP8, Vargo and Lusch, 2008a, p. 7).

In a comprehensive review Brodie and colleagues (2011) highlight that the term 'engagement' has been explored in different conceptual approaches in fields including psychology (Huo, Binning and Molina 2009), sociology (Mondak et al., 2010), political science (Resnick, 2001), organisational behaviour (Catteeuw, Flynn and Vonderhorst, 2007), management (Greenwood, 2007) and health (Cornwall and Jewkes, 1995). For

example, Saks (2006, p. 600) defines employee engagement as 'the amount of cognitive, emotional and physical resources an individual is prepared to devote in the performance of one's work roles'. Higgins and Scholer (2009, p. 102) define engagement as 'a state of being involved, occupied, fully absorbed, or engrossed in something – sustained attention.'

The literature has generally adopted a three-dimensional perspective of engagement (i.e. cognitive, emotional and behavioural) (Hollebeek, 2013; Brodie et al., 2011; May et al., 2004). Patterson and colleagues (2006) articulate the multidimesion of engagement which is 'the level of a customer's physical, cognitive and emotional 'presence' in their relationship with a service organisation'. Customer engagement has been analysed as 'psychological process' (Bowden, 2009) with a focus on emotional and cognitive aspects; as customer 'engagement behaviours' with a focus on customer activities (Van Doorn et al., 2010); as a process centred on interactive experiences (Brodie et al., 2011); or as an active relationship with a 'focal object' or brand (Mollen and Wilson, 2010). Vivek and colleagues (2012, p. 127) emphasise the participatory dimension of customer engagement: 'the intensity of an individual's participation and connection with the organisation's offerings and activities initiated by either the customer or the organisation'.

The engagement concept builds on the 'who engages with what' perspective in the literature, which addresses the engagement subject (e.g. customer) and the engagement object (e.g., a brand, product, category or organization) (Hollebeek, 2011, p. 789). The definition provided by Brodie and colleagues (2011) is considered comprehensive as it explicitly identifies both the engagement subject/object (actor/organisation or offering) and acknowledges that engagement can be seen as both, a psychological state and process (Hollebeek, 2013). Drawing on the conceptualisations of authors such as Patterson, Yu, and de Ruyter (2006), Hollebeek (2011), Mollen and Wilson (2010), Brodie and colleagues (2011, p. 262) define customer engagement as a 'multidimensional concept', a 'psychological state' that occurs in a dynamic stakeholder context due to interactive, co-creative customer experiences with a focal agent/object in focal service relationships.' Brodie and colleagues' (2011) definition recognises the multidimensional nature of engagement and emphasises the interactive experience which provides a broad conceptual framework that resonates with the SDL view.

A number of scholars, (Cova and Dalli, 2009; Ind and Coates, 2013; Zwick, Bonsu and Darmody, 2008) adopt a critical stance to customer engagement and participation as producer and collaborator in the marketing process. Cova and Dali (2009) raise the issue of exploitation and argue that even when consumers play the role of producers they cannot fully benefit from their labour. Zwick and colleagues (2008) argue that the discourse of value co-creation is linked with a notion of corporate power which allows consumers to work within their own terms. The notion of value-in-context which assumes that value is co-created neglects the economic dimension of value which belongs to the brand's shareholders (Campbell et al., 2013; Zwick, Bonsu, and Darmody 2008). Peñaloza and Venkatesh (2006, p. 307) critique the view of customers as operant resources and argue that from this perspective SDL continues the 'objectified treatment of customers'. Ind and Coates (2013) suggest that co-creation is often used to denote an approach that favours customer involvement to 'create' tangible and/or intangible things. In both cases, this narrow understanding of co-creation is considered to lead to a managerialist orientation in which customers' participation is instrumental for the focal organisation (Ind and Coates, 2013).

Contrary to this position, a number of authors (Firat, Dholakia, and Venkatesh 1995; Firat and Venkatesh 1993) argue that becoming a producer liberates the postmodern consumer from the previous role of consumer. Etgar (2008, p. 105) also challenges the deterministic view arguing that co-production can be considered an 'explicit consumer strategy' to achieve customisation of the offerings. In their review of literature strands underpinning co-creation, Ind and Coates (2013, p. 92) indicate that adopting a broader view of actor engagement and co-creation as a network based, more spontaneous and 'playful' process can contribute to 'participation and democratisation that does create meaning for all'.

As previously discussed in this chapter, recent marketing trends articulated by SDL highlight the actor-to-actor, collaborative feature of value creation (Bhattacharya and Korschun, 2008; Gummesson, 2008; Vargo and Lusch, 2008a; Vargo, Maglio and Archpru Akaka, 2008). Further, social marketing programmes usually require understanding and cooperation of multiple actors to address the complex layers of change. Relationship marketing and stakeholder theory have made important

contributions to acknowledging the implications of marketing on other actors than customers and the firm. The following section covers stakeholder engagement as another key concept necessary to understand a service orientation and value creation.

2. 3. 5 Stakeholder engagement

Freeman's influential text (1984) defined stakeholders (p. 46) as: 'all of those groups and individuals that can affect, or are affected by, the accomplishment of organisational purpose'. Recently Polonsky and colleagues (2003) stated that there are 'no universally accepted definitions of stakeholder theory or even what constitutes a stakeholder' (p. 351). One view distinguishes between primary stakeholders, considered absolutely necessary for the business (e.g. employees, customers, suppliers, investors and shareholders) and secondary stakeholders, usually not engaged in transactions with the organisation and not essential for survival (e.g. media, trade-associations, non-governmental organisations) (Maignan, Ferrell and Ferrell, 2005, p. 959).

Traditional marketing was centred on the firm and profit maximisation with less attention given to the rest of the stakeholders. However, complex changes in the society such as climate change, obesity crises, human rights violations and the pressure from activists and public raised the issue of a new role for marketing challenging organisations to extend their focus from the customer and immediate profit to adopt a network centric approach that includes stakeholders (Bhattacharya and Korschun, 2008; Bhattacharya, 2010). A service perspective adopts a stakeholder approach with an emphasis on collaboration beyond the immediate transaction (Payne, Ballantyne and Christopher, 2005). This can involve creating exchanges of mutually beneficial value (Christopher et al., 2002), interactions within networks of relationships (Gummesson, 1995; 2008; Prahalad and Ramaswamy, 2004), and mutual commitment and trust (Morgan and Hunt, 1994). Lusch and Vargo (2006a) argue that the context is essential in the process of value creation and that the social, ecological, and governmental aspects are important resources that are integrated in the process of value creation. This means that in an 'actor-to-actor' mode (Vargo and Lusch, 2011) value is being co-created with stakeholders that include firms, employees, customers, stockholders, government agencies, and other entities involved (Vargo, Maglio and Archpru Akaka, 2008, p. 148).

The management literature identifies two different perspectives on the stakeholder approach: a strategic one where stakeholder engagement is required to achieve firm success (Noland and Philips, 2010) and a moral one where it means 'maximising social welfare and minimising the level of harm produced within the exchange process' (Polonsky et al., 2003, p. 351). Greenwood (2007) argues that the predominant view of stakeholder engagement in business is related to corporate social responsibility practices. Stakeholders are seen providing both tangible (operand) and intangible (operant) resources to the focal organisation (Freeman, 1984; Maignan, Ferrell and Ferrell, 2005). As operant resources stakeholders may bring knowledge, values and norms that shape organisational practices (e.g. regulations on child labour, fair trade). As operand resources they may bring financial capital and existing infrastructure (Maignan, Ferrell and Ferrell, 2005). These managerial approaches to stakeholder engagement indicate a rather functionalist perspective. Less attention was given to stakeholder engagement from a service dominant perspective which articulates the subjective and collaborative nature of value. As other authors point out (Greenwood, 2007) stakeholders play different roles and have different power positions which raises the question of the benefits they might obtain from engaging with an organisation. Furthermore, stakeholders' values and norms might clash with the focal organisation's objectives (Maignan, Ferrell and Ferrell, 2005) which creates tensions and points to the challenge of negotiating value in collaborative value creation networks.

The view that value creation is a collaborative process which involves interacting with various actors that are part of a network assumes stakeholder engagement as a central principle. However, management of the myriad of stakeholders is identified as a challenge in both commercial (Maignan, Ferrell and Ferrell, 2005) and social marketing contexts (Dibb, 2014; Domegan et al., 2013; Gordon, 2013; Russell-Bennett, Wood and Previte, 2013; Stead, Arnott and Dempsey, 2013). Recent work stemming from SDL investigated stakeholders in relation to value propositions (Ballantyne et al., 2011; Frow et al., 2014). This work is relevant for social marketing in the context of finding new ways to increase reflexivity of the social change processes (Gordon and Gurrieri, 2014) and the critical implications of this process at different levels (Gurrieri, Previte and Brace-Govan, 2013). Polonsky and colleagues (2003) make an important contribution in articulating the role of stakeholders in creating value in the public policy area by

minimising the harm caused by marketing activities. The authors (Polonsky et al., 2003) stress the need to consider different 'exchange phases' and the dynamic of relationships with stakeholders over time. Despite the importance of partnerships, little attention has been dedicated to researching stakeholder engagement and value in a social marketing context (Gordon and Gurrieri, 2014). Traditional social marketing theory centred on dyadic exchanges (Domegan et al., 2013) is limited in accommodating the focus on multiple stakeholders' perspectives. Complex interactions amongst stakeholders in a value network raise indeed the issue of governance and accountability and there is an identified need to investigate the management of these networks of relationships (Domegan et al., 2013; Gordon and Gurrieri, 2014; Polonsky et al., 2003; Wilkinson and Young, 2002).

Stakeholders in this study refer to those actors who are engaged as partners of the organisation developing the social marketing programme. Although members of the public are also stakeholders in social marketing programmes, this study will make the distinction between these two groups given the different roles they usually play and the members of the public status as 'customers'/service users and direct beneficiaries of such programmes. Having made this distinction which was necessary to understand the marketing developments to date, the study uses the generic term 'actor' to refer to both member of the public and staff of collaborating agencies and focal organisation. This is consistent with SDL and other service oriented groups such as the Industrial Marketing and Purchasing (IMP) Group (Gummesson and Mele, 2010; Vargo and Lusch, 2008a). SDL uses the term actor to refer to resource integrators. The term 'actor' is preferred to making the distinction between 'customers', 'firm', 'stakeholders' which might suggest different positions of power in a value network. The term 'actor' is more appropriate in a context such as the social marketing programme under analysis, given the variety of participants and the changing roles in the network (e.g. the role of collaborating staff as main actors in implementing the programme, the role of 'service users' as co-creators within their own networks).

This section explored the concepts of customer and stakeholder engagement to provide an understanding of these concepts in the light of SDL. In the next section attention turns to motivation of actors for engaging with the value proposition.

2. 3. 6 Motivation for engagement

Exploring actor engagement requires understanding motivation as factors that energise and guide the behaviour of one individual (Moisander, 2007; Ryan and Deci, 2000). Examining actor motivation allows for understanding how engagement changes over time. From a SDL perspective, consumer engagement is linked with a 'motivational state' (Brodie et al., 2013). Fishbach (2009) refers to engagement as 'motivation to act' suggesting that goals can motivate engagement. Other scholars indicate that engagement moves beyond motivation to a 'maintained state' or 'sustained attention' (Scholler and Higgins, 2009).

One of the basic definitions of motivation distinguishes between *intrinsic motivation and extrinsic motivation (*Ryan and Deci, 2000; Ryan et al., 2009). *Intrinsic motivation* refers to performing an activity because it is interesting or enjoyable and it is associated with high quality learning, creativity, greater autonomy and feelings of competence (Ryan and Deci, 2000; McDonald, Harrison and Checkland, 2008). In this sense the activities driven by intrinsic motivation are seen as being rewards themselves (Ryan and Deci, 2000). E*xtrinsic motivation* refers to performing an activity because it leads to a separable outcome and it may be driven by external pressures or rewards (Ryan and Deci, 2000, p.71).

Prominent motivation studies draw on Self-Determination Theory (Ryan and Deci, 2000). Self-Determination Theory is an approach to human motivation and personality that is centred on humans' inner resources for personality development and behaviour self-regulation (Ryan, Kuhl and Deci, 1997). In particular, Self-Determination Theory holds that the innate psychological needs for competence, autonomy, and relatedness are central to human motivation (Deci and Ryan, 2000). Work drawing on Self-Determination Theory (Ryan and Deci, 2000; Ryan et al., 2008) identified different forms of extrinsic motivation. Extrinsic motivation can range from external regulation (e.g. complying with an external request) to forms of identification and internal regulation (Ryan et al., 2009). Through 'identification' the actor identifies with the behaviour to adopt whilst internal regulation occurs when the regulations have been assimilated and synced with personal beliefs (Ryan and Deci, 2000). In a health

behaviour change context motivation is usually associated with autonomy and competence as critical to the processes of internalisation and identification (Ryan et al., 2008).

Extrinsic motivation is often examined in relation to rewards and competition (Benabou and Tirole, 2003; Ryan and Deci, 2000). However, the literature indicates that competition and rewards are in fact seen as undermining intrinsic motivation (Reeve and Deci, 1996; Ryan and Deci, 2000; McDonald, Harrison and Checkland, 2008). Further, drawing on different studies, Ryan and Deci (2000) state that also threats, deadlines, directives and competition pressure have a negative effect on intrinsic motivation. Choice and self-direction are associated with a greater sense of autonomy which enhances intrinsic motivation (Gagné and Deci, 2005; Ryan and Deci, 2000).

In a social marketing context motivation has been explored generally in relation to individual behaviour change (Spotswood and Tapp, 2013; Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, 2013) but less attention has been dedicated to the motivation of other actors that are identified as key stakeholders (e.g. midstream actors such as community services staff) (Dibb, 2014; Whitelaw et al., 2010).

This part of the chapter reviewed SDL principles including value creation as a network based process comprising facilitation, co-creation and resource integration, the multi-dimensions of value-in-context and actor engagement and motivation. The review identified further areas for research in connection with social marketing applications. The last part of this chapter explores these concepts in public health which is the empirical context of this research.

2. 4 Rationale for a service orientation in health

As previously mentioned in this chapter, although marked by confusion and debates regarding ethical implications and applicability, social marketing grew to become a popular approach in the public health area. The following section examines how SDL principles are reflected in the public health literature and whether this literature supports the transition towards a service orientation.

2. 4. 1 Participation and co-production in health

In the light of the limitations and criticisms of the consumerist approach (Alford, 2002) it has been suggested that the SDL literature can provide an area for a deeper understanding of the service delivery process in the public sector (Jung, 2010; Osborne 2010). A service orientation perspective seems to fit well in the public health field where the concept of public and stakeholder engagement for partnerships and capacity building is not new (Boote, Telford and Cooper, 2002; Beresford, 2007; Chiu and West, 2007).

Participation, engagement and more recently co-production of services have been viewed as central concepts in healthcare (Boote, Telford and Cooper, 2002; Beresford, 2007) in the last decades in line with the shift to a systems approach (Hunter, Marks and Smith, 2007) to tackle prevention of lifestyle illnesses (Blumenthal and Yancey 2004). It has been argued that a relational paradigm shift has occurred in public health with the increasing interest in population health and participatory approaches (Navarro and Shi, 2001; Poland et al., 1998; Robertson, 1998) which bring the community at the heart of interventions, focusing on engaging individuals, hospitals, health service providers, social organisations, and government officials (Blumenthal and Yancey 2004; Cornwall and Jewkes, 1995; Ozanne and Anderson, 2010; Travers, 1997). In England, public and patient involvement in the NHS activities including research, service planning and evaluation, education and training has been supported by policies and guidelines (Hunter, Marks and Smith, 2007; Minogue and Gilderstone, 2010). However, public and patient involvement is still fragmented and it lacks a consistent expertise (Minogue and Gilderstone, 2010).

2. 4. 1. 1 Engagement, participation, involvement?

In the public management and health literature the terms engagement, participation and involvement are sometimes employed interchangeably (Bovaird, 2007; Cornwall and Jewkes, 1995). Participation and involvement of public and users in healthcare draw on literatures on consumerism, democracy and citizenship and sociology (Harrison, Dowswell and Milewa, 2002). The health literature distinguishes two different approaches to the involvement of patients and public, a consumerist one emphasising the

individual freedom of choice (Mullen and Spurgeon, 2000) and a collective one that emphasises a democratic developmental process of engagement over time (Thompson, 2007). Criticisms have been raised regarding the appropriateness of consumerist logic borrowed from the private sector in a public service context where individuals have less choice (Alford, 2002; Fountain, 2001; Jones and Needham, 2008; Jung, 2010). The latter one may be traced in Arnstein's (1969) referential text where citizen participation is considered citizen power that enables participation and inclusion of people in the political and economic process.

Thompson (2007) contends that the main element that distinguishes between patient participation and involvement is given by the degree of participation in the process of decision making. Higher degrees of participation correspond to higher levels of involvement (Thompson, 2007). Patient involvement is defined as 'a complex, multi-faceted and dynamic concept' as its levels can vary depending on context and moment in time (Thompson, 2007, p. 1308). Minogue and Gilderstone (2010) contend that involvement of the public in health services can occur at different stages assuming different levels of engagement and empowerment.

Recent conceptualisations in the marketing literature also distinguish engagement from 'involvement' (Mollen and Wilson, 2010) and 'participation' which are considered antecedents or consequences of engagement (Brodie et al., 2011). Customer participation is considered a necessary condition for co-production activities (Cova and Dali, 2009; Karpen, Bove and Lukas, 2012; Lusch, Vargo and O'Brien 2007) and co-creation behaviour (Yi and Gong, 2012). Research efforts on customer participation have traditionally adopted an organisational, managerial perspective focusing on the behaviours required for co-production of services/offerings and the role of the organisation in providing the necessary resources for co-production (Hibbert, Winklhofer and Temerak, 2012; Yi, Nataraajan and Gong, 2010). However, a number of authors reject this deterministic perspective (Firat, Dholakia, and Venkatesh 1995; Etgar, 2008; Firat and Venkatesh 1993) arguing that becoming a producer liberates the postmodern consumer from the previous role of consumer. This agency based perspective conceptualises the consumer as having the power to resist the market and even shape it through their practices. Consumer Culture Theory scholars contribute a socio-cultural perspective to unpacking the concept of consumer and the dynamic relationships

between consumers – citizens and markets. For example, Arnould (2007) argues that although consumers cannot escape the marketplace they can use marketing as an 'apparatus' for practising citizenship and engagement.

Evidence suggests that active engagement of the audience in community development initiatives may help develop interventions that respond to real needs and are culturally appropriate, generating a sense of ownership and capabilities that have an impact on interventions implementation (Attree, 2004; Johnstone and Campbell-Jones, 2003; Matthews, 2001; Owens et al., 2011; Waller et al, 2006; Winters and Patel, 2003). In addition, some studies suggest that community engagement can have a positive impact on individuals' perceptions of personal empowerment (Bolam et al., 2006; Callard and Friedli, 2005) and contribute to social integration of vulnerable populations (Joshi and Moore, 2004; Scharf et al., 2001).

The concept of actor engagement is connected with the idea of empowering individuals to take control and shape their lives. The construct of empowerment together with the idea of choice are positioned at the core of public health efforts to encourage individuals to take active part in improving their lives (Crawshaw, 2013; Mol, 2008). The next section is dedicated to a discussion of these two concepts.

2. 4. 1. 2 Empowerment as a core approach in public health

The literature highlights two key dimensions of the concept of empowerment: personal commitment and learning (Rappaport, 1987; Zimmerman, 1990), and achievement of important social goals (Lord and Farlow, 1990). Segal, Silverman and Temkin (1995) and Boyce (2001) state that empowerment is a relational concept that assumes ongoing interaction and equity to participate. In this sense empowerment includes a social-political dimension (Boyce, 2001). Wallerstein (1992) defined empowerment as a multilevel construct which involves people assuming control over their lives within their broader social-political context. The empowerment construct also includes an element of decision making and power over economic resources (Riger, 1993; Petersen, 1994; Wallerstein, 1992; Zimmerman, 1995).

In the literature empowerment is often linked with the idea of choice (Crawshaw, 2012; 2013; Jung, 2010; Mol, 2008; Petersen, 1997). Mol (2008) makes an important contribution to the critique of the 'logic of choice' which tends to dominate the discourse and practice of healthcare. Mol (2008, p. 8) suggests that the idea of choice in contemporary healthcare constitutes a 'logic' which 'carries a whole world within it: a specific mode of organising action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad and so on'. The logic of choice operates on the principle that there are options and that we have the freedom to choose between them (Mol, 2008). It also emphasises the notion of the right to choose and the responsibility that comes with this (Crawshaw, 2013). Drawing upon examples from ethnographic research on diabetes, Mol (2008) suggests that this logic of choice is challenged by the practice of management of illness and prevention. Mol (2008) emphasises that the logic of care, 'does not start out from what people know or want but from what they need'. The logic of care involves consolation and encouragement, customised courses of action and offers of support to build capacity and enable individual action (Mol, 2008). Drawing on Mol's work, Henwood, Harris and Spoel (2011, p. 2026) suggest that healthy living is one of those 'situations of choice' 'where information and technologies are understood as neutral aids to decision-making in support of 'correct' choices.'

Social marketing programmes generally focus on changing the behaviour of individuals. Often the social marketing value proposition is framed in terms of information and choice (Crawshaw and Newlove, 2011; Wymer, 2010). As previously illustrated in this chapter, one of the social marketing critiques is the focus on individual behaviour change associated with a neo-classical economics perspective which assumes people as rational agents able to make the best choices once they have the right information (Buchanan et al., 1994; Crawshaw, 2012; Spotswood and Tapp, 2013).

The following section explores co-production and stakeholder engagement in the public sector to provide a better understanding of the health context of this research. This discussion is necessary to unpack the meanings of these concepts in a non-commercial context and to explain the factors that suggest a service orientation seems to resonate well with the context of health programmes.

2. 4. 2 Co-production and co-creation in health

In healthcare research public and stakeholder engagement has been linked with policy development (Glover, Hillier and Gutmanis, 2007), community health (Ozanne and Anderson, 2010) and more recently with co-production of services (Bovaird, 2007; Ottmann et al., 2011). Co-production is being promoted at both the discourse and practice level as the 'emerging paradigm' in public services (Bovaird 2007, p. 846; Farrell, 2010; Needham, 2008; Wooding, 2008). Co-production has become a common practice in marketing (Bowen, 1986) being linked with the value creation perspective (Grönroos, 2011a). However, co-production is often conceptualised in the public service and health literature as a change of paradigm that moves from a consumer focus to citizen participatory models (Farrell, 2010; Ottmann et al., 2011).

Similar to the marketing literature, the health literature emphasises dialogue and partnerships (Dunston et al., 2008, p. 46) and resource integration (Ostrom, 1996) as key aspects of co-production. A recent definition (Bovaird, 2007) emphasises the relationships and the community resources mobilisation involved in co-production. A co-production approach allows for power transfer from the 'expert' to the user, gives a voice and widens choice (Bovaird, 2007) through resource integration. Needham (2008, p. 223) emphasises that co-production can be a 'therapeutic tool' building relationships between participants but also a 'diagnostic tool' when it reveals citizens' needs and problems and searches for ways to respond to them. However, Needham (2008) makes the distinction between 'zero sum' models of co-production where the labour of professionals is being transferred to citizens and 'positive sum' models which involve a collaborative effort between citizens and professionals. Ottman and colleagues (2011) point out that the term co-production changed its meaning in the public sector over the years depending on the politico-economical context. In the 80's co-production referred mainly to the joint provision of services and social engagement. In the last two decades co-production has been increasingly associated with the empowerment of citizens (Berge, Mendenhall, and Doherty, 2009; Dunston et al., 2008; Ottmann et al., 2011) to build capacity and play an active role in the planning, development and improvement of public services (Needham, 2008).

Capacity building has received growing attention in public health arena within the efforts to tackle issues beyond the individual level (Garkovich, 1989; Goodman et al., 1993; Hawe et al., 1997). It has been argued that capacity building should be an indicator of a campaign success (Hawe, 1994; Hawe et al., 1997) when the intervention empowers the community or the partner organisation to address not only the current health problem but to tackle other health issues. Recent efforts to engage with communities have adopted the 'asset based community approach' (El-Askari et al., 1998; Kretzmann and McKnight, 1996; Sharpe et al., 2000) which concentrates on the positive aspects of the community instead of the deficits and problems. An assets orientation aims to build capacity by identifying, supporting and mobilising existing community resources (Sharpe et al., 2000). Having built the capacity, the community members are then enabled to collaborate and address the problems in a creative way (Sharpe et al., 2000).

Although some authors (Needham, 2008) identify 'co-production' with 'co-creation' in the public service literature, as explained in the previous sections, the marketing literature makes a clear distinction between these terms (Vargo and Lusch, 2004; 2008a; Grönroos, 2012). Co-production is linked with the performing roles of customers as 'co-producers' within boundaries set by the firm (Bolton and Saxena-Iyer, 2009) whereas co-creation is considered a perspective on value (Echeverri, and Skålén, 2011; Vargo and Lusch, 2008a) based on interaction and experience (Prahalad and Ramaswamy, 2004).

This study makes the distinction between co-production of services and products and co-creation of value as a broader perspective that can encompass co-production (Lusch and Vargo, 2006b). It is important to highlight here that the nature of the social marketing offering (i.e. as behaviour) assumes a view of the customer as co-producer. As discussed in this chapter, social marketers initiate social/value propositions (e.g. quit smoking, exercise daily, recycle etc.). It is customers' role to 'produce' the behaviour (Peattie and Peattie, 2003). Further, in a social marketing context, customers may play the role of co-producers when they are involved in the process of developing products and services aimed to support engagement with the actual offering (i.e. the desired behaviour). As co-creators, network actors (including customers and other stakeholders) interact, integrate and adapt resources to suit their own contexts, projects and goals. For clarification, in this study, co-production is used to refer to the process of citizen/customer participation in the design/development of products and services. This is in line with the SDL and the

public health conceptualisations that this study draws upon. Given the upstream dimension required by social marketing programmes, the myriad of stakeholders involved in such programmes, the importance of context in behaviour change interventions, and the intangible nature of the social marketing offering this research focuses on co-creation of value as a network process. The focus on co-creation, as a process where actors interact to create value, rather than co-production is justified by the connotations of co-production in SDL - a firm focused perspective which is linked with the goods-dominant logic - the aims of this study to examine the relevance of SDL for social marketing and the changes driven by a collaborative and interactional approach.

This study also makes the distinction between engagement, participation and involvement as different concepts each referring to different stages of actor action, state and roles. The marketing definitions emphasise the experiential dimension of customer engagement (Prahalad and Ramswamy, 2004) and the value or moral dimension for stakeholder engagement (Greenwood, 2007). Aiming to bridge the conceptualisations from the marketing and the public health literature this study examines actor engagement as a process centred on interaction (Brodie et al., 2011) defined by relationship experience and the stage of involvement in the social marketing process. This perspective on actor engagement is in line with SDL and co-creation of value as a process centred on interactions (Grönroos, 2011a). Also, interaction has been suggested as a potential key principle of social marketing and alternative to exchange (Peattie and Peattie, 2003). In the marketing literature relationship experience has been defined in terms of the emotional, cognitive and behavioural dimensions (Payne, Storbacka and Frow, 2008). Payne and colleagues (2008) suggest that understanding the cognitive, emotional and behavioural dimensions of actors' engagement can help the organisation to address their needs and support the value co-creation process. Adopting this view on engagement, this study aims to examine actor engagement beyond the participatory process (Arnstein, 1969) in order to understand better the motivations and perceptions of value of stakeholder and service user engagement in a social marketing context.

It is important to note that many of the SDL principles are not new in the public health area. Principles like stakeholder engagement, community networks, resources (more often examined in terms of social capital) and co-production have guided community driven health and more recently social marketing programmes. However, often their

application is fragmented being guided by different approaches which seem to operate in silos. SDL contributes a mindset that draws on these principles to propose a systematic approach that places interaction at the core of value creation indicating potential to transform a broader set of service management processes. The next section turns to some of the challenges of collaborative and interaction based approaches which are associated with value creation.

2. 4. 3 Challenges of collaborative value creation

This section examines the potential limitations of a collaborative approach to value creation in social contexts aiming to provide a critical perspective and emphasise the need to carefully analyse which concepts are applicable to social marketing. The marketing literature has been vastly focused on positive value as a result of co-creation. Less attention has been given to the negative, destructive effects of co-creation experiences (Cova and Dalli, 2009; Echeverri and Skålén, 2011; Plé and Chumpitaz Cáceres, 2010*).* Furthermore, due to the debates and various conceptualisations of co-creation some clarity regarding the challenges associated with this perspective is necessary.

Collaborative approaches in a social change context may pose difficulties due to the diversity of population and the social, political, cultural, and economic contexts of individuals within the community (Drevdahl, 1999; Corburn, 2007). Findings from a review of community based interventions suggest that community engagement can have unintended negative consequences resulting in feelings of disappointment, distress and divisive action (Attree et al., 2011, p. 257). For example, people engaged in service planning, reported that they had experienced disapproval from other community members, who contested their motives for involvement (Chau, 2007). Another study noted that short interventions did not allow for sustainable projects which generated disappointment among participants (Bolam et al., 2006).

Social marketing programmes need to consider the difficulties in engaging vulnerable users and the lack of financial resources (Contandriopoulos, 2004; Ram et al., 2007; Chiu and West, 2007). A participatory approach is usually time consuming (Yoo et al.,

2004) and participants might lose interest or experience stress and 'consultation fatigue' (Bickerstaff and Walker 2005; Gunn, 2005). A collaborative approach requires that members of the community have to work together despite their different cultural backgrounds and political views which in practice may cause tensions and distress raising issues of representativeness (Contandriopoulos, 2004), parity and inclusiveness (Woelk, 1992), community heterogeneity (Larsen and Stock, 2010), manipulation and exploitation (Arnstein, 1969; Cornwall and Jewkes, 1995). Brunt, Lindsey and Hopkinson (1997) raise the issue of 'cultural juxtaposition' when engaging communities and 'the ethnocentricity of empowerment' (p. 25-26) which may undermine communities' cultural and spiritual values while Labonte (1994) emphasises that empowerment is not the perfect cure for all problems in all contexts. Rimal and colleagues (1997) contend that the focus on community empowerment in terms of self-help may reinforce the logic of individualism and neglect the context and the power dynamics.

Engaging customer competence and expertise is a key principle of co-creation (Ramaswamy, 2011). The view of the customer as an active agent indicates a shift from the view of customers as 'targets' for company's offerings. However, in a health context, there have been concerns regarding citizen expertise and availability to participate in co-creation (Pestoff, 2006; Bovaird, 2007; Needham, 2008; Timotijevic, Barnett and Raats, 2011). In addition, professional identity, norms, values, participant expectations, and culture can also act as barriers to include users in the process of decision making in expert dominated areas such as health (Martin and Finn, 2011; McDonald, Rogers and Macdonald, 2008). A value creation approach might also challenge the social marketing principle of setting clear behavioural objectives (Andreasen, 2003; Stead, Arnott and Dempsey, 2013) as it is centred on the premise of multi actor value (Domegan et al., 2013). Institutionalised resistance (Barnes, Newman and Sullivan, 2007) and conflicting priorities of funders and community stakeholders (Fawcett et al., 1994) have been recognised as barriers to community empowerment and capacity building (Adamson, 2010).

The application of a marketing logic in a health context raises the issue of representation of the 'customer' and their perceived role given the public dimension of such a context. As some authors indicate, public service users can perceive themselves as 'patients',

'service users', 'members of the public' or as 'members of the local community' rather than 'consumers' or 'citizens' (Clarke and Newman 2007) and they can act differently from customers of the private sector (Fotaki, 2009). Other authors suggest that the application of a consumerist logic borrowed from the private sector can be inappropriate in a public service context where individuals have less choices and interaction can occur involuntarily (Fountain, 2001; Jones and Needham, 2008; Jung, 2010). For example, some authors (Goetz and Gaventa, 2001) suggest that communities do not always want to co-produce and they might be forced by their socio-economical context to become co-producers in order to compensate for the lack of services.

2. 5 Conclusions

This chapter reviewed a range of literature streams including social marketing, SDL and public health to provide a comprehensive understanding of the foundations of this study. This final section summarises the main conclusions of this chapter identifying the research gaps that are addressed by this thesis.

The first part of the chapter reviewed the social marketing literature with a focus on the evolution of social marketing and the main critiques and debates in the field. Social marketing has developed around the transactional (goods-dominant) model of marketing without participating in the contemporary debates brought by the emergence of relational and service marketing (Hastings, 2003; Domegan, 2008). The main critiques of social marketing such as the focus on the individual and the neglect of contextual factors (Crawshaw, 2012; Wymer, 2010), solutions framed in terms of dyadic exchanges (Wood, 2008), managerial mentality (Brenkert, 2002) and predominance of psychology and behavioural models (Lefebvre, 2012) were influenced by the goods-dominant theoretical roots of social marketing. The calls for midstream and upstream action to tackle social issues require not only a change of applications focus, as some scholars would argue to change behaviour of policy makers and public services staff (Andreasen, 2002; Hastings, 2003), but also a revision of the theory that grounded the field.

The second part of the chapter reviewed SDL core principles. The emergence of SDL as a set of theories oriented towards context, processes, networks and active actors provides

an opportunity to explore the relevance of these concepts for social marketing. Comparing the theoretical roots and key concepts of goods-dominant and service-dominant models of marketing indicates the limitations of traditional social marketing in supporting a collaborative systems approach (Domegan et al., 2013; Lefebvre, 2012; Vargo and Lusch, 2008a). Table 2 in the Appendices illustrates the comparison between SDL propositions, the goods-dominant perspective and traditional social marketing. SDL principles suggest a theoretical framework more suited to collaborative, multi-stakeholder approaches required by tackling change at the midstream and upstream levels (Domegan et al., 2013; Lefebvre, 2012; Russell-Bennett, Wood and Previte, 2013).

Despite a growing interest in service marketing, SDL and contributions to conceptualise value creation in a social marketing context (Russell-Bennett, Previte and Zainuddin, 2009; Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, 2013) less attention was given to the implications of these new perspectives for the theoretical core of social marketing. Social marketing research is dominated by applications of behaviour change interventions at the final user level (Carins and Rundle-Thiele, 2014; Gordon, 2013; Truong, 2014). Service informed thinking is considered to facilitate transition from downstream to midstream and upstream focused action (Russell-Bennett, Wood and Previte, 2013). Social marketing literature acknowledges the importance of partnerships and the engagement of various stakeholders in the social marketing process to build capacity and reach sustainable change (Andreasen, 2006; Brennan and Binney, 2008; Bryant et al., 2001; Gordon, 2013; Hastings 2003; Hastings and Domegan, 2013; Lefebvre, 2011; 2012). However, in practice less attention has been given to building capacity (Whitelaw et al., 2010) and there is little research available on network actor engagement and the processes required by inter-organisational collaborations to build capacity for change (Gordon and Gurrieri, 2014; Faulkner et al., 2009; Whitelaw et al., 2010). The collaborative process of value creation (including facilitation, co-creation and resource integration) has been under researched in social marketing (Domegan et al., 2013; Dibb and Carrigan, 2013; Dibb, 2014; Gordon, 2013; Zainuddin, Previte and Russell-Bennett, 2011).

From a marketing perspective, the normative claims of SDL need further empirical interrogation (Wright and Russell, 2012). The literature on value creation (Prahalad and

Ramaswamy, 2000; Vargo and Lusch, 2004, 2008a) underscores a need to better understand interactions among organisations, their customers, employees, and other stakeholders in value networks (Archpru Akaka and Chandler, 2011; Grönroos, 2012; Lusch, Vargo and Tanniru, 2010; Vargo and Lusch, 2010). Previous research has concentrated on value outcomes (i.e. perceived value) and less attention has been given to value creation processes (i.e. value facilitation, resource integration and co-creation) (Arnould, 2008; Grönroos, 2012; Gummerus, 2013; Hibbert, Winklhofer and Temerak, 2012). Grönroos (2012) asserts that co-creation of value has been initially proposed as a metaphorical term, and as such, it requires further conceptualisation in order to explore its implications for marketing and management practice. Despite the amount of literature on value creation, there is still little known about how customers co-create (Jaakkola and Hakanen, 2013; McColl-Kennedy et al., 2012; Payne, Storbacka and Frow, 2008; Woodruff and Flint, 2006), the roles of the actors during this process and the sub-processes and factors underlying value creation (Grönroos, 2012).

The literature indicates that a greater understanding of customers' perceptions and experiences of relationship marketing and co-creation is required as the organisational perspective on the advantages of these approaches prevails in the literature (O'Malley and Prothero, 2004; Gummesson, 2008; Heinonen et al., 2010). Supporting this argument, other authors (Brown, 2007; Heinonen et al., 2010) contend that both the 'goods dominant and the service dominant logic' are 'provider dominant' lacking a real focus on the customer's perspective (Heinonen et al., 2010, p. 533). More research is also required to learn about customer and stakeholder resource integration, how accessibility to different types of resources in service encounters enhances value for both the customer and the service provider (Grönroos, 2012) and under what circumstances and how customers (Hibbert, Winklhofer and Temerak, 2012) and stakeholders (Frow et al., 2014) can use their operant resources in value creation (Arnould, 2008).

Another section of this review explored the rationale for a service orientation in public health. From a health perspective, despite the amount of public sector and health literature on describing the mechanisms of participation and co-production of offerings (i.e. active involvement of citizens) there is little empirical attention to the realities of different forms of participation and co-production in particular health contexts (Davies, Wetherell and Barnett, 2006; Morris et al., 2007) and the implications of a co-creation

perspective. Few studies focus on the process of participation of community members (Charlier, Glover and Robertson, 2009; Butterfoss, 2006) and community based services (Thompson et al., 1993) in preventative health projects and the experiences and motivations of individuals that engage and are engaged in these programmes (Baker et al., 2011; Fotaki, 2011).

The challenges of participatory approaches in health contexts and the paucity of research on value creation and engagement in social marketing require more research to better understand how individuals experience engagement in social marketing programmes, and if and how service dominant social marketing can tackle the factors associated with the context of behaviour. Examining SDL implications for social marketing theory and practice, the study contributes to the efforts of exploring new contemporary marketing concepts for expanding social marketing theory. In doing so, the study also contributes to improving the social marketing framework. The next chapter introduces the ontological and epistemological considerations of the study, followed by the research design.

Chapter 3: Methodology

3. 1 Introduction

This chapter describes the research philosophy and methodology employed in this study. The study adopts an 'inductive top-down' (Shepherd and Sutcliffe, 2011) qualitative case study approach to examine actor engagement and value creation in a health social marketing context. Section 3. 2 discusses the ontological and epistemological position adopted in this study. The research methodology and the rationale for a qualitative case study approach are described in section 3. 3. Section 3. 4 introduces the Smokefree case, reviews tobacco control social marketing applications and sets the context of this research to provide a rationale for the selection of the case. The data generation methods utilised in this study and the analysis techniques are described in sections 3. 5 and 3. 6. Section 3. 7 discusses the means used to ensure the quality of the research. The chapter ends with a discussion of the research ethics.

As explained in previous chapters, the advocated shift towards a service perspective in health social marketing requires further research to examine how different actors engage in collaborative practices for health improvement. In the light of the limitations and criticisms of the consumerist approach (Jung, 2010), a 'transformative' co-creation approach (Needham, 2008) is encouraged as a return to participatory citizen models and a solution to addressing structural change. The study interrogates the applicability of central principles of service dominant logic (SDL) - network actor engagement and value creation - in a social marketing context. One of the aims is to explore the process of value creation in a social marketing context. In doing so it examines value facilitation, co-creation and resource integration as processes of value creation (Grönroos, 2012). The study also investigates motivation of actor engagement and the dimensions of perceived value in a health social marketing programme. Drawing on different streams of literature including social marketing, SDL and public health literature, this study aims to improve our understanding of network actor engagement (stakeholders as partners and members of the public as service users) and value creation in a health social marketing context.

In order to accomplish these aims the study proposes the following research questions:
Overarching research question:

1. What are the theoretical and practical implications of adopting a service-dominant logic lens to value creation and actor engagement in social marketing?

Underlying research questions:

1. What factors influence actor (stakeholder and service user) engagement in a health social marketing context?
2. How do actors integrate resources to facilitate and (co-)create value in a health social marketing context?
3. What motivates network actors (stakeholder and service user) to engage in a health social marketing programme?
4. What value dimensions are present in a health social marketing context?
5. What are the barriers and challenges of a collaborative approach to value creation in a health social marketing context?

The following section is devoted to the philosophical considerations that informed this study.

3. 2 Ontology and epistemology

In any research it is important to be aware of the philosophical stance the researcher adopts, in other words, what is 'the nature of the world, the individual's place in it, and the range of possible relationships to that world and its parts' (Guba and Lincoln, 1994, p. 107). As Johnson and colleagues (2006, p. 146) emphasise, 'adopting a piori knowledge is unavoidable, as there is no space available to the researcher that is not regulated by some organising philosophical logic'. This section describes the ontological and epistemological considerations of this study which is informed by the critical realist paradigm.

Drawing on the works of Bhaskar (1989; 1998) and Archer (1995) critical realism emphasises the importance of (1) generative mechanisms, (2) the stratified character of the real world, (3) the dialectical interplay between social structures and human agency and (4) the critique of the prevailing social order. Society is seen as morphogenetic, changing its shape and form (Archer, 1995) where only 'relations endure' (Bhaskar, 1998). This paradigm provides useful insight to guide research on the implications of

processes, structures, mechanisms and factors that influence human action. A critical realist philosophy resonates with the view that the processes that are under analysis at one moment in time are dynamic and changing (Easton, 2010; Ryan et al., 2012). The shift of paradigm proposed by SDL adopts a systems approach emphasising the importance of processes and context in understanding value creation. Exploring value creation and engagement in social marketing requires an in-depth investigation of the factors and contexts that influence actors' engagement and the dynamics of the processes involved.

Ontology is concerned with the nature of reality. The ontological position can assume that 'reality' is objective and observable (a positivist view), or that 'reality' is constructed subjectively or inter-subjectively (a constructivist view) (Johnson et al., 2006). I align with the argument made by Morgan and Smircich (1980) and later on by Cunliffe (2011) that the objective-subjective paradigm dichotomy is 'rough and oversimplified' (Morgan and Smircich, 1980, p. 491) and that rigorous research requires 'being open and responsive to the possibilities of experience, people, ideas, materials and processes, and understanding and enacting the relationship between our metatheoretical position, our methods, our theorising, and their practical consequences' (Cunliffe, 2011, p. 667).

As a researcher I adopt the ontological position of a 'transcendental realist' (Bhaskar, 1989). Critical realists adopt a transcendental ontology that admits the existence of a 'reality' independent of individual experience and knowledge (Bhaskar, 1989). To illustrate, in a health context, a transcendental realist position recognises the existence of risks for illness independent of individuals' perception of whether those risks exist (Clark, MacIntyre and Cruickshank, 2007). The world is seen as stratified comprising three domains: the real domain, the actual domain, and the empirical domain (Bhaskar, 1989). The real domain consists of causal mechanisms which make things happen in the world (Danermark et al. 2002). The actual domain consists of events that are produced when these mechanisms are activated (Danermark et al. 2002). The empirical domain consists of experiences (direct or indirect) of those events produced by the mechanisms (Bhaskar, 1989). The relationship between these domains is marked by 'an ontological gap between what we experience and understand, what really happens, and – most important – the deep dimension where the mechanisms are which produce the events'

(Danermark et al., 2002, p. 39). In a health social marketing programme, this means acknowledging that there are 'causal' mechanisms (e.g. individual and contextual factors) that lead to events (e.g. changing behaviour) and that the experience of these events (e.g. positive or negative) can have an influence on how future events unfold.

At the same time critical realists distinguish a social reality which is shaped by social processes in which people create and negotiate meanings forming and reproducing social structures. Once formed, these social structures exert a causal influence over individuals but through human agency individuals can change these structures (Bhaskar, 1998). It is important to note that from a critical realist perspective, causation is seen in 'generative terms', which means that the causal power of an entity (i.e. a programme, intervention) is dependent on a 'number of its parts coming together in particular ways to generate the outcome(s)' (Clark, 2013, p. 190). Thus, in a critical realist view, social reality is an open system characterised by change where individuals and structures can influence each other (Archer 1995; Bhaskar, 1998). Bhaskar (1989, p. 76) defines a 'transformational model of social activity' and a 'relational model of society' where 'being social […] consists only in the relationships between persons or between such relationships and nature that such objects causally presuppose or entail' (1989, p. 81). One of the implications of seeing social reality as an open system in health is that there are many different factors, contexts and generative mechanisms that can affect outcomes. These factors may be geographical, historical, social, cultural, environmental and physical (Sayer, 2000). Open systems are complex and function in non-linear ways which makes it difficult to draw clear links between the characteristics of a programme and outcomes (Clark, 2013). According to critical realism, explanation in social inquiry needs to identify these 'mechanisms and how they work, and discovering if they have been activated and under what conditions' (Sayer, 2000, p. 14). Therefore, an exploration of actors' decisions to engage in health interventions should extend beyond personal motivation and willingness to examine the structural factors that enable or constrain them to take action.

There has been a growing support for adopting a critical realist approach in health research (Connelly, 2000; Connelly, 2001; Cruickshank, 2012; Pawson and Tilley, 1997) and evaluation (Clark, MacIntyre and Cruickshank, 2007; McEvoy and Richards, 2003). Marketing management research also indicates a growing interest for critical realism

especially in guiding case studies (Easton, 2010; Johnson and Buberley, 2003; Tapp and Hughes, 2008; Tsang, 2013). Marketing research that adopts a critical realist approach tends to adopt an objectivist epistemology (Easton, 2010; Tsang, 2013). Health research inspired by critical realism underpinnings tends to adopt a more relativist approach to knowledge (Connelly, 2001; Clark, MacIntyre and Cruickshank, 2007). Critical realism has also been proposed as an appropriate approach to deal with the complex ontological and epistemological considerations raised by co-creation (Hilton, Hughes and Chalcraft, 2012) and networks within SDL literature (Peters et al., 2013; Ryan et al., 2012).

A critical realist philosophical position is relevant for this study because it brings a stratified ontology which distinguishes between (1) experiences (e.g. actors' accounts on their engagement and their experiences with the programme), (2) events/outcomes (e.g. value creation and value dimensions) (3) deep structures that exert a real power over action (e.g. individual factors such as motivation and structural factors such as institutions, policy etc.) (Clark, MacIntyre and Cruickshank, 2007). The philosophical position adopted in this study inclines towards a view of the social word which recognises 'that human beings, social structures, and cultural entities each have their own distinct existences and influences on social outcomes' (Elder-Vass, 2007, p. 332). Thus, humans, social and cultural structures are interrelated but also possess their own characteristics and power and an explanation of social reality needs to consider them all (Archer, 2000; Elder-Vass, 2007; 2008).

The relevance of critical realism is reaffirmed when considering other research paradigms for this study. A constructivist approach which focuses on individual experiences only and assumes that all reality is socially constructed (Cunliffe, 2011) would be problematic given the role of structures and hidden mechanisms impacting behaviour and change in health improvement programmes (Clark, MacIntyre and Cruickshank, 2007; Cockerham, 2005; Cruickshank, 2012). Similarly, a positivist approach which centres on 'fixed empirical effects' and description of events (Cruickshank, 2012) would exclude many 'unobservable and unmeasurable phenomena' and the transformative processes which are essential components of a health improvement programme (Wilson and McCormack, 2006, p. 52).

Critical realism questions the extreme positivism and relativism, acknowledging that knowledge is context influenced and co-created by 'human consciousness' (Guba and Lincoln, 2005, p. 203). I align my epistemological position with the approach adopted by Miles and Huberman (1994, p. 4) acknowledging 'the importance of the subjective, the phenomenological, the meaning making at the centre of social life' and searching for hidden mechanisms that influence action. Meanings and intentions operate within social structures and interpretation is important as it influences human action. As Miles and Huberman (1994, p. 4) suggest, social phenomena (i.e. language, decisions, conflicts, and hierarchies) exist in the world and influence human activities because they are commonly construed and interpreted. As such they become an important object of inquiry to understand some of the factors that influence action. However, a critical realist view acknowledges that generative mechanisms have potential to impact action, independent of human knowledge and interpretation. Thus, from a critical realist perspective, actors' views provide one object of inquiry in addition to the 'social relationships between agent and structure and between agent and agent' (Connelly, 2000, p.265). As such, the objectives of this research extend beyond understanding experiences to examine the relationships between the actors (i.e. collaborating staff and staff from STOP service as the focal organisation; staff – members of the public) and between actors and structures (i.e. staff and their employer; staff and policy; members of the public and public service etc.).

Bhaskar (1998) argues for an epistemic relativism, which states that knowledge of reality (the intransitive domain) is always relative to a theory and interpreted through theories. But these theories are also exposed to critique and change as critical realism formulates that knowledge is 'transitive', consisting of contingent, changing and fallible ideas about the world based on prior theoretical perspectives, dominant discourses, on researcher's intellectual curiosity and motives and methods of research (Sayer, 2000). Thus critical realism rejects methodological individualism and universal claims of truth (Denzin and Lincoln, 2005) being more concerned with the practicality of knowledge (Sayer, 2000). Pawson and Tilley (1997, p. 86) suggest that research findings are not static, but reflect the researcher's current understanding of 'mechanisms and contexts' that shape the phenomena under research.

Given the interdisciplinary nature of this project the approach is 'inductive top-down' which is appropriate for theory building when the research topic requires an investigation of different literatures going across disciplines and paradigms (Shepherd and Sutcliffe, 2011). The 'inductive top- down' researcher approaches the literature as 'data' in order to 'carve out' paradigms, tensions, oppositions and contradictions (Shepherd and Sutcliffe, 2011, p. 367). The questions that emerge as a result of this exercise will guide the empirical research.

Critical realism accepts a pluralism of perspectives and acknowledges the value of qualitative approaches for gaining in depth understandings of the phenomena under analysis (Healy and Perry, 2000). Critical realism shares with interpretivism the view that social phenomena need to be understood by revealing subjective meanings and motivations that can constitute actions but at the same time it asks for explanations (Tapp and Hughes, 2008, p. 275). A key element in learning about engagement of stakeholders in a health social marketing programme is examining their motivations, the meanings they give to their actions and how these shape practices.

One of the key principles of critical realism is the acknowledgement of the interplay between human agency and structure and how this shapes social reality (Archer, 1998). Agency refers to the capacity to choose behaviour and action whilst structure is defined by 'regularities in social interaction (e.g., institutions, roles), systematic social relationships (e.g., group affiliations, class and other forms of social stratification), and resources that script behaviour to go in particular directions as opposed to others that might be taken' (Cockerham, 2005, p. 55). Hays (1994) distinguishes between 'structurally reproductive agency' and 'structurally transformative agency'. The former reproduces the existing structures while the latter modifies the structural conditions. One of the limitations of health behaviour change programmes is that agency is often linked with biology and behavioural change while neglecting individuals' experiences, meanings and context (Clark, MacIntyre and Cruickshank, 2007). Abel and Frohlich (2012) argue that 'structurally reproductive agency' is illustrated by certain health behaviours such as sedentary lifestyles and unhealthy eating habits leading to reproduction of certain social patterns and health disadvantages over time. In this sense, health promotion programmes that target only certain populations may contribute to the

exclusion of hard to reach populations and the increase of the inequality gap (Frohlich and Potvin, 2008).

Critical realism includes elements of critical theory in supporting the argument that knowledge can be used for emancipatory goals to change illegitimate practices and unfair situations (Bhaskar 1998). A critical perspective in health acknowledges the limitations of current practices in behaviour change interventions focused on the individual (Lee and Garvin, 2003) and it maintains that the development of health programmes is shaped by social structural processes that often reflect power imbalances, marginalisation, and domination by one group or knowledge form over another (Adams et al., 2009). In addition to understanding the actors who are interacting in a specific context, critical realism emphasises the need to understand the 'generative mechanisms' which have produced the situation (Connelly, 2000). A critical realist approach acknowledges the fact that things could be different and a better understanding of the mechanisms that underlay events and the factors that influence those mechanisms can provide the potential for an alternative and change (Danermark et al., 2002). Understanding involves 'explanatory critique' to 'expose not just false beliefs, but the false beliefs by which oppression and injustice are disguised, whether consciously or not, and perpetrated' (Bhaskar and Collier, 1998, p. 389).

This section introduced the philosophical considerations that position this study within the critical realist paradigm. The justifications for a 'transcendental realist' ontology and 'epistemic relativism' were presented in detail. The following section discusses the rationale for a qualitative methodology.

3. 3 The rationale for a qualitative case study

In my study I am guided by Gummesson's (2005) argument that research should aim for 'the understanding of a systemic whole, a context, with individual and complex patterns of interactive relationships' (p. 322). The complexity of actors involved in a health social marketing programme and the focus on engagement and value creation require a qualitative approach to facilitate an exploration of actors' experiences and the factors that influence their engagement in value creation in this context.

A quantitative approach would have been useful if we already knew how actor engagement and the process of value creation were reflected in health social marketing practice and we wanted to test the impact of different variables on programmes' outcomes. Also, the aim of our research is to reveal 'the how' and the 'why' on exploring understandings, relationships, interactive processes and contexts (Silverman, 2000).

One of the common beliefs behind qualitative research is that its methods can provide a deeper understanding of social phenomena than quantitative data (Silverman and Marvasti, 2008). Qualitative research is seen as especially useful in exploring processes and meanings while focusing on 'understanding particulars' (Maxwell, 1992, p. 296). Qualitative methods are particularly relevant for this study because they can provide a holistic view of engagement, focusing on participants' experiences while taking into account the importance of the context, interactions, roles, organisational structures and mechanisms (Strauss and Corbin, 1990).

The social marketing research domain has been described as being too positivist (Dholakia and Dholakia, 2001), lacking reflexivity (Gordon and Gurrieri, 2014) and critical discourse (Tadajewski and Brownlie, 2008). Despite the positivist focus of social marketing research it has been argued that social marketing lacks a strong evidence base for behaviour change due to the non-experimental design of interventions (Hornik, 1997), establishing unrealistic objectives, not assessing behaviour change, or focusing on irrelevant objectives (Balch and Sutton, 1997). Another perspective suggests that research in social marketing should focus on the process and take into account that interventions are not 'fixed' but changing (Doner, 2003). All these controversies make the research and methodology in social marketing a challenging domain of action (Fry, 2007).

If social marketing continues to look at commercial marketing as a model discipline, then it has to take into account the changes in research methodology. Deshpande (1983) argued that the methods used in marketing science are those suited to confirming theories rather than discovering theories and that marketing scholars have focused less on theory generation. There has been a growing support for interdisciplinary and extensive

qualitative research in marketing research (Brownlie et al., 1994; Brown, 2003; Burton, 2001; Goulding, 2005) to allow researchers to manage 'the complexity, context and persona and their multitude of factors, relationships and fuzzy phenomena' (Gummesson, 2006, p. 167). A qualitative approach is particularly appropriate for researching health interventions as complex phenomena which include various components such as individuals with their beliefs, attitudes, values, skills and knowledge, upstream factors, cultural and social norms, aspects of community, geography and history (Clark, 2013).

This study adopts a 'qualitative' case study approach (Stake, 2005) in which the researcher learns about engagement and value creation in a health behaviour change setting through what the others reveal as their experience, through observation and their own experience. Case study is not a qualitative method per se. As Stake (2005, p. 443) emphasises 'if case study research is more humane or in some ways transcendent, it is because the researchers are so not because of the methods.' Qualitative case study is characterised by researchers observing and participating, spending time on site, reflecting, and revising descriptions and meanings of actions, interactions and processes (Stake, 2005).

Yin (2003) suggests the use of a case study approach when aiming to explain, describe, evaluate and explore processes, contexts, interventions. This project adopts a case study approach to examine actor engagement and the process of value creation in a community health programme setting, to describe the context and reveal factors and mechanisms for action and explore participants' meanings and understandings of this approach and its implications. A case study approach is particularly useful in management research for a holistic perspective that allows researchers to study 'the complexity, context, ambiguity and chaos' (Gummesson, 2007, p. 229). As such, case studies accommodate SDL informed research which explores the dynamics, mechanisms and contexts of networks, resources and business-to-business relationships (Easton, 2010; Eisenhardt, 1989; Halinen and Törnroos, 2005; Järvensivu and Törnroos, 2010).

In addition case study allows for both inductive and deductive approaches and a variety of data generation methods (Gummesson, 2007). A number of authors contend that the degree of detail and the 'analytical generalisation' (Yin, 2003) in a single case study can

serve to create theory (Hamel, 1993; Stake, 2005; Eisenhardt, 1989). Yin (2003, p. 10) argues that case studies, like experiments, are generalisable to theoretical propositions and not to populations or universes.' Providing rich description and a strong iterative analysis of the data a case study should enable the reader to make connections between this particular case and other similar ones (Patton and Appelbaum, 2003). A strong single case study must be able to generate understanding of 'a phenomenon in depth and comprehensively' (Easton, 2010, p. 119).

The literature indicates that a single case study is appropriate when the case is representative or typical of the phenomenon under analysis (Yin, 2003). The choice of a single case study of a smokefree homes and cars programme is based on the characteristics of the programme which engages a range of actors to reach the public and operates a pledge model. The smokefree programme is thus similar to other smokefree initiatives in the approach employed being selected as an 'instrumental case study' (Stake, 2005) to provide insight and facilitate our understanding of engagement and value creation in social marketing.

The selected case includes multiple contexts as it involves medical (Hospital) and local community settings (Children's Centres, community centres), different stakeholder groups (nurses, health visitors and administrative staff) and service users. An in depth case study requires exploring relationships and interactions of all these groups and in all these contexts to be able to provide a holistic perspective on value creation and engagement in a health behaviour change context.

This section covered the rationale for a qualitative methodology. The features of qualitative case study design were explored as suitable for providing a holistic view of the complexity of a health social marketing programme including actors, resources, and processes. The next section covers the case study selection process, setting the background of this research and introducing the Smokefree case.

3. 4 The case: Smokefree homes and cars (Smokefree)

This section describes the rationale for a single case study focusing on the Smokefree homes and cars programme to explore actor engagement and value creation in a health

social marketing context. The public service context, the focus on stakeholder and community engagement in developing and delivering the intervention, as well as the acknowledgement of external influences on behaviour change make this smokefree homes and cars initiative an appropriate and valuable case for exploring engagement and creation of value in social marketing. In addition, the wide range of stakeholders involved in this initiative provides a case for examining the factors that influence engagement, the capabilities and resources required when adopting a collaborative value creation perspective, and the influence of context and stakeholders' roles. This section provides an overview of social marketing applications in the area of tobacco control and introduces the Smokefree case to set the context of this research.

3. 4. 1 Background of the case: tobacco control and social marketing

This section provides an overview of social marketing approaches in the area of tobacco control. To date, the Stead and colleagues (2007) systematic review provides a detailed description of tobacco control social marketing programmes and evaluation of their effectiveness. The aim in this study was not to replicate the Stead and colleagues (2007) review but rather to provide a snapshot of the social marketing lessons learned in smoking prevention/cessation programmes. In addition to the social marketing initiatives identified in the Stead and colleagues' review (2007), electronic databases including Emerald, Sage, Wiley, Science Direct and Oxford Journals were searched for smoking related social marketing studies. Table 3 provides a summary of tobacco control social marketing programmes related research.

Social marketing has a long tradition in informing the development of smoking prevention and cessation programmes (Hastings and Saren, 2003; Stead et al., 2007). Early social marketing smoking cessation and prevention programmes adopted media approaches, including TV, radio, newspapers and outdoor posters (Stead et al., 2007). Social marketing smoking cessation and prevention interventions have also been part of multi-component programmes aiming to reduce cardiovascular risks (Carleton et al., 1995; Fortmann et al., 1993). Some adopted a school-based approach drawing upon social influences theory (Maibach and Parrot, 1995) and an anti-tobacco curriculum (Botvin, 1997). The social influences approach highlights the importance of social and

psychological factors in shaping behaviour. This approach builds on the premise that teaching young people to resist pressures from peers and media influences through normative education and resistance skills training is effective in preventing smoking (Botvin, 2000; Maibach and Parrot, 1995).

A common feature of smoking cessation and prevention programmes is the use of fear appeals (Brennan and Binney, 2010; Hastings, Stead and Webb, 2004) and rational theory to create persuasive messages. However such approaches have been criticised for raising ethical issues and indicating limited effectiveness (Hastings, Stead and Webb, 2004). More recent anti-smoking campaigns have used positive emotional appeals such as humour, irony and supportive messages with promising changes in awareness, attitudes and behaviour (Hastings, Stead and Webb, 2004). Cessation programmes include strategies such as emphasising incentives for quitting smoking (better health, losing weight and financial savings) aiming to minimise the social costs of not using tobacco (De Gruchy and Coppel, 2008). A common strategy in cessation programmes is the use of quit contests as a way of encouraging commitment to quit smoking and stay smokefree (Carleton et al., 1995; Fortmann et al., 1993; Lavack et al., 1997; Schorling et al., 1997).

In the last two decades, social marketing has moved towards approaches that acknowledge the role of context in behaviour and social change (Gordon and Gurrieri, 2014; Lefebvre, 2012). Critical social marketing (Gordon, 2011) has made important contributions to the way smoking prevention and cessation programmes are carried out. A critical social marketing approach to smoking focuses on the impact of tobacco industry marketing efforts on shaping the environment to position smoking as socially accepted. As a result, smoking prevention programmes started to focus on the de-normalisation of tobacco use (Hoek, Newcombe and Walker, 2011). Prevention programmes targeting youth adopted a counter-marketing approach using tobacco industry strategies to engage with their audiences (Schmidt, Kiss, and Lokanc-Diluzio, 2009). Efforts in this area draw on Social Identity Theory[11], acknowledging the

[11] Social identity theory is concerned with how individuals see themselves as unique individuals and as members of wider social groups (Taifel and Turner, 1979). This theory posits that individuals adopt behaviours and attitudes to align with the group's norms and it highlights the importance of social relationships in shaping personal identity (Kobus, 2003).

interaction between tobacco brands and young people's construction of their identity (Hoek, Newcombe and Walker, 2011). The 'Truth' programme is a classic example of how social marketing has blended different theories, including the Theory of Planned Behaviour and Social Identity Theory to de-normalise smoking and counter the effects of tobacco marketing (Hoek, Newcombe and Walker, 2011).

The social influences approach remains key in smoking prevention and cessation with the majority of programmes using refusal skills development strategies, messengers, peer support and social norms (Ary et al., 1990; Kong et al., 2014; Schmidt, Kiss, and Lokanc-Diluzio, 2009). The social norms strategy is widely used in social marketing, in particular in areas such as alcohol consumption reduction (Szmigin et al., 2011), drug abuse prevention (Botvin, 2000) smoking cessation and prevention (MacAskill et al., 2002) and pro-environmental behaviour (McKenzie-Mohr and Schultz, 2014). Social and cultural norms are 'the behavioural expectations, or rules, within a society or group, or alternatively a standard, customary, or ideal form of behaviour to which individuals in a social group try to conform' (Dolan et al., 2012, p. 268). The role of social norms in influencing smoking behaviour has been long established (Gielen and Green, 2015). Based on a comprehensive study testing youth's response to different smokefree messages, Pechmann and colleagues (2003) highlighted the potential of norm-based appeals, particularly those that emphasised the social unacceptability of smoking for Smokefree programmes (Song and Glantz, 2008).

Evaluation of a many social marketing smoking prevention programmes indicate the effectiveness of these initiatives in reducing smoking rates among youth, whilst the evidence for smoking cessation is more mixed (Stead et al., 2007). A quantitative methodology was predominant in these studies, including randomised controlled trials, and pre-post surveys. Supportive social norms, smokefree policies; research, monitoring, surveillance and evaluation; comprehensive and culturally appropriate interventions which require participation of stakeholders and a long term approach; public support and advocacy have been identified as key factors that led to the success of tobacco control (Gielen and Green, 2015). Calls were launched for tobacco control to consider smoking in a broader structural context of diverse opportunities, rather than as an individualised behavioural trait (Poland et al., 2006). As explained in the previous sections, strategic (French and Blair-Stevens, 2010) and critical social marketing (Gordon, 2011) has

encouraged more engagement with structural approaches to behaviour and social change. The following section discusses the context of behaviour in the Smokefree programme.

3. 4. 2 Smokefree programmes

Cigarette smoking remains the leading cause of preventable death in the UK (Bauld et al., 2010) being responsible for up to 100 000 deaths per year (Peto et al., 2012). There has been a strong commitment to reduce smoking prevalence through demarketing measures such as banning tobacco advertising, increasing price, banning smoking in public places and the creation of a national network of smoking cessation services (McNeill et al., 2005). The smoking cessation service is usually a component of a larger programme that blends social marketing (De Gruchy and Coppel, 2008), health promotion and other community approaches (Hacker and Wigg, 2010

Smokefree homes initiatives are an important component of tobacco management and control programmes aiming to diminish the exposure to second-hand smoke which represents a major public health risk for both adults (Jamrozik, 2005) and children (Simms et al., 2010; Holliday et al 2009; Priest et al. 2008). Second-hand smoke was estimated to cause 600 000 premature deaths per year worldwide in 2004 with 31% of these occurring among children (Öberg et al., 2011). There is clear evidence linking second-hand smoke exposure to worsening of illnesses such as asthma and middle ear infections, which might lead to poor school attendance and attainment and increased hospital admission (Muller, 2007; Ritchie et al., 2009).

3. 4. 2. 1 From behaviour change to behavioural contexts

Smokefree programmes indicate a novel approach which centres on the context of behaviour (i.e. where and how people smoke) rather than on the behaviour itself. Community research has made important contributions to the articulation of the essential role that context plays in understanding human behaviour (Brodsky et al., 2004). Social theorists emphasise the need to understand the relationship between place and health in order to develop context sensitive programmes (Cummins et al., 2007).

The concept of ‘context’ in public health coalesces notions of ‘space’ (as physical environment including community level resources such as parks, stores, schools, local services etc.) and ‘place’ (as collection of human meaning and significance including social networks and social capital dimensions) (Frohlich, Corin, and Potvin, 2001; Frohlich et al., 2002). As discussed in this chapter, understanding the context of behaviour requires examining the relationship between structure, agency and practice (Cockerham, 2005; Frohlich, Corin and Potvin, 2001) and the meanings people attach to their ‘contexts’ (Frohlich et al., 2002). Examining structures helps to understand power relations and the influence of rules and resources and individuals’ relationships to each other on behaviour (Frohlich et al., 2002). Exploring practices provides insight into how routinised activities of actors shape their behaviour (Frohlich et al., 2002). Defining the context in relation to agency reveals the individual dimension, or the ability of people to act and change.

Tobacco control research has been traditionally focused on understanding barriers to smoking cessation and competition to smokefree behaviours from a social influences perspective, highlighting identity related factors (Hoek, Newcombe and Walker, 2011). More recently, research into smoking has started to explore the meanings of smoking for different groups (e.g. women, youth) in managing their everyday lives in areas marked by inequality and poverty (Frohlich et al., 2002).

Examining the context in the Smokefree programme requires exploring the structure dimension given by the formal and informal rules around smoking, legislation and policies, institutions and resources and the ‘space’ (i.e. homes, cars and local services). It also requires understanding the practices of the actors involved (i.e. collaborator staff; STOP service staff; members of the public) and the meanings they give to their contexts (i.e. the ‘place’).

Smokefree programmes have been developed in the context of stronger policy and demarketing measures to tackle smoking. In a tobacco management and control context, demarketing aims to reduce demand by discouraging consumption of cigarettes (Comm, 1997). Government demarketing measures may involve raising prices, decreasing product availability and tobacco advertising bans (Shiu, Hassan and Walsh, 2009). This approach has been adopted in social marketing programmes working with retailers,

policy makers and other community based organisations to reduce youth access to tobacco (Biglan et al., 2000; Forster et al., 1998; Wildey et al., 1995). Evidence highlights policy measures and legislation enforcement as effective strategies to support smokefree behaviours (Stead et al., 2007). Demarketing campaigns have contributed to a negative view of smoking in public places and a negative public perception of smoking (Pechmann and Knight, 2002; Shiu, Hassan and Walsh, 2009). However, demarketing requires a stakeholder approach, community participation and ethical transparency to be able to attract the public's support for the tobacco control policies. For instance, an ethnographic study evaluating an upstream social marketing programme aimed to control counterfeit tobacco use, raised concerns about the lack of involvement of the local communities in the development and implementation of the programme (Carro-Ripalda et al., 2013). Although the programme adopted a collaborative stakeholder approach drawing upon consultation and involving a wide range of actors in the process of development and implementation, institutional agendas and the lack of engagement of the local communities raised ethical concerns about the power relationships and the framing of smokers of illicit tobacco as criminals (Carro-Ripalda et al., 2013).

Smokefree legislation in public and work places was introduced in England in July 2007 (DoH, 2008) and is associated with significant reduction of preterm births and hospital attendance for asthma (Been et al., 2014). Evidence suggests that a smoking ban in public places encourages people to implement smoking restrictions at home (Borland et al., 2006) and may have provided an incentive for some smokers to cut down or quit (Hargreaves et al., 2010). A recent study conducted by Jarvis and colleagues (2009, p. 491) indicates 'a marked secular trend towards smokefree homes, even when parents themselves are smokers'. Despite the optimism reflected by Jarvis and colleagues' study (2009), another comprehensive study of second-hand smoke exposure among children in England reveals that although exposure to household second-hand smoke among children aged 4-15 has declined since 1996, great numbers of children still remain highly exposed (Simms et al., 2010). The study indicates that 'reducing exposure in the home is key to reducing children's morbidity from second-hand smoke exposure' (Simms et al., 2010, p. 551).

Despite the growing risk discourse of protecting children from second-hand smoke within their homes and the range of media campaigns and local community and

individual approaches to encourage a smokefree environment, there is still little evidence on the effectiveness and design of these specific interventions (Ritchie et al., 2009). Priest and colleagues (2008) found that intensive counselling appears to be effective in reducing the second-hand smoke exposure at home. A study investigating the drivers for smokefree homes in 4 cities in UK, China, Mexico and India, highlighted that knowledge of second-hand smoke exposure risks, addictiveness of tobacco, level of smoking, concern for other house residents and anti-tobacco social marketing influence smokefree home support (Fenton et al., 2014). In addition, a qualitative study conducted by Amey (2011) found that young mothers believed that the use of informational leaflets alone was not enough to help them change behaviour and they supported the idea of counselling/advice sessions. Studies have shown that when discussing smoking, children react against the practice of smoking in the house while expressing feelings of frustration and disempowerment (Amey, 2010). These findings support the study conducted by Woods and colleagues (2005) which indicated that children felt helpless in taking action to change the smoking environment where they lived and they expected protection from their parents from smoke. Another study (Alwan et al., 2010) highlighted the success of a smokefree intervention in developing children's capacity to negotiate smokefree environments with their parents through activities in schools. Evidence indicates that only a complete smokefree home is effective to eliminate the risks of second-hand smoke (Blackburn et al., 2003) and thus smokefree programmes need to engage not only mothers but also partners of caregivers (Jones et al., 2011).

Despite the promising trends following the smokefree legislation in the UK, research emphasises that smoking behaviour is strongly influenced by the context, and in particular the social networks, of smokers (Hargreaves et al., 2010). Such research suggests that the power of individual agency is shaped by social structural factors (Hargreaves et al., 2010). A number of studies revealed insight into the barriers to a smokefree home (Amey, 2011; Jones et al., 2011; Phillips et al., 2007; Robinson and Kirkaldy, 2007; Robinson and Kirkaldy, 2009). Some of these include the absence of an outside space for smoking, shared accommodation, inability to leave the house due to caring responsibilities, smokefree homes not being seen as a priority, insecurity, beliefs that older children can avoid the smoke and, other members of the family that smoked. These studies also indicate that the rules around smoking inside the house are fluid

despite a certain awareness regarding the negative health effects of second-hand smoke (Jones et al. 2011).

3. 4. 2. 2 Commitment and pledges

Using social marketing and community models a number of smokefree initiatives in the UK operate a 'pledge' approach engaging various community stakeholders and the members of the public to promote smokefree homes and cars (Hacker and Wigg, 2010; Allmark et al., 2011). Pledges are used as a strategy to build commitment in behaviour change and social marketing initiatives, in particular in the area of environment protection (Kassirer, Korteland and Pederson, 2014; Lokhorst et al., 2013; McKenzie-Mohr and Schultz, 2014). The pledge/commitment format asks people to make a promise to do something (Lokhorst et al., 2013). The commitment approach includes various psychological processes and builds upon several self-efficacy theories and models. A common model is the Theory of Reasoned Action (Amey, 2011). The Theory of Reasoned Action operates on the premise that individuals are rational beings that take action after processing the information available to them. Their behaviours are shaped by intention and by their subjective norm (Azjen and Fishbein, 1980). This model suggests that commitment is used to persuade people into thinking about the behaviour which will lead to a change of attitudes and behaviour.

Commitment is linked with self-perception or the way people perceive themselves (Bem, 1972, McKenzie-Mohr and Schultz, 2014). A review of commitment studies indicated that self-perception is the most important factor in influencing commitments (Burger, 1999; Cialdini, 2007). Work on self-perception and commitment indicates that once people view their behaviours as voluntary and a reflection of their own motivations they are likely to achieve behaviour change (Cialdini, 2007). Commitment may lead to a change of self-perception (i.e. people who have recently quit smoking start to think about themselves as ex-smokers) and maintenance of behaviour change (Lokhorst et al., 2013).

Commitment effects are also explained in relation to social influence and norms (Cialdini, 2007). Studies indicate that written commitments seem to work better than verbal ones (McKenzie-Mohr and Schultz, 2014) and that commitments may become

more effective as the costs for failure increase (Dolan et al., 2012). A common strategy for increasing such costs is to make commitments public as this may lead to reputational damage (Cialdini, 2007).

Commitment strategies have also been used in smoking cessation interventions that launched quit contests (Carleton et al., 1995; Fortmann et al., 1993; Lavack et al., 2007) and pledges to stay smokefree in October (i.e. Stoptober) (Brown et al., 2014). The pledge/formal agreement approach is also used in smokefree school based programmes and by parents to encourage youth to stay smokefree (den Exter Blokland et al., 2009; Harakeh et al., 2005). Research indicates that making a commitment can activate processes related to self-concepts, attitudes and norms which may lead to individual behaviour change (Kotler and Lee, 2008; Lokhorst et al., 2013). For instance, Stoptober is estimated to have generated an additional 350,000 quit attempts (Brown et al., 2014).

In the Smokefree context, signing the pledge is considered an act of commitment to keep the home and car smokefree and protect children from second-hand smoke. The focus is still on individual action and self-management, a feature of classic health social marketing. However, reviewing a number of smokefree programmes (Amey, 2011; Hacker and Wigg, 2010; Allmark et al., 2011) indicated a trend to engage different stakeholders in order to build capacity to support the behaviour change which is a sign of change from an individual based and interventionist to a more collaborative and structural approach. Indeed, evidence indicates that commitment strategies work better in combination with other approaches within multi-level holistic programmes (Lokhorst et al., 2013). This approach where smokefree programmes are integrated into existing social and health services has been proposed as a way to support socially marginalised populations (Frohlich et al., 2012).

3. 4. 3 Introduction to the case: Smokefree Homes and Cars (Smokefree)

The research is in the form of a multisite qualitative case study as the sites are geographically defined in terms of two NHS Trusts boundaries to include the partners of the Smokefree homes programme. This is appropriate to the study considering the range of stakeholders involved in the social marketing initiative under research.

Since 2011, the ‘Smokefree Homes and Cars programme' (Smokefree) has been dedicated to encourage people to sign a pledge to keep their homes and cars smokefree. The overall aims of the Smokefree Homes and Cars programme are to encourage individuals to change their behaviour to not smoke in their homes or cars and to support a change of the social norm regarding smoking.

The aims of the programme target both, the downstream (i.e. change of behaviour of parents who smoke and those who allow smoking in the home and car) and midstream levels (i.e. develop capacity of the frontline staff to address smoking environments; change of behaviour of the staff to integrate Smokefree within their practice). More specifically, at the downstream level, the Smokefree homes and cars programme aims to:

- Increase the number of people committed to keeping their homes and car smokefree
- Increase understanding among the general public and in areas of greatest health inequalities and highest smoking prevalence, of the potential harms of second-hand smoke
- Develop significant brand recognition after one year of the ‘Smokefree’ campaign in the areas of highest smoking prevalence

At the midstream level, the programme aims to

- Develop the understanding and ability of frontline workers (stakeholder partners) to deliver the campaign messages effectively
- Engage frontline workers to have the Smokefree conversation with their service users
- Generate referrals for the NHS Stop Smoking Services (through the pledge form) (Anonymous Group, 2012)

STOP Smoking Service adopted a social marketing approach to the development of the programme. The programme used formative research with community health workers and community members to develop the promotional and educational materials. It had clear behavioural goals for its target groups, including members of the public and collaborating staff. The programme targeted parents (as the final users or the customers) and staff of local services (as collaborators in developing and implementing the programme).

Targeting parents and professional staff

The programme targeted parents and staff of local services in deprived communities. In these deprived communities where the smoking prevalence is higher than average, the perceived social norm is that 'everybody smokes' (MacAskill et al., 2002). These communities are often separated from other, more affluent communities and the city as a whole which contributes to limited interaction with people from outside their communities and to non-smoker and ex-smoker role models (MacAskill et al., 2002). Adopting a social norms strategy for behaviour change requires emphasising how many people do the behaviour and/or approve that behaviour (McKenzie-Mohr and Schultz, 2014). Applying this strategy in deprived communities requires exposing the communities to non-smoking role models and highlighting that smoking rates are lower than the numbers they perceive.

Social marketing programmes have a long tradition of involving parents as the main target audience in particular in relation to diet, exercise, car seats and other child safety and health issues (Cuijpers et al., 2002; De Vries et al., 1994; Gielen and Green, 2015; Truong, 2014). Research emphasises the importance of encouraging parents/carers to change their smoking behaviour (e.g. stop smoking, smoking outside and away from their children) to reduce second-hand exposure (Alwan et al., 2010; McEwen et al., 2012; Ritchie et al., 2009). The protection of children's health and safety, was identified as a better argument for gaining the public's support than arguments that were seen as imposing constraints on individual freedom (Gielen and Green, 2015). Engaging parents in social marketing programmes is also a strategy to shape the social norms by recognising the role of networks in influencing individual behaviour (Gielen and Green, 2015). Training is generally provided to parents to educate and build their skills to change behaviour and/or reinforce social norms conducive to a smokefree environment (Daynard, 2003). A systematic review of social marketing initiatives suggested that teaching families how to handle emotions and conflict and resistance skills is an effective strategy to support youth to resist to tobacco, alcohol and drugs (Stead et al., 2007).

Similar to other social marketing programmes employing emotional appeals (Brennan and Binney, 2010; Luca and Suggs, 2010), Smokefree emphasises parental care and responsibility as key emotional appeals to engage with parents. Smokefree targeted

parents, mothers in particular, as they were easier to reach as users of local services (e.g. Children's Centres, health visitors) and women are thought to spend more time with their children. Indeed, smokefree homes programmes, are often addressed to women (Amey, 2011; Allmark et al., 2011; Hacker and Wigg, 2010; Ritchie et al., 2009; Stewart et al., 2010; White, Oliffe and Bottorf, 2012). The limitations of targeting women only will be discussed in detail in the following chapters.

The engagement of local services was identified as key to build capacity at the midstream level and address the context of behaviour. Collaborating with local services to implement the programme allowed customisation of the Smokefree conversation to the context of the service users. The programme launched the promotional campaign 'Smokefree' and targeted a range of stakeholders, particularly those professionals who were more likely to have an ongoing relationship with families with young children (staff from Children's Centres, Children's Hospital nurses, health visitors, community health development coordinators and their volunteers) with specialist training to enable them to deliver the message to their service users and encourage them to sign the pledge.

The Smokefree 'offering'

Smokefree included different products/offerings depending on the context of the desired behaviour and the actors involved. The study draws on the model proposed by Kotler and Lee (2008) as it provides a comprehensive conceptualisation that includes the dimensions suggested by Rothschild (2009), Smith (2009) and Peattie and Peattie (2003) to define the offering in the Smokefree programme. As previously explained, given the service orientation adopted by Smokefree, and the SDL theory employed in this study, the terms 'offering' and/or 'value proposition' are used to refer to social marketing products/services.

At the downstream level, the Smokefree actual product/offering involved not-smoking in homes or cars where children are involved; stepping outside to smoke at home; stopping smoking; signing the pledge and washing hands and faces after smoking. At the midstream level, for staff, in addition to the Smokefree related behaviours, the actual offering included engaging in the 'conversation' about Smokefree; asking people to sign the pledge and referring people to the STOP service. The core offering, or the benefits promised in the exchange process for members of the public included better health for

children, reassurance they are protecting children, cleaner air and reduction of the number of cigarettes smoked. For staff, the core offering included protection of children from second-hand smoke and reassurance they are doing their job. The resources that shaped the augmented offering included a smokefree kit (e.g. information, leaflet, tips and strategies to keep the home and car smokefree), a conversation with a Smokefree advisor which provided the opportunity to ask questions and receive more information and access to smoking cessation services. For staff, the leaflet acted as a tool to support the Smokefree conversation and capture data through the pledge form. As part of the augmented offering for staff, Smokefree provided training, information leaflets and free gifts. In addition, in exchange for their involvement in the programme, the local agencies received data reports on their contribution and number of pledges. The feedback and data reports were valuable instruments in showing local services' involvement in tackling smoking and contributing to their own evaluations.

The staff training consists of interactive sessions and practice scenarios and it has been conceived as a resource to demonstrate and discuss ways of delivering the message about second-hand smoke to the members of the public. The intervention guide suggested that staff should 'ask' people if they would be interested in learning about Smokefree; 'advise' people about the effects of second-hand smoke and 'take action' to ask people to sign up. The clinical practice 'Ask. Advise. Take action/Refer' used by Smokefree has been used in smoking cessation programmes as a systems-based approach to improve the practice of health professionals on tobacco addiction treatment (Revell and Meriwhether, 2011).

Segmentation and Stages of Change

Smokefree did not ask people to quit smoking but to make a small change of their behaviour (i.e. change where they smoke). By advancing a value proposition centred on changing one aspect of a problematic behaviour (i.e. smoking), the programme acknowledged that some people may not be ready to consider quitting. The understanding that signing the Smokefree pledge may be one step towards quitting and the framing that behaviour change is a process points towards Prochaska and DiClemente's (1983) Stages of Change Theory. The Stages of Change theory (Transtheoretical Model) has been one of the main theories of behaviour change in social

marketing (Lefebvre, 2000; Luca and Suggs, 2013), in particular as a way to segment people into groups and predict behavioural change and potential barriers to change of these groups (Logie-MacIver, Piacentini and Eadie, 2012). In an influential text, the model is proposed as a key element of the social marketing approach (Andreasen, 1995). The model posits that people move through five stages (precontemplation, contemplation, preparation, action and confirmation or maintenance), from ignorance to commitment and change (Prochaska and Di Clemente, 1983).

During the precontemplation stage, the individual does not acknowledge the behaviour as a problem and has no intention to change. In the contemplation stage, the individual is considering the problem and efforts to address it. In the preparation stage the individual is ready to take action and initiate change. The action stage occurs when the individual makes changes to their behaviour or changes to their environment to facilitate behaviour change. During the maintenance stage the individual adapts to the changes into their life and attempts to prevent relapse. The maintenance stage may last for an indeterminate time period if individuals need to constantly ensure that behaviour change is successful (Cismaru et al., 2008). The termination stage occurs only when there are no temptations for relapse (Prochaska and Di Clemente, 1983). The model is not linear and acknowledges that people may move between stages or relapse. Maintaining the desired behaviour may involve going through the stages several times (Cismaru et al., 2008).

Further developments of the model introduced 10 processes of change to understand how people change behaviour (Prochaska and Di Clemente, 1992; Prochaska, Di Clemente, and Norcross, 1992). The processes include five experiential processes, cognitive in nature (e.g. verbal processes such as education and information; commitment processes to overcome barriers to change) associated with the stages before action and five behavioural processes (alternative activities to the unhealthy behaviour, referring back to original plans to change) most frequent post action (Logie-MacIver, Piacentini and Eadie, 2012, Rosen, 2000).

The programme under analysis has recognised that people may be at different stages of change regarding their smoking status when they interact with the staff regarding Smokefree. However by asking people to smoke outside in order to protect children, the programme was able to target people at all stages of change, from precontemplation to

action. It acknowledged that people at different stages may require different strategies and processes to change (Prochaska, Di Clemente, and Norcross, 1992). People in the precontemplation stage were targeted with information and education to develop knowledge about second-hand smoke. For those in the contemplation, preparation and action stage the programme provided the opportunity to access the cessation service. For those in the maintenance stage, the programme provided a way of reinforcing the non-smoker status. Although Stages of Change has informed the segmentation of the smokers' group in the Smokefree context, the programme did not follow this model for the other groups targeted. The programme also targeted non-smokers and staff who were difficult to assign to a stage of change group.

The evidence regarding the effectiveness of this model is mixed. Stages of Change has been tested in various interventions such as smoking cessation, substance abuse and condoms promotion (Prochaska and Velicer, 1997). The best available evidence of its effectiveness in health interventions is limited by the methodological quality of studies (Bridle et al., 2005). A number of studies indicated limitations of the Stages of Change algorithm, measures of intention and previous quit attempts (Etter and Sutton, 2002; Hughes et al., 2005; Littell and Girvin, 2002; Riemsma et al., 2003; Schumann et al., 2006; West et al., 2001). Although Stages of Change has been demonstrated as a useful model to classify people into stages of change, studies highlight the limitations of this model in explaining the actual behaviour and the 'lived experiences' when trying to change behaviour (Brug et al., 1997; Logie-MacIver, Piacentini and Eadie, 2012). The model is centred on personal motivation and self-efficacy, thus neglecting external factors such as culture, social influences and other environmental and institutional factors (Adams and White, 2005; Dahl, Eagle and Ebrahimjee, 2013; Logie-MacIver, Piacentini and Eadie, 2012). Other studies have indicated that the Stages of Change model has not been able to measure changes in behaviour as people approach the action and maintenance stages (Steptoe et al., 1996; Brug et al., 1997; Adams and White, 2005). Given the limitations of the Stages of Change model in explaining the context and process of behaviour and social change, alternative theories and models are needed in order to explore structures, social influences and other environmental factors.

The programme was developed to emphasise the importance for smokers of leaving the house and/or car when smoking in order to protect others from second-hand smoke.

Promotional materials were developed to illustrate the potential harms to children breathing in second-hand smoke, and to encourage families to sign the pledge to keep their homes and cars smokefree. The evaluation commissioned by STOP services indicated that the majority of people (82%) reported that they were keeping the pledge six months after having signed the Smokefree pledge (Anonymous Group, 2013b).

This section has introduced the Smokefree case. The programme's elements will be discussed in more detail in the following empirical chapters.

3. 4. 4 The rationale for a Smokefree case study

The wide range of stakeholders involved and the community approach employed make smokefree homes programmes complex phenomena that are changing and evolving with the contributions from the participants. The diversity of actors involved in these programmes makes them good cases to explore the implications of roles and structures on engagement and co-creation practices. Health professionals constitute a key stakeholder group in the smokefree programmes. Previous research (Hovell et al., 2000; Ritchie et al., 2009; Tyc, Hovell and Winickoff, 2008; Winickoff et al., 2003) emphasises the role of health professionals in advocating for smokefree environments, especially for children, and the need for continuing training and education on second-hand smoke. However, other studies reveal contradictory evidence regarding the members' of the public reactions to receiving smokefree messages from health professionals (Hacker and Wigg, 2010) and the professionals attitude to taking up this role (Whitelaw et al., 2010). For example, formative research with communities in Salford, UK, has shown the preference for local people to deliver the Smokefree programme rather than health professionals (Hacker and Wigg, 2010). Yet, evaluations of capacity building to deliver Smokefree programmes indicate that health visiting professionals (i.e. health visitors, community nurses) are more likely than other local services staff, to engage with such programmes (Gordon, Friel and McGanachan, 2012; Robinson, 2009). Another study describing health professional capacity building for social marketing programmes highlighted the need for time, resources and comprehensive training to change professionals' attitudes to particular sensitive topics (e.g. healthy weight) and approaches (e.g. social marketing) (Whitelaw et al., 2010).

Case studies can be selected because of issues of access, uniqueness, representativeness of the case, or geographic proximity (Yin, 2003). The features of this programme make it the typical case for smokefree homes and cars programmes. Its 'representativeness' for such programmes, the nature of behaviour change (i.e. stop smoking inside one's own house), the efforts to change the norm around smoking, the diversity of the actors involved (assuming diverse value dimensions in this context) provide a unique opportunity to examine actors' experiences when engaging with the intervention requires commitment and sustainable action. The efforts to engage stakeholders and the community are relevant for the aspect of capacity building in a social marketing programme. Gaining insight from the variety of stakeholders involved in this programme on their experiences with this participatory approach can create a better understanding of stakeholder engagement implications for social marketing programmes and the barriers and challenges of this approach. Further, the long term access and geographical proximity make it an appropriate case to undertake an in-depth exploration of factors underlying engagement and value creation. The choice of one single case study should not be seen as a limitation as this study does not aim for statistical generalisation but for a rich account of the processes and analytic transferability (Miles and Huberman, 1994).

This section has covered the background of this research including a review of social marketing and smoking behaviours, smokefree initiatives and an introduction to the Smokefree case which is examined in this thesis. The rationale for selecting Smokefree as a case study has been discussed. In the following chapters, the analysis of the programme is centred on the processes of value creation and the engagement of actors. Social marketing, public health and SDL principles are interrogated to explore their compatibility for updating the social marketing framework. The next section discusses the methods of data generation employed in this research.

3. 5. Methods of data generation

3. 5. 1 The selection of participants

The study employs multiple methods of data generation through interviews, observation and document analysis to provide a holistic view of engagement and value creation in a

health social marketing programme. The data generation process is guided by the critical realist paradigm. Critical realism sees social reality as an open system which 'relies on human agency and activity to create it, sustain and transform it' (Connelly, 2000, p. 265). According to Bhaskar (1989) the object of enquiry in social science is provided by social relationships between actors and structures and between actors and actors. The units of data generation in this study are the actors (staff from Children's Centres, Community Health Development Coordinators and their volunteers, Children's Hospital nurses, health visitors, midwives and members of the public as their service users and programme organisers) involved in the health initiative. The unit of analysis is represented by actors' understandings, actions, interactions and relationships in a health behaviour change programme.

The recruitment strategy is guided by the research objectives and methods selected for this study (qualitative case study where the researcher is an observer participant). Purposive sampling is used to include actors with specialist knowledge (i.e. the programme manager), different levels of experience in delivering the intervention and from different contexts (i.e. community workers, health visitors). Purposive sampling allows participants to be selected according to predetermined criteria relevant to a particular research objective (Guest, Bunce and Johnson, 2006). This sampling technique is in line with the critical realist orientation which acknowledges the influence that context, experiences and structures have on actors actions. This technique is appropriate in order to capture the broad range of experiences required by the study (Darlington and Scott, 2002). Although Children's Hospital staff did not indicate a high level of engagement with the programme, despite the numerous staff that received the Smokefree training, it was included in this research as a 'deviant case' to prevent the research 'holistic fallacy' of seeking only congruent and patterned responses (Miles and Huberman, 1994).

The guidelines for qualitative research sample size do not agree on a certain ideal number as the context usually guides the number of participants. For example, Morse (1994) recommends at least six participants for phenomenological studies and approximately 30-50 participants for ethnographies, grounded theory studies, and ethnoscience studies. Creswell's (2009) recommends between five and 25 interviews for a phenomenological study and 20-30 for a grounded theory study. However, most

qualitative research authors indicate that sampling should continue until theoretical saturation occurs (Guest, Bunce and Johnson, 2006).

The heterogeneity of the sample has influenced the number of interviews as the aim was to capture the views of different stakeholder groups. The number of participants is a derivation of the number of stakeholders involved in the Smokefree homes and cars project and of service users that signed the pledge. The aim was to include participants from all stakeholders groups (as collaborator staff and the organisers of Smokefree) and participants from service users that signed the pledge after having interacted with Smokefree in one of the stakeholders' settings in order to capture perspectives of different actors involved in the intervention. However, since the stakeholder groups vary in size it was not possible to have equal numbers of participants from each stakeholder group.

Staff interviewees were identified in collaboration with the Smokefree project manager and the host organisations. The manager of Smokefree provided the contacts of managers from the partner agencies (who were participating in Smokefree) and forwarded them the invitation to participate in research on researcher's behalf. The invitation to participate in the study was sent to those centres/services which had received the Smokefree training. The researcher followed up the initial contact made by the Smokefree manager to discuss with the service managers their potential participation in the research. 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 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. Additional participants were recruited during the observation sessions. As the study aimed to investigate engagement and how actors create value in the context of Smokefree, it focused on understanding the experiences of those individuals who had signed the pledge as this was considered a sign of engagement with the programme. However, during the observation sessions, informal interviews were conducted with all users attending the sessions. Twenty seven out of the 43 participants

who were interviewed during these sessions had not signed the pledge. The majority of these respondents did not smoke and/or did not hear about Smokefree.

Having a person acting as a 'facilitator' that introduces the researcher to the setting can be helpful (Marshall and Rossman, 2011). Having the project manager of the Smokefree programme act as a 'facilitator' was helpful in reaching a number of participants. However, the presence of the 'facilitator' may shape the sample of participants according to their own agenda. The Smokefree manager suggested a number of centres and services as potential sites for research. The researcher sent invitations to the managers of the centres and services who were identified by the Smokefree manager as engaged with the programme. In order to avoid potential biases in selecting participants, potential participants were also identified from the researcher's observations at the site, analysis of the referral numbers and areas (i.e. additional sites from areas with lower numbers of pledges) and through snowballing techniques (i.e. where participants recommended, other relevant people were identified and invited to participate in the study).

3. 5. 2 Interviews

The study includes 47 semi-structured interviews with the main actors involved in the programme (staff from Children's Centres, Community Health Development Coordinators and their volunteers, Children's Hospital nurses, health visitors, midwives and members of the public as their service users and STOP Smoking Services as programme organisers). The interviews were digitally recorded and transcribed verbatim. The interview length ranged from 30 minutes to 2 hours.

The Children's Centre staff interviews included seven Children's Centre leaders/managers; five administrator and business support/receptionists; four family support officers; one Children's Centre teacher, three childcare early learning officers and play workers (CELOS) across nine Sure Start Children's Centres. The interviews also included seven health visitors covering six different areas of the city; two Children's Hospital staff; two community health development coordinators covering three different areas of the city, two community midwives and one maternity support worker. The study also includes 11 interviews with members of the public from different areas of the city.

Table 4 in the Appendices provides a complete list of the participants.[12] Children's Centre staff interviews were conducted between February and April 2013. All the other interviews were conducted between May and October 2013.

Although the Fire Service, the Road Safety team, the City Council housing department and Hostels staff were identified as potential collaborator actors by the Smokefree team, their limited involvement in Smokefree, combined with study resource limitations influenced the decision to limit the interviews to the staff who indicated sustained engagement and produced Smokefree referrals.

The study also employs informal interviewing at the observation sites. Informal interviews allow for 'naturalistic records' (Griffin, 2007) and a natural conversation. This technique is also useful when time constraints and work activities do not allow for a formal interview. In addition to the formal interviews the study includes 43 short informal interviews conducted during the observation sessions. The 43 informal interviews were spontaneous, as a result of the interactions with members of the public and some of the staff during the observation sessions. The informal interviews aimed to identify further participants in the study from those who were aware of the programme and examine members of the public's awareness of the programme. The informal interviews were not digitally recorded and notes were taken by the researcher. During the informal interviews members of the public were asked if they had heard about Smokefree. If they said yes they were asked if they signed up and the reason for doing so. They were also shown the Smokefree leaflet and asked for their feedback. Following the ethical guidelines, for the interviews taken during the observations sessions verbal consent was obtained from the participants.

The study uses face-to-face in-depth semi-structured interviews with open ended questions aiming to capture the perspectives of the different network actors involved in the project (staff from Children's Centres, Children's Hospital, nurses, health visitors, community health development coordinators, members of the public and programme organisers). Interviews are used to give participants voice (Creswell, 2009) and gain insight into their experiences, challenges and barriers of engagement in a health social

[12] All actors (staff and members of the public) are given fictional names to protect their identity

marketing programme. In-depth interviews are appropriate to elicit participants' experience and reflection on the topic (Miller and Glassner, 2011). Face-to-face interviews allow for an interactional encounter between the researcher and the interviewee. As an interactional process, interviews provide extra information by allowing the researcher to observe social cues, such as voice, intonation, body language (Sturges and Hanrahan, 2004).

Acknowledging the influence of context, structures and roles on actor action the study uses interviews with stakeholders from different groups that operate in specific contexts and have different roles. Interviewing staff from Children's Centres, community health development coordinators and nurses provides different perspectives as they have different roles and they operate in different contexts as non-medical staff, community development coordinator/ volunteers and medical staff. Interviews with health visitors and family support officers provide insight from actors that may have a closer relationship with families and who may be more likely to engage with families on the topic of second-hand smoke in a more sustained manner (Gordon, Friel, and McGranachan, 2012). However, they may also face different challenges due to the nature of relationships and the setting where they operate (people's homes) (Gordon, Friel, and McGranachan, 2012).

In-depth interviews with members of the public are employed to capture the perspective of those actors who play a different role as service users and audience of the social marketing programme. Exploring members of the public's experiences with the programme provides rich insight into the implications of engagement for behaviour change, limitations and barriers of the approach. In addition, examining members' of the public understandings and interpretations contributes to revealing factors and mechanisms that influence their action. The semi-structured interview with open-ended questions format has the advantage of guiding the conversation allowing for richer responses (Patton, 2002) giving people the opportunity to describe, recollect, and explore their experiences with the process of participation.

The interview requires building a relationship of trust between the researcher and the interviewee which shapes the interview process (Darlington and Scott, 2002). The researcher must be aware that the interviewee is not there waiting to be discovered and

that interviews are interactional situations where ‘mutual understanding’ and authenticity can occur (Miller and Glassner, 2011). This means that the researcher needs to make their intentions clear, talking about research with participants, explaining the purpose of the research and how data will be used (Miles and Huberman, 1994). This depends on the researcher skills not only on building the relationship but also on reaching the participants.

Open-ended questions are used to elicit participants’ perceptions and to tell the story of their experience, generate discussion on their thoughts, their views of their role and specific activities (Patton, 2002). The aim is to follow the conversation flow to allow people to share their experience and construct narratives. Open-ended questions explore issues that are new, or that are sometimes overlooked by the researcher. However, they are time consuming and they might raise issues of misinterpretation and coding (Patton, 2002). In order to ensure the capture of relevant data, the interview protocol uses sub-questions.

The interview protocol is designed to elicit the participant’s experiences, knowledge of the Smokefree programme and other health initiatives and attitudes and perceptions to engagement in health programmes, their role in these programmes, and what they perceive as barriers and challenges to engagement. The stakeholder (staff) interview topic guide covers topics such as: role in the organisation and in the Smokefree programme, awareness of other health initiatives, participation in other health initiatives, perception and understanding of the Smokefree programme, motivation for participating, interaction with members of the public and with the organisation developing the Smokefree programme, perception of value of health campaigns, capacity building and challenges of participation. The member of the public interview topic guide includes topics such as: awareness and perception of the Smokefree programme, awareness of other health initiatives, interaction with the staff of the organisation where they received the Smokefree information, perception about the notion of value (meaning of the pledge and of their actions), perception about the capacity to change, barriers and challenges of the approach. Data analysis is an iterative process with the researcher going back and forth to the data to look for more meanings and new findings. During the fieldwork, listening to the recorded interviews allowed the review of the interview guide to identify issues that needed further questioning (Grbich, 2007).

3. 5. 3 Observation

This study employs participant observation at the sites of partners involved in delivering the Smokefree message. As the literature indicates, interviews 'allow access to what people say but not to what they do. The only way to find out what 'actually happens' in a given situation is through observation' (Darlington and Scott, 2002, p. 51). Yet, 'what happens' is mediated by context and researcher presence. The issue of 'researcher's effect' (Miles and Huberman, 1994) is covered in detail in the section on reflexivity. In this study, observation is used as a triangulation technique. This allows for observation of interactions between Smokefree programme organisers, partners and the public and it helps examine if and how participants engage in co-creation activities. Observation at the sites of the project focuses not only on behaviours and interactions of actors but also on the context of the encounter, the structures and roles involved.

Approximately 30 hours of observation were conducted at five Children's Centres and at the Children's Hospital. The sessions observed included group sessions delivered by Children's Centre staff to service users, such as Stay and Play, Peak-a-Boo and Discovering babies. Observation sessions also included the reception activities at Children's Centres, the Smokefree training provided to nurses and the Life Training Support offered to parents in the neonatal section of the Children's Hospital. The field notes were transcribed and coded using the framework designed for interview analysis.

Observation is a common data generation technique in qualitative research allowing for in-depth examination of behaviours, interactions and actions within a specific context (Cresswell, 2009). This method provides the researcher with first-hand experience of the Smokefree interactional process. Observation methods allow for in-depth examination of how participants communicate and interact with each other and events that informants may be unable to share (Marshall and Rossman, 2011). Observation also provides the opportunity to analyse any discrepancies between the data obtained within interviews (Marshall and Rossman, 2011). As observation occurs at the same time as participants' everyday activities it requires little active involvement from the participants (Darlington and Scott, 2002). This can be particularly useful when research participants work in a high paced environment (i.e. health professionals).

Observation was not limited to visual notes. When observing, the researcher monitored both verbal and non-verbal clues in everyday language (Patton, 2002). Field notes include descriptions of settings, people, activities, language and sounds. The researcher noted verbal behaviour and interactions, physical behaviour and gestures, personal space (how close to each other people stay when they talk), number of people in the setting, people who stand out (Mack et al. 2005). As observation data was based on researchers' field notes and no visual or audio recording was being done during the observation sessions, it was imperative that the researcher updated the field notes at the end of the day to add further detail and comments on what had been observed.

Observation also has its limitations as it does not provide information on internal processes of cognition and on the reasons behind people's actions or the meanings of these actions for them (Darlington and Scott, 2002). Furthermore, the focus of the observation is limited to present events that are unfolding while observation takes place. A position as an observer-participant does not minimise the importance of reflexivity in the process of qualitative research. People who are observed may alter their behaviour, consciously or unconsciously which will affect the situation observed (Darlington and Scott, 2002). Although observation may seem more 'objective' than interviews (Sim and Wright, 2000), even in this case, the presence of the observer can influence the natural scene. One of the concerns raised about participant observation is the effect of the researcher's presence on those within the research setting, or the problem of 'reactivity' (Emerson, 1981). Classical conceptualisations of the researcher role in the field emphasised that the researcher must make efforts to minimise their impact on the situation observed (Emerson, 1981; Marshall and Rossman, 2011). More recently, it has been suggested that rather than limiting reactivity by adopting an unobtrusive approach, the aim of the researcher should be to recognise and take account of their impact during their analysis (Emerson, Fretz and Shaw, 2011).

In this study, the researcher entered the observation setting with a broad interest without strict observation checklists aiming to understand the place and discover interactions and relationships (Marshall and Rossman, 2011). The researcher adopts the position of an observer as participant where they adopt an overt stance as regards their role but participates minimally in the social situation (Sim and Wright, 2000). This position is

appropriate for this research as one of the aims is to examine the factors (such as structures) that influence action.

3. 5. 4 Document analysis

The review of documents linked with the health programme, including reports of formative and process evaluation and geo-demographical data, communication materials (leaflets, posters, information materials and training DVD) provided by Stop Smoking Services is necessary to understand the contextual factors and structures that shape the programme. The study also reviews health policy and guidance reports (e.g. DoH strategy for behaviour change programmes; DoH plan for health visitors) (DoH, 2010a; DoH, 2011) to better understand the historical dimension that frames the case. A critical realist orientation requires an understanding of individuals who are interacting within a specific context and of mechanisms which (historically) have produced the situation (Connelly, 2001). In addition to providing data on the context of the case, documentary sources help shed light on the organisational perspective and the rationale for adopting certain approaches to behaviour change. Corroborated with observation sessions and interviews, documentary analysis can help reveal contradictions between the organisational perspective and how actors experience and implement projects in practice.

It is important to acknowledge that documentary sources might present potential limitations and bias given by the nature of the social and historical context where they originated, editing and censorship reasons, deliberate distortion and misrepresentation (Scott, 1990; Sim and Wright, 2000). Thus, documents are not neutral accounts of organisational life, as they construct realities (Atkinson and Coffey, 2011). A critical analysis of the documents linked with the case aims to reveal not only the story itself but also the story behind it. This can be accomplished by comparing the documentary data with data from other sources such as observation and interviews, looking for discrepancies, identifying their objective and checking for messages 'between the lines' (Yin, 2003). In addition, document analysis raises issues of selection bias and access to the relevant sources (Yin, 2003). This can be addressed by examining a wide range of documents including those that may seem of little relevance for the particular case (i.e. organisational policy, evaluation records and articles) (Marshall and Rossman, 2011).

In this study the document analysis was guided by the findings emerging from interviews and observation. The promotional materials were examined to verify meanings and understand better how they fit with the aims of the organisation, the collaborator staff and the members of the public. The Department of Health strategy for behaviour change programmes (DoH, 2010a) was reviewed to examine the official guidelines for such programmes and how the Smokefree programme fits within those scripts. Previous publications linked with the Smokefree programme were reviewed in order to investigate changes in the STOP Smoking Services' approach to smoking and social marketing in general.

This section described the data generation methods used in this study. Interviews, observation and documents analysis were identified as relevant for this study. Purposive sampling and snowballing were used to select the participants. The following section introduces the approach that guided the data analysis process.

3. 6 Data analysis

The literature indicates many different approaches to qualitative data analysis depending on the philosophical, ontological and epistemological considerations that inform them (Mason, 1996; Miles and Huberman, 1994; Strauss and Corbin, 1990; Silverman, 1993). Hence, the selection of the data analysis approach is influenced by the ontological and epistemological considerations of the study.

Considering the nature of this research, a thematic analysis (Miles and Huberman, 1994) with theoretical sampling and a process of 'constant comparison' between theory and data (Partington, 2002) are appropriate for providing a systematic framework for data analysis. In line with the ontological and epistemological positions previously expressed, this study adopts a reflexive approach to data analysis promoted by those authors that emphasise the researchers cannot avoid 'the baggage' they bring into their research (Miles and Huberman, 1994; Partington, 2002).

The data analysis process is guided by the structure for data analysis suggested by Miles and Huberman (1994). This choice is justified by the critical realist position of these authors that is reflected in their framework for analysing qualitative data. A critical realist approach views the world as complex, marked by patterns and 'demi-regularities' or deviations (Clark, Lissel and Davis, 2008). Miles and Huberman (1994) propose that the data analysis process is guided by answering questions regarding patterns, common themes and deviations from those patterns. These patterns are considered the result of numerous aggregate factors which 'generate' an outcome (Clark, Lissel and Davis, 2008). Table 5 provides a few examples of how the thematic framework guided the data analysis in this study. The thematic framework is guided by the anticipated themes derived from the research questions and the aims of the study, as well as emerging themes raised by the data (Ziebland and McPherson, 2006). In addition to the inductive thematic approach, the study also uses deductive analysis when drawing on DoH reports (DoH, 2010a; 2010b, 2011) and staff and member of the public interviews to map the interactions between the actors participating in Smokefree (the findings illustrated in Figure 1 of Chapter 4 and description of actors in Chapter 4). Theoretical concepts are linked with the data to enhance explanation of the emergent themes. Qualitative researchers use deductive approaches as the data analysis evolves to focus on 'elucidating what appears to be emerging' (Patton, 2002, p. 194). The analysis is systematic and iterative with data being coded and recoded to accommodate new emerging themes until no new themes result (Miles and Huberman, 1994; Strauss and Corbin, 1994). The iterative analysis enhances our interpretation of the data and increases the reliability of the analytical process (Miles and Huberman, 1994).

The early analysis started with coding each transcript individually followed by associating codes with themes and then searching for patterns across the interviews. It is important to specify that although coding is an inductive process in this study, the analysis is affected by the preceding literature review, fieldwork experiences, and research questions (Ziebland and McPherson, 2006). The coding scheme was developed to identify patterns and themes that emerged from the data during an initial process of open coding of the transcripts (Berg, 2001). Codes are 'tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study' (Miles and Huberman, 1994, p. 56). Codes are associated with words, phrases, sentences, or whole paragraphs. Codes are not fixed as they are refined throughout the analysis

(Grbich, 2007). Initial codes (or first level codes) are more descriptive and closer to the text (Miles and Huberman, 1994). As the analysis progresses, codes are refined, pattern codes (second level) are identified and a smaller number of codes is generated to identify the themes and support the development of concepts (Miles and Huberman, 1994). Bhaskar (1998) argues for an epistemic relativism, which states that knowledge of reality is always relative to a theory and interpreted through theories. Thus, pattern codes are linked with themes and then the themes are developed around the theoretical concepts (e.g. value creation, networks, active customers, empowerment, engagement, resource integration etc.). The early themes were checked by two other researchers followed by another analysis by the lead researcher to refine and clarify meanings and themes. Table 6 in the Appendices, illustrates the process of coding and some of the main codes and associated themes of this research.

The early coding of the Children's Centre staff interviews was done in a Microsoft Word document, using colour codes for different respondents to organise themes and patterns. The primary reason for this choice was the familiarity with this method and a certain perceived flexibility. As the data progressed, NVivo qualitative research software was used for the analysis of the data. This change was due to the advantages of computer assisted data analysis when dealing with a large volume of data (Welsh, 2002). The selection of NVvivo over other similar software packages was determined by its features and recommendations from other researchers. This software assists in managing documents, organising raw data (interviews, observations), linking data with memos, coding, managing categories, editing and reshaping ideas (Walsh, 2003). The software allows for more freedom in playing with the data, searching for patterns across documents, and keeping the log from one session to another (Walsh, 2003).

Some commentators expressed concern that the use of software in qualitative data analysis might 'guide' the researchers in a particular direction (Seidel, 1991) and transfer quantitative principles into qualitative research (Barry, 1998). However, other authors argued that the use of qualitative software can help increase accuracy and transparency of the data analysis process contributing to the rigour of research (Richards and Richards, 1991). Although a software package may be useful in organising the data and helping to find patterns and exceptions, it cannot create the links between theories and data or define the structure for analysis (Pope, Ziebland and Mays, 2000). It is the

researcher's role to go beyond descriptions and codes to gain a deep understanding of the data, analyse meanings and theorise (Welsh, 2002).

This section covered the data analysis approach adopted in this study. Data analysis was guided by the framework for thematic analysis suggested by Miles and Huberman (1994). Coding of the data was done using Microsoft Word and NVivo. The following section discusses the quality criteria in qualitative research.

3. 7 Quality criteria of research

The richness of data generated by qualitative research can have disadvantages as it becomes difficult to manage. Some of the criticisms of qualitative research are that data are nonquantified, hence not generalisable (Silverman, 2000), descriptive and exploratory (Yin, 2003). As such, case study research has been criticised for lacking precision, rigour and objectivity (Yin, 2003). These issues can be addressed if the researchers carefully choose the appropriate method of research to answer their questions and make clear their purpose and the value of the exploratory dimension. The positivist tradition in which research has been grounded for decades still has an influence on the way qualitative research is being assessed today and efforts have been made to define the criteria for evaluating qualitative research. The following section discusses the quality criteria that guided this research.

3. 7. 1 Criteria for evaluating qualitative research

There is a debate regarding the criteria to judge the quality of qualitative research. A number of authors (Golafsani, 2003; Maxwell, 1992; Yin, 2003) identify construct validity, internal validity, external validity and reliability as research criteria that qualitative research has to meet. Other authors argue that authenticity, rigour, plausibility and reflexivity are more appropriate for assessing the quality of qualitative research (Guba and Lincoln, 2005; Silverman, 2000). Patton's (2002) criteria of credibility, confirmability, data dependability and trustworthiness are also widely accepted. This study follows the criteria suggested by Miles and Huberman (1994) who paired up the traditional terms identified in the literature to evaluate the quality of qualitative research:

objectivity/confirmability; *reliability/dependability/auditability*; *internal validity/credibility/authenticity*; *external validity/transferability/fittingness*; *and utilisation/application/action orientation*.

Objectivity/Confirmability

One of the concerns of qualitative research is the issue of objectivity and replication of studies. Researchers are advised to clearly describe the research process, methodology and methods, keep a detailed record of the study stages and reflect on potential biases of the research and ways to address them (Miles and Huberman, 1994). Miles and Huberman (1994) indicate the most common types of analytical biases in qualitative research and suggest tactics to avoid them. *The holistic fallacy* refers to the interpretation of the phenomena observed as patterned and congruent and ignoring the elements that do not confirm these patterns. *Elite bias* occurs when more focus is given to data from well informed individuals at the cost of underrepresenting data from less articulate individuals. *Going native* can be a source of bias if the researcher loses their own perspective by adopting the views of the researched (Miles and Huberman, 1994). Tactics such as checking for representativeness, triangulation, checking for researcher effects, looking for deviations (e.g. Children's Hospital data), following 'surprises' (e.g. data that indicated a negative view on Smokefree effectiveness) checking for rival explanations and getting feedback from participants (Miles and Huberman, 1994, p. 263) were found useful to avoid biases in this research.

The accuracy of the field data was ensured by recording interviews and their verbatim transcription. The observation field notes were updated at the end of every observation session to capture new reflections and enrich the notes taken during the sessions. The research methods are clearly described and the research process is thoroughly revealed to the reader step-by-step. Keeping a field log of the research procedures (dates of the interviews and names of persons, the meetings observed) helped minimise biases and errors when reporting the study (Miles and Huberman, 1994). In addition, a clear definition of the role of the researcher and the ontological and epistemological considerations in the research process contributes to the reliability of the research (Guba and Lincoln, 2005). In order to clarify meanings, identify multiple realities and verify plausibility of findings, this study uses data source (various stakeholder groups) and method triangulation (interviews, observation and document analysis) (Miles and

Huberman 1994). Although observations or interpretations are not perfectly repeatable, triangulation and rigorous analysis can serve to clarify meaning by identifying different ways the case is being seen (Silverman, 1993) and separate 'experiential knowledge ' from opinion and preference (Stake, 2005).

Reliability/Dependability/Auditability

A common concern in qualitative research is related to the issue of *reliability* (Hammersley, 1992) because the researcher shows only pieces of their fieldwork notes and transcripts, shaping the data, adding to the original meaning. Other scholars (Healy and Perry, 2000; Guba and Lincoln, 2005) emphasise that reliability and validity are criteria grounded in the positivist paradigm and that consistency, dependability or trustworthiness (Seale, 1999) are more appropriate as essential criteria for quality. The underlying issue is if the research process is consistent over time and across methods. The consistency of the data is obtained by verifying raw data, data reduction, code checking and process notes (Miles and Huberman, 1994).

Internal validity/Credibility/Authenticity indicates how credible the claims of 'truth' are regarding social phenomena (Denzin and Lincoln, 2005). Maxwell (1992) distinguishes between descriptive, interpretive, theoretical and evaluative as different types of understanding that can be generated by qualitative research. The researcher needs to make clear to the reader the types of findings and the research process for reaching those findings. The use of multiple sources of data including actors from all groups involved in the Smokefree programme contributes to a holistic image of the case while making sure that all voices are being heard. In-depth interviews were conducted to provide rich accounts of participants' experiences while observation and document analysis were used to give context-rich descriptions (Miles and Huberman, 1994).

External validity/Transferability refers to how the findings can be transferred to other settings similar to the one in which the study occurred (Miles and Huberman, 1994). This study aims for what Maxwell (1992) calls 'theoretical' validity which requires research to provide a more abstract explanation of the meanings and experiences captured and create a link with the theory. This case study is an example of a representative case for smokefree homes and cars programmes. As such, the findings of this case may be used to search for similarities with other cases of smokefree programmes, particularly those

which adopt a service perspective in a community setting. The findings may also be used as a starting point to explore programmes that deal with other health behaviours and aim for a collaborative value creation approach. Reports of the findings were shared with a range of participants (i.e. Smokefree team) in the project at different stages of the research to consult for respondent validation. The aim of this study is to contribute to theory extension and the understanding of engagement and value creation in health social marketing. Thus, the focus on one case aims to provide an in-depth and rich description of the interactions, relationships and factors shaping actors' engagement to allow for understanding of the value creation process in health social marketing.

Utilisation/Application/Action Orientation

Another key criterion for assessing the quality of qualitative research is its application or 'pragmatic validity' (Kvale, 1989 as quoted in Miles and Huberman, 1994). Particularly critical methodologies stress the emancipatory dimension of research (Ozanne and Anderson, 2010) and that committing to social justice, equality, nonviolence, peace and universal human rights agenda is no longer an optional extra (Denzin and Lincoln, 2005). Qualitative research has to be fair, meaning that 'all stakeholder views, perspectives, claims, concerns, and voices should be apparent in the text' (Guba and Lincoln, 2005, p. 207). A good piece of qualitative research sets cues to action and it is accessible intellectually and physically to potential users (Miles and Huberman, 1994). Conversations with the manager of Smokefree and presenting initial findings at practitioner oriented conferences helped to articulate the practical implications of the research. The quality of research is also given by the research agenda proposed at the end of the study and the way it enables understanding of those researched about their context (Johnson et al., 2006). Exploring the implications of a service perspective in a health/social change context, this study aims to provide an updated framework (as informed by service driven benchmarks) for social marketing programmes. In doing so, the study contributes to theory, practice and policy. The research agenda proposed at the end of this study provides a comprehensive view of important issues that need further exploration as well as of areas where SDL requires adaptations in a social change context. The discussion of quality criteria for qualitative research continues in the next section with an account dedicated to reflexivity as another key issue to consider in qualitative research.

3. 7. 2 Reflexivity

Reflexivity and the ways in which 'our subjectivity becomes entangled in the lives of others' (Denzin, 1997, p. 27) is a key issue in qualitative research (Denzin, 1997, Hammersley, 1992). Qualitative researchers are required to exercise a high degree of reflexivity not only about their influence on the research but also about revealing the research process step by step to the reader for transparency and credibility (Maxwell, 1992). Qualitative researchers play multiple roles as an 'inquirer and respondent, as teacher and learner' at the same time striving to reveal 'the self within the processes of research itself' (Guba and Lincoln, 2005, p. 210). Some scholars assert that even our emotional response to respondents can influence the research process (Mauthner and Doucet, 2003).

Reflexivity has been discussed in relation to the 'social location' of the researcher (Olesen, 2005). Particularly critical studies have examined how researcher's social background, race, gender, class and their similarities or differences with the researched may influence the research process (Olesen, 2005). Furthermore, the choices that shape the research process and outcomes are influenced by interpersonal, political and institutional contexts of researchers (Hammersley, 1992; Mauthner and Doucet, 2003; Miles and Huberman, 1994). The research methodologies and schools of thought predominant at the researcher's institution and, the research agenda promoted within the field are factors to consider when reflecting on how the research was shaped (Mauthner and Doucet, 2003). My academic background and my interests in developing the social marketing domain and improving its framework for behaviour and social change shaped the focus of this study. My ontological beliefs (critical realist belief that 'there is a reality out there') have influenced the selection of the object of research and research methods (interviews, observation, document analysis) and how they have been used (semi-structured, open-ended interviews) to capture participants' perspectives. My normative beliefs and interests in empowering communities and building capacities for change influenced the choice of the case. The field work experiences added rich insight into the world of the participants. Being able to participate at various sessions at Children's Centres and Children's Hospital provided background to the lives of the participants in the study. Further, my own socio-cultural background meant an increased self-awareness

of the research context and efforts to participate without being an 'intruder'. As previously discussed, some scholars suggest that rather than viewing reactivity to researcher's presence as a problem that needs to be eliminated, the researcher needs to reflect on these aspects and acknowledge them as part of the research process (Clarke, 1975; Emerson, Fretz and Shaw, 2011).

Scholars have acknowledged the importance of being reflexive about how researchers collect and analyse the data and about the 'baggage' of assumptions and preconceived notions they bring with them to the research (Kincheloe and McLaren, 2005; Strauss and Corbin, 1990). Thus, reflexivity is inherent to all stages of qualitative research from defining ontological, epistemological and theoretical constructions to data collection, analysis and writing up (Mauthner and Doucet, 2003). Reflecting and recording my interpretations during the research process helped the process of revealing to the reader how I reached those findings (Hammersley, 1992). When writing up the case, reflection on the quality of data and making those reflections available to the reader (Miles and Huberman, 1994) ensures reflexivity. Other scholars (Mauthner and Doucet, 2003) suggest allowing time, distance and detachment from the research to help deepen the reflexivity over the research process. The research process was iterative with stages of data collection alternating with data analysis allowing time to reflect on the data. Data collection and analysis stages alternated with other research activities such as writing reports and papers and presenting initial findings to different audiences. These 'gaps' and sharing the initial findings with different audiences (i.e. social marketers, sociologists, health practitioners, public health policy officers) helped in gaining a fresh perspective on the data and reshaping some of the initial themes. In addition, reviewing the literature for novel work drawing on SDL has provided new sources for refining initial concepts and ideas.

This section covered the criteria for qualitative research which guided this study. The criteria suggested by Miles and Huberman (1994) to evaluate the quality of qualitative research - *objectivity/confirmability*; *reliability/dependability/auditability*; *internal validity/credibility/authenticity*; *external validity/transferability/fittingness*; *and utilisation/application/action orientation* - were discussed in relation to how they were applied in this study. A separate section was dedicated to reflexivity and the role of the researcher on this study. A high degree of reflexivity was acknowledged not only about

the researcher's influence on the research but also about explaining the research process to the reader for transparency and credibility. The following section of this study concerns the ethics process that guided this research.

3. 8 Research ethics

The study is conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social Care, 2005. The general ethical principle is that 'respondents should not be harmed as a result of participating in the research, and they should give their informed consent to participate' (Bowling, 2009, p. 176).

Research in National Health Service (NHS) settings that involves NHS staff and users requires ethics and research and development (R & D) approvals from the NHS bodies. The study was not initiated before the protocol, consent forms and participant information sheets had received approval/favourable opinion from the Research Ethics Committee (REC), and the NHS R & D departments of the two Trusts where research takes place.

The research endeavours to protect the rights of the study's participants to privacy and informed consent, and adheres to the Data Protection Act, 1998. The process for obtaining participant informed consent is in accordance with the REC guidance and Good Clinical Practice (GCP). Participants were informed they could withdraw from the study at any time and the researcher answered any questions they had regarding the study. Confidentiality and privacy can pose problems in research when dealing with delicate topics and vulnerable participants such as patients, victims, people with disabilities etc. (Shaw, 2003). This was not the case with this study interviewing staff and members of the public participants in a smokefree programme. However, the researcher is bound to respect the same rules of confidentiality and privacy.

As an observer participant, the researcher aims to limit social interaction. However, there is the risk that the presence of the researcher during observation sessions might be

perceived as a burden or it might make the staff believe they are being evaluated in their jobs. This was addressed by explaining clearly the purpose of this study and of observation sessions and trying to minimise any interference with their work. The aim was to avoid situations that might be uncomfortable or pose the risk of distress for participants. Given the nature of the behaviour promoted by the programme under analysis (keep your home/car smokefree) there was a risk that participants would feel they were being assessed by the researcher. Interactions with the participants were guided by this consideration and the purpose of the interview was made clear from the beginning in order to avoid people feeling that they were judged by the researcher or that the study intends to measure the effectiveness of their performance in the Smokefree project.

The findings of the study are accurate, including the identification of challenges and barriers to engagement and value creation processes, but all reporting was anonymised. All information is kept confidential, including the encryption of electronic data. There was no information disclosed during the study that could pose a risk of harm to the participant or others.

3. 9 Conclusions

This study adopts an 'inductive top down' approach to explore the implications of a service perspective in health social marketing. Evidence indicates that one of the key lessons of social marketing regarding the social determinants of health is that, in order to bring about sustainable behaviour and social change, social marketing programmes need to tackle internal and external factors (NSCM, 2012). There is a growing understanding that health behaviour change programmes are complex open systems (Bhaskar, 1989) where individual, socio-cultural and organisational factors influence health outcomes (Cruickshank, 2012; Clark, MacIntyre and Cruickshank, 2007). This suggests that a focus on experiences, events and generative mechanisms is important to be able to better understand the inextricable psychological and structural factors that influence human action. The nature and objectives of research combined with the researcher beliefs have led to selecting critical realism as a research paradigm informing the ontological and epistemological considerations of this study and a qualitative methodology with case

study as a research method. The choice of multiple data generation methods is used to provide 'context rich and meaningful descriptions' (Denzin and Lincoln, 2005) and insight from the range of actors involved in the health programme. This chapter also discussed the quality criteria and the ethical considerations of this research.

The methods employed in this study are based on the principle that research is an iterative process and that new information from the field continuously shapes the research design. A case study design can be modified by the discoveries from the field (Yin, 2003) while a thematic analysis supports the idea of a constant interplay between data collection and data analysis (Miles and Huberman, 1994).

The following chapters concentrate on the findings of this study. The findings are organised in three chapters: one chapter that discusses the actors, their roles, work practices and networks as factors that influence engagement and value creation; a chapter focused on the process of value creation (value facilitation, co-creation and resource integration) in a social marketing context and one chapter concentrated on value dimensions (outcomes) and motivation for engagement. Throughout the empirical chapters the challenges and barriers of a collaborative value creation model in social marketing are discussed. The final chapter is dedicated to the conclusions of this study.

Chapter 4: Understanding actors in a collaborative value creation network

4. 1 Introduction

This chapter opens the empirical section of this thesis. Given the interdisciplinary nature of this project the approach is 'inductive top-down' (Shepherd and Sutcliffe, 2011), starting with an investigation of different literatures going across disciplines and paradigms in order to identify key areas for research. The study draws on social marketing, SDL and public sector/public health literature to search the data for factors that influence engagement. As described in the Methodology chapter, the thematic framework is guided by issues derived from the research questions (i.e. What factors influence actor (stakeholder and service user) engagement in a health social marketing context? What are the barriers and challenges of a collaborative approach to value creation in a health social marketing context?), the aims of the study (i.e. to investigate the implications of engagement of both, members of the public and collaborating staff for value creation), and new issues raised by the data (Miles and Huberman, 1994). The mapping of the networks (actor-actor; actor-structure) and the description of actors draw on interviews, official reports, policy documents (DoH, 2010a; 2010b) and other publicly available data (i.e. NHS services websites). The participants' interview accounts were complemented by the analysis of such documents to triangulate the information and provide a comprehensive picture of the role and position of these services in the community. Inductive coding generates categories and themes which are then developed to answer the study questions (Berg, 2001). Themes may focus on activities, behaviour, stories, common phrases, shared experiences or understandings. As the data analysis progresses and new themes emerge, the literature review is updated to accommodate new concepts and theory relevant to the data.

One of the key propositions of SDL is that value is created in context as a result of a collaborative process that involves suppliers, customers and other actors in their own networks (Chandler and Vargo, 2011; McColl-Kennedy et al., 2012). Adopting an SDL lens, one of the aims of this study is to gain a deeper understanding of the factors influencing engagement of actors in collaborative value creation. The critical realist philosophy principles which inform this study recognise the importance of relationships

and networks as having a 'causal power' on action (Bhaskar, 1989; Peters et al., 2013). As such, the study examines the actors in the context of support networks existing in the community, to gain an understanding of the nature and extent of their interactions and their professional roles. The analysis is conducted at the individual level (of each member of staff/member of the public account) and then the findings are aggregated at the group level. Patterns and deviations are searched across groups.

The literature review indicates that anticipated themes around engagement are centred on the context of individual actors. Broad anticipated themes hinted at the importance of networks and actors' roles for engagement with Smokefree. The analysis of the data indicates professional roles, work practices and actor's networks as key structure related factors that influence actor engagement with the health social marketing programme. The findings reveal complex interactions - among the staff actors and members of the public as service users - that require adaptation of the social marketing offering to the encounter context.

The literature review chapter notes that the marketing (Brodie et al., 2011) and public service literature (Thompson, 2007; Bovaird, 2007) distinguishes between engagement, participation and involvement as different concepts, each referring to different stages of actor action, state and roles (Brodie et al., 2011). Fishbach (2009) refers to engagement as 'motivation to act'. Other definitions describe engagement as a psychological process centred on interactive experiences (Bowden, 2009; Brodie et al., 2011) or as an active relationship with a focal object (Mollen and Wilson, 2010). Drawing on conceptualisations from the marketing and the public service literature this study examines actor engagement as a process centred on interaction defined by relationship experience and the stage of involvement in the social marketing process. As such, actor engagement is defined by active participation and motivation to interact and collaborate with other actors within the network to co-produce the social marketing offering, facilitate and co-create value.

The chapter examines the professional roles, work practices and networks of the actors involved in developing a social marketing smokefree programme. The chapter starts by

examining the actors involved in developing and implementing Smokefree [13], their roles and the relationships/ties among them. The following section will focus on the work practices of collaborator staff which shaped their engagement with Smokefree. Another chapter will focus on value creation as an encompassing process that includes value facilitation, co-creation and resource integration (Grönroos, 2012).

4. 2 A network perspective

The Smokefree programme engaged health visitors, midwives, nurses, community health development coordinators (CHDCs), STOP Smoking Services and Children's Centre staff to have a conversation about the 'Smokefree message' and encourage their users to sign a pledge to keep their homes and cars smokefree. These actors[14] were identified as being part of 'networks of support' in the community. The Smokefree team aimed to strengthen existing collaboration relationships (such as community health development coordinators who were promoting STOP Smoking Services) and develop new relationships with actors that had an element of interaction with the final users of the programme (families with young children) and/or had a strong health and wellbeing interest. Additionally, collaboration was sought with other actors in the community such as the Road Safety crew, hostel staff, the City Council housing department and the Fire Service department. These actors were identified as having a common interest in preventing smoking in homes or cars due to the implications for safety. However, as explained in the Methodology chapter, their limited involvement in Smokefree, combined with study resource limitations influenced the decision to limit the interviews to the staff who were most engaged and produced Smokefree referrals.

Smokefree identified the staff actors that would be suitable to deliver the Smokefree message as one of the audiences of the programme. The approach of STOP Smoking Services is centred on the principle that understanding how networks operate and collaborating with them can increase the reach and spread the message about smoking.

[13] In this study, the social marketing smokefree homes and cars programme under analysis is identified as 'Smokefree'. The real name of the programme is not disclosed in order to comply with confidentiality and anonymity requirements. All actors (staff and members of the public) are given fictive names.
[14] Each Children's Centre is based in a different area of the City. Each area is given a number (i.e. Centre 5 is located in area 5). When the participants are not interviewed/based at the Children Centre their location is associated with the area number (i.e. Centre 5 is located in area 5)

The outreach work involves understanding the practices and priorities of other agencies and a search for ways to offer something that is relevant to their roles.

> "I suppose I realised a while ago that if that's a hundred percent of your population and twenty five percent of them smoke, that's seventy five percent who don't smoke and if you can talk to them and get them communicating with the people that they're in contact with every day whether it's family, friends, colleagues, bosses, service providers whatever you increase the noise that you make. And if we can all do that you know I've got a team of thirty four people, if we're all doing that with our networks and talking to all those non-smoking people we're making a very loud message to that twenty five percent…" (Lydia, manager STOP)

As discussed in the literature review chapter, Network Theory is a useful perspective to help with the mapping and understanding of relationships between the various actors involved in this social marketing programme. Gummesson and colleagues (2009, p. 37) suggest that a network view can be employed to analyse value creation processes in relation to inputs ('many-to-many resources'), processes ('many-to-many resource integrators') and outcomes ('many-to-many value') for different actors (not only customers).

It is important to clarify that the aim was not to adopt a whole network theory approach to analysing the data. For this study, it is rather argued that Network Theory can provide some useful concepts in understanding value creation in a deeper relational context. Examining value creation in context requires understanding that the relationships among actors and the location of individual actors in the network may have 'behavioural, perceptual, and attitudinal consequences' for individuals and for the system as a whole (Knoke and Kuklinski 1982, p. 13). The critical realist perspective that informs this study is aligned with the position proposed by Emirbayer and Goodwin (1994) where network theory is a structuralist approach that acknowledges the interplay between social structure, culture, and human agency. The focus of the study is not only the relationships between various actors but also the role of ideals, beliefs, and values of those actors in influencing action. Thus the study rejects structural determinism (Emirbayer and Goodwin, 1994) acknowledging the role of individuals and transformative agency (Hays, 1994).

Gummesson (2007) argues that networks are not only structures but also 'the processes going on in the structures and the processes of changing the structures' (p. 241). Sayer (2000) notes that social structures may exist where individuals (re)construct them. Once created those structures 'may empower or constrain social action and tend to be reproduced by that social action' (Sewell, 1992, p. 19). As described in the Methodology chapter, structures are 'regularities in social interaction' including but not limited to networks, institutions, roles, group affiliations, practices etc. (Cockerham, 2005). Therefore, when researching creation of value in a social marketing context we need to understand actors in their context and explore the interplay between structures (roles, organisation, rules, social relationships and practices) and agency (Danermark et al. 2002).

In the case under analysis, the Smokefree programme was developed taking into account the existing networks of support (professionals) in the community and the link between smoking and their work objectives and interests. In this case, interaction of the Smokefree team with different actors in the existing network has generated new relationships (collaborations with neonatal nurses) and redefined others (Children's Centre staff who became champions in promoting the programme) reshaping the Smokefree network.

The following section is dedicated to describing the actors' professional roles and position within the Smokefree network.

4. 3 Introducing the actors

4. 3. 1 STOP Smoking Services

The Smokefree programme has been developed by STOP Smoking Services. The STOP Services aim to help people to stop smoking but also work on smoking prevention, protection from second-hand smoke, legislation and regulation. The overall approach to stop smoking has changed over the years from target oriented towards a more holistic service aiming to prevent, support cessation and reduce smoking prevalence in the population.

> "I think when I started the job it was almost just an office manager's job just making sure that we hit our targets and I think we've been able to develop that through extra funding […] into a much more comprehensive programme to try and reduce smoking prevalence all together. So we're not just looking at short term quits but a complete change of behaviour in the population to reduce smoking rates." (Lydia, manager, STOP)

The Service has adopted a network approach working with partner agencies which may use their position in the communities to influence their users. The STOP Smoking Services liaised with potential partners and provided them with training to facilitate their involvement in the programmes. The manager of STOP emphasised the diffusion and network effect (Scott, 2000) when the message is spread not only within the formal staff-user network but also within the staff's personal networks.

> "Other examples might be that we, we do a lot of training and advocacy work with partner agencies who are in a really good position to use their influence with their patients services users, even their friends and family on smoking and you know getting the message out there." (Lydia, manager, STOP)

4. 3. 2 The communities targeted by Smokefree

Initially, the Smokefree programme was targeting young families and families with chronic obstructive pulmonary disease (COPD). Once the programme was rebranded as a specific project, they aimed for a larger audience. The communities targeted by the Smokefree programme are labelled as deprived communities (NHS PT, 2010). Children's Centre staff, health visitors and midwives highlighted common problems of families in those communities including high unemployment, domestic violence, high alcohol intake, smoking, drugs, general ill health, general poor diet, people feeling unwell, an unhealthy lifestyle, poverty and deprivation. As the manager of STOP emphasised:

> "…it's not […] business people, executives and so on that are still smoking, it's routine and manual people who read the red top newspapers, who shop at the lower cost supermarkets […] a lot of people who aren't in work, so whatever campaigning we do has got to speak to those people." (Lydia, manager STOP)

Nonetheless, the members of the public interviewed used positive words to describe their communities. This was also supported by the community health development coordinators (CHDC) who emphasised the communities featured good support networks.

> "… Yes, it's lovely round here. […] so I've worked away a lot and all round, all round England and I've worked abroad […] and still this is the best place to live." (Gilbert, member of the public, area 8)

> "…This is a good area. […] Yes, it's a lovely community round here […] We're all friends around here, we all look out for each other." (Jessica, member of the public, area 7)

> "We've got a good Sure Start on the estate as well so they support them but the majority, the vast majority have good support mechanisms with mum and gran living within a couple of streets, […] quite a close knit community." (Karla, CHDC, areas 6 & 8)

People living in the most deprived areas tend to be one of the most challenging groups to reach and information alone is unlikely to be enough to help them change behaviour (DoH, 2011). Traditional short social marketing campaigns/interventions are unlikely to reach these individuals through conventional channels. These groups require a comprehensive approach that builds on existing networks in the community to support individuals through the process of change.

Reaching people that would benefit the most from changing behaviour is one of the central issues in social marketing and public health. This raises the question of segmentation and targeting, a central feature of social marketing programmes. As mentioned in the literature review, the segmentation of audiences in social marketing programmes has raised criticisms that they might miss those groups that are more difficult to reach and support to change (Brenkert, 2002; Newton et al., 2013; Stead, Hastings and McDermott, 2007).

4. 3. 2. 1 Targeting and interaction

The SDL literature argues that the traditional notion of targeting customers with promotional messages only assumes a passive role for the customer and a view of marketing 'done to people' (Karpen, Bove and Lukas, 2012; Vargo and Lusch, 2011). One of the social marketing criticisms is that this unidirectional communication approach reduces the opportunities for interaction and citizen participation in the development of the change programme (Brenkert, 2002). 'Targeting' was suggested as a key element of the approach adopted by Smokefree, by both, partner staff such as health visitors and Children's Centres, and STOP Services. The manager of the Smokefree programme talked about the different target audiences of the programme and 'targeting' the partners with relevant training. In this case targeting was used to customise the training and the conversations to suit the needs of the actors participating in Smokefree.

> "I think the most important thing that we've learnt over the years is to make the campaign easy to relate to by our target audience…" (Lydia, manager, STOP)

One of the CHDCs suggested that community driven health programmes should look beyond demographics to the existing networks and culture which differentiate communities. One of the CHDC's experience with social marketing suggested that social marketing campaigns that were developed at the national level were actually not reaching populations which are generally more difficult to reach such as certain ethnic groups or people living in deprived communities. CHDCs emphasised that the communities in some of the areas targeted by STOP (4, 6 and 8) were stable communities where three generations were living on the same street and strong ties seemed to provide good support.

> "[Area 6] it's got a great community, it's not a transient community, it's a very stable community where you get generations living you know all on one street […] I think you need to know the community, I think you really need to know the people that you're working with because people might look at the demographics and say well actually two and six are identical, you know, if you look at the white population the majority of the white population etc. […] they're absolutely different, the way that they work is completely different. So the networks are completely different…" (Minnie, CHDC, area 6)

The target audience of the Smokefree programme was identified as the population living in areas with high prevalence of smoking. It would have been challenging reaching such a diverse population using a traditional promotional social marketing approach. The campaign would have needed different promotional materials for each socio-economic and cultural group. The network interaction was meant to allow an individual customised approach where the Smokefree conversation was tailored to suit the individual user but also the practice of the staff engaging in the conversation. Nevertheless, the agencies engaged with Smokefree (i.e. Children's Centres and health visitors) are dealing mostly with women, which influenced a great number of the sign-ups from women.

The health visitor staff suggested the programme should be more inclusive and aim to extend its reach to target older people and men. Particularly when young families live with the extended family there is a need to address the smoking issue with members of the family such as grandparents who are likely to spend time with young children. The focus on young families and particularly women was sometimes perceived as biased and excluding men who are likely to be smokers as well.

> "But it is interesting that we are seeing women predominantly, I can't tell whether that is a man or woman in the car […] it seems quite biased. […] And it demonises women actually, so I don't like that." (Sandra, health visitor, centre 8)

Programmes aimed to tackle smoking, in particular those promoting smokefree homes, are often addressed to women (Amey, 2011; Allmark et al., 2011; Hacker and Wigg, 2010; Ritchie et al., 2009; Stewart et al., 2010). A smokefree programme focusing on women only does raise concerns regarding the health effects of men's second-hand smoke (White, Oliffe and Bottorf, 2012). Previous studies indicate that men's smoking acts as a barrier against women's tobacco reduction and cessation attempts (Bottorf et al., 2006). Furthermore, men's smoking has been shown to increase the chances of their children being smokers (Oliffe et al., 2009). The Smokefree manager acknowledged this limitation and highlighted that the programme aims to address this issue and to involve fathers more.

> "I've got a campaign that is rolling and keeping rolling and I've got new added elements coming in all the time and little bits that I can develop […] I feel there's still stuff to be done particularly around working with men, fathers and engaging men." (Kathleen, manager, Smokefree)

People that you never reach

The manager of STOP Services indicated that the programme reached its audiences, specifically people who needed it the most. However, some of the partner agencies' staff indicated that the initiative might have missed men and those people who avoid public services.

> "…Kathleen [the manager of Smokefree]'s very much concentrated on the priority of wards where we know that smoking rates are highest from the City Lifestyle survey […] we know where smoking in pregnancy is highest, they're all the same wards, that's where the community development coordinators are working, where the Children's Centres are working." (Lydia, manager, STOP)

The limitations of health initiatives in reaching some groups of population have been acknowledged by the community health development coordinators (CHDCs). They noted that community initiatives tend to engage the same people. This is in line with other studies which indicate issues of representativeness and reach of community based programmes (Attree et al., 2011).

> "I would say between the groups and the organisations you're only reaching twenty percent of the community and it's the 'usual suspects' that always get involved that have always been active within their community." (Karla, CHDC, area 4 & 8)

Reaching people that are more difficult to engage remains a central challenge of social marketing health initiatives (Brenkert, 2002; Stead, Hastings and McDermott, 2007). Despite the interaction and collaborative approach adopted by the Smokefree programme under analysis, there are groups of individuals who avoid or simply do not engage with local community services. An interaction based approach poses limitations in terms of restraining their action to those who are service users.

> "…some people you can never reach. Because you might see their new baby, you might see them at six weeks, and you might not see them again until that child is one year. Now if they're not flagging up any issues, then you might not see them. If they don't come into Sure Start, if they don't use the facilities, come and see the health visitor, or ring them up and ask them anything, then things aren't being flagged up and things can be missed." (Marcia, health visitor, centre 10)

The staff reflected how sometimes their job is to identify people with problems and support them to access the services that might help them. As one of the health visitors suggested, part of their job is to 'hunt people out'.

> "We actively search for people with problems now and target people and I don't think we did that years ago…" (Lucy, practice teacher and health visitor, centres 4 & 8)

However, some of the staff suggested that there will always be those people that they cannot reach with information.

> "Not that they're oblivious, they're not bothered, 'Oh I only have one a day, it doesn't matter, I don't need to sign up to anything like that'. We do get a lot of blasé comments like that. And they [the staff]'ll chip away, they'll keep working with the family but some of the families don't want to know." (Victoria, manager, centres 1 & 2)

A tailored approach

The manager of STOP emphasised that they aim to adapt to people's needs and desires which sometimes meant going against what the evidence suggested. One example was having stop smoking one-to-one consultations instead of group sessions because this is what people have requested.

> "People won't come [to a closed group session] and we've tried it so many times and often they don't want to come, they want a private one to one session with their advisor because they often disclose a lot of other stuff mental health issues, health problems, marital difficulties and so […] [and] that's what you offer." (Lydia, manager, STOP)

SDL emphasises a shift from geo-demographic segmentation to personalised approaches (Karpen, Bove and Lukas, 2012) informed by the type of value sought by the audience, their contexts and their engagement levels with the offering. Segmentation and targeting were useful in identifying an initial audience for the Smokefree programme. However, one of the common themes that emerged was that each individual was different, so the approach to Smokefree or to stopping smoking for example needed to be tailored/customised to each individual. Unlike other social marketing programmes focused on cessation or prevention which tailored offerings at the group level (De Gruchy and Coppel, 2008; McCausland et al., 2009), Smokefree's focus on the

behavioural context and the interaction based approach allowed for customised targeting at the individual level within the selected segments (i.e. users of local services; staff of local services).

The next section examines the actors identified as potential key partners of STOP services in implementing the Smokefree programme. The term actors is used to describe both collaborator staff and members of the public that are involved in Smokefree. The analysis focuses on their relationships, position within the network and roles as central factors underlying engagement. The study also examines institutions/organisations such as Children's Centres, Stop Smoking Services in order to better understand the structural context (organisational culture, policies, routines etc.) of the programme. As explained in the Methodology chapter, although the Fire Service, the Road Safety team, the City Council housing department and Hostels staff were indicated as potential collaborator actors by the Smokefree team, due to their limited engagement in the Smokefree, the study aims (i.e. to examine engagement and value creation) and study resource limitations, this research focused on the staff who were engaged with Smokefree.

4. 3. 3 Children's Centre staff

Sure Start Children's Centres are a national initiative introduced by the UK Government in 1998 to provide local, integrated and coordinated support services to young children under four and their families (Loyd and Harrington, 2012). The Centres targeted services at the 20% most deprived local communities in England (DfEE, 1999; DfE, 2011; HM Treasury, 2008). During the New Labour Government, Sure Start Children's Centres were implemented as a national universal programme aimed at all families with children aged under five rather than their previous targeted programme at deprived communities (Lloyd and Harrington, 2012). However, the current coalition Government (2010-2014) has proposed moving away from the 'universal model' towards services targeted at vulnerable families with identified needs (Asthanam, 2010). In the light of the changes brought by the reform of Children's services co-production is being actively encouraged as 'the new way'. During one observation session at centre 2, the manager of the centre talked about co-production as a different way of delivering services and having sessions run by parents/volunteers (Victoria, manager centre 1 and 2).

Participants' accounts (both staff and member of the public) emphasised that Children's Centres play a key role for supporting families of young children. They are appreciated and respected in the community reaching a great number of families.

> "The centre is really good, for most people it makes life a lot easier." (Jenna, member of the public, centre 5)

Engaging Children's Centres in promoting and disseminating the Smokefree message means aiming to reach a wide audience of parents that already have a relationship with these centres. As the manager of the Smokefree project stated, Children's Centres had been considered a key partners from the beginning of the project because of 'the mechanisms and structures already in place' that were likely to facilitate their engagement (Kathleen, manager Smokefree).

The nature of the Children's Centres' work and their role in the community makes them an important actor within the prevention networks. A key area of the Children's Centres' role is safety and preventing children going into social care. The staff of Children's Centres deal with issues including but not limited to: problematic child behaviour, unhealthy eating, alcohol, smoking and drug abuse, teenage pregnancy, domestic violence, mental health issues, unemployment, social isolation, parents not being able to cope and children with disability. The staff suggested they have to manage difficult cases and sometimes they felt that it was not easy to make a difference to those families. The support role of these centres, their health agenda and the smoking targets make them a key actor in reaching families with the Smokefree message.

The Children's Centre staff involved in the Smokefree programme have various professional roles. One of the aims of this study is to examine the roles of network actors involved in the process of value creation in a social marketing health context. Interviews were conducted with managers and staff from different partner agencies in order to understand how their roles and work practices influenced their participation in the Smokefree programme. Roles are seen as resources in the process of value creation because they draw on norms, positions and relationships connected to an actor (Archpru Akaka and Chandler, 2011). From this perspective, roles are structures that connect actors in a value network (Archpru Akaka and Chandler, 2011; Connelly, 2000). In this

study ‘roles’ is used to refer to the professional job role and the position of the actors involved in Smokefree in the community network.

The term practice[15] is used in this study to describe the work practices as the ‘everyday’ assemblages of images (meanings and symbols), skills (forms of competence, procedures) and stuff (materials, technology) that are dynamically integrated by practitioners through regular and repeated performance (Shove and Pantzar, 2005). The study acknowledges that work practices as routinised actions have an influence on actors’ action but at the same time human actors have the capability to act beyond those practices through agency (Archer, 2000; Elder-Vass, 2007). It is important to note that work practices of the actors involved in the Smokefree are defined as having an influence on how actors engage with the social marketing programme but that there are other factors which have an impact on their engagement. A critical realist view seeking to understand the ‘generative mechanisms’ behind engagement requires examining the personal and contextual factors (Clark, Lissel and Davis, 2008). Practices are acknowledged as being part of the ‘context’ of actors and their value creation processes. As such, actors’ actions are understood in relation to their interaction with the context (Korkman, 2006).

Children’s Centres managers/leaders are key actors in influencing practices and dynamics within the organisation by means of different management activities (e.g. setting the agenda, coaching, monitoring of service interactions). Children’s Centre managers are also the main point of contact for the Smokefree project team acting as a ‘gatekeeper’ in facilitating training of the staff. Capturing managers’ views is essential to understand the organisational context, rules and procedures and existing practices.

Management support was seen as a central factor in influencing staff motivation and involvement with the Smokefree programme. The manager has the main role in ensuring the staff keep Smokefree on the agenda. They may take action to incorporate the

[15] It is important to stress that the study does not refer to practices in the sense of deterministic and ignoring the role of human agency in modelling action (Bourdieu, 1990). Rather the study accepts that practices as routinised actions have an influence on actors’ action but at the same time human actors have the capability to act beyond those practices through deliberative reflexivity (Archer, 2000; Elder-Vass, 2007).

Smokefree element in the staff job role. One such example was adapting the safety assessment carried out by family support officers to include questions about smoking.

> "So we try, really hard to get them to sign up to Smokefree homes and it's now routine part of the family support workers when they go on their first assessment visit they will talk about Smokefree homes, about the advantages of smoking outside the home, but also encouraging other people that come in their house to smoke outside." (Laura, family support manager, centre 3).

However, although some managers emphasised that the staff would broach the Smokefree topic on the first visit, other members of staff reported judging when 'it's appropriate' to have the conversation about Smokefree (Kady, family support officer, centre 3). This indicates that in practice the staff needed to adapt to the encounter situation and the priorities of their users which sometimes meant postponing the Smokefree conversation.

The manager has also a key role in facilitating interaction between Smokefree and the rest of the team. As illustrated in the literature review, interaction is a required condition for enabling co-creation (Ballantyne and Varey, 2006; Gummesson and Mele, 2010). Frequent interaction between Children's Centre managers and the Smokefree project team was vital in order to maintain interest about the programme. Sharing data produced by the referrals and feedback from Smokefree was identified as a way to keep the programme on the agenda. This is an example of reciprocity and 'service-for-service exchange' (Chandler and Vargo, 2011) between the social marketing organisation and partner actors. However, as will be discussed in the following chapter, the interactions between collaborator staff and the Smokefree team were more focused on providing specific feedback and did not always assume dialogue.

> "And it was, if you wrap it like that, it's a gift that people find hard to turn down. I mean, you then have to keep that agreement, I can't be late with my report […] because the moment I make my data not as useful to them they start to plan me out…" (Kathleen, manager Smokefree)

The managers' position regarding smoking was also a factor that influenced the involvement of the centre with the programme. A Children's Centre manager (Callie, manager centre 4) emphasised the power they have to support this change. As a non-smoker she strongly believed in the importance of non-smoking. She even referred to Smokefree as 'a one woman campaign' to emphasise her efforts to promote it within the

centre. She stressed the fact that she had implemented a strict non-smoking policy at the workplace which was reinforced by other members of her staff:

> "Our staff have to go right round the back of the building, but the school come and stand outside our gate [and smoke]." (Ellie, family support officer, centre 4)

The Children's Centres' administrator/business support officer/receptionist has also been identified as an important actor in the implementation of this programme. In some centres, the majority of sign-ups came from reception, particularly at the beginning of the programme. The administrator/receptionist is the first point of contact with the users at Children's Centres. Their position involves asking new users to register which allows them to identify who is a smoker and then target them with the Smokefree message. However, in some cases they would target every parent (smoker or non-smoker) that visited the centre. They identified their role within the Smokefree programme as promoting a health message and making people aware about the campaign.

> "We're trying to promote that [Smokefree] obviously, everybody that comes in, what we are trying to do is: 'Can you please sign up? […] so… they fill in this form, and then we give them a free mug, and then we send off the tear off…" (Penny, administrator, Centre 6).

However in some cases they were handing out the Smokefree leaflet without actually having the conversation about it. In this case, the 'offering' proposed by STOP was reduced to the tangible element (the leaflet) and the staff were acting as a 'communication channel'. Although their front position facilitated access to a high number of people accessing the Centre services, this meant a fast paced environment which reduced the amount of time they were able to spend with each user. Thus, the administrator/receptionist position was acting as a barrier to engaging in a longer conversation about the Smokefree issue.

Childcare learning officer (CELOS)/teachers' role is to educate and inform parents about different issues regarding child development and education. They deliver sessions to groups of parents which facilitate access to a 'captive audience' they could target with the Smokefree message. Observation sessions conducted at some of the Children's Centres showed different practices of delivering the Smokefree message during such sessions. Some teachers were adopting a 'one-to-one' approach with their users while others would present it to the whole group in one session and then ask people to sign the

pledge. These sessions may raise the issue of peer pressure as individuals were targeted as a group and the decision to sign up to the campaign was public.

Family support officers/workers work with families with identified needs in their homes. The relationship with their users is influenced by the prolonged contact required to support families to overcome their difficulties. Their position gives them information about their users and provides them with more opportunities to discuss Smokefree messages. At some Centres the Smokefree element became part of the assessment form they were required to undertake during the first visits. However, during the interviews, family support officers were the Children's Centre staff group which identified some key barriers and challenges to having the Smokefree conversation with their users. Other priorities, the difficulties their clients were facing made postponing the conversation about smokefree environments even if this was part of a formal requirement such as the safety assessment. These issues will be explored in more depth in relation to the empowerment theme in section 4. 5 of this chapter. The following subsections introduce community health development coordinators (CHDCs), health visitors, midwives (including maternity support workers) and Children's Hospital nurses as actors representing the health professionals that were part of the support network identified by Smokefree.

4. 3. 4. Community Health Development Coordinators (CHDCs)

CHDCs are also key actors in supporting the development and implementation of the Smokefree programme. The CHDCs are based in areas of high deprivation and large health inequalities. Their role involves engaging and empowering local people to take actions to improve health. The CHDCs run different health initiatives including identifying the early signs and symptoms of breast, bowel and lung cancer, the risk factors for cardiovascular disease, weight management courses and identifying those at risk of developing diabetes. The CHDCs' approach is based on facilitating and building capacity for local people to take care of their health. They train volunteers to support community prevention services which are usually voluntary owned and community led such as the pregnancy testing and counselling service. The CHDC team aims to support the existing ties in the community by working as intermediaries to connect members of

the community and volunteers. They refer community members to other local services' projects such as physical activity, healthy eating and smoking cessation.

> "…so we try and find things that don't cost money within the community so walking groups that sort of thing, friendship groups. We've found a lot of people are isolated and have learning difficulties so the social aspect of that and like the arts group are just as important to somebody who's not ready to tackle their health issues for want of another word. They just need to get more connected to others within their community to feel worthy, I suppose, of thinking 'I deserve better'." (Karla, CHDC, areas 4 and 8)

More recently CHDCs have adopted an 'assets based community development approach' where the focus is on identifying existing resources in the community and encouraging fully community owned and led programmes without organisational interference. Community consultation is centred on what is positive in the area as opposed to previous consultation that has focused on the problems of the area.

> "…it [asset based community development] works on the principles of we're a socially rich community that has a lot to offer so if you give us a little bit of money we'll find the rest and we'll find our own answers and we'll support each other to do that. We don't particularly need your organisation to fix us, give us some inspiration and a little bit of money and we'll find our own way of surviving and fixing what really needs fixing, not what organisations say need fixing." (Karla, CHDC, areas 4 and 8)

In the UK the 'assets based or community capacity approach' (El-Askari et al., 1998; Kretzmann and McKnight, 1996; Morgan and Ziglio, 2007) has gained support within the efforts to engage communities and adopt co-production as a way to involve users in the process of developing services that are relevant to local realities (Domegan et al., 2013; Needham, 2008). The assets based community capacity approach is focused on community's resources (skills, knowledge, ideas) for creating change rather than on their problems and deficits (Sharpe et al., 2000). The CHDCs welcomed the assets based approach as being more community driven and focused on the positive aspects of communities of being connected and having different types of resources. By mapping resources and actors who possess them, CHDCs act as connectors who help to draw the potential links between these actors.

Having worked for years in the community, CHDCs have accumulated a rich knowledge and insight about that community. The CHDCs know people in the community and build a relationship with volunteers. They know the key influencers in the community, how the black market operates and who is going to the food bank more than three times, although the rule limits access to three times per individual only. One of the CHDCs emphasised that they are operating within a network where the aim is to enable collaboration among all agencies to make the best use of the resources.

> "I sit on a number of strategic boards and local boards so I'm the chair of the area six network which is a multi-agency network, so what we do is much of its around engagement, some of it's about having quite open chats as agencies about what's going on and how we're doing, how can we take things forward and it's to prevent people working in silo." (Minnie, CHDC, area 6)

The Stop Smoking Services manager liaised with CHDCs in order to facilitate the involvement of local residents and ensure the community focus of the project from the early stages. One of the CHDCs participated at different Smokefree planning meetings and social marketing training. It was emphasised that the Smokefree team had involved the community workers from the beginning of the project, whereas before, they only were engaged after the materials had been completed.

> "So she [the manager of Smokefree] didn't come, she didn't ever come with a completed leaflet, she came with ideas and there were lots of ideas and she really engaged, you know, both myself and local volunteers and local residents around their thoughts and feelings regarding that…" (Minnie, CHDC, area 6)

The CHDCs highlighted the community engagement approach that STOP Smoking Services adopted from the early stages of the project. One of the CHDCs notes that as opposed to the cancer awareness campaign organised by the Department of Health, this time community consultation was real and volunteers felt they had ownership over the project and their contribution was appreciated. Community volunteers helped craft the message and choose the images on the leaflet.

> "But yes, my volunteers definitely feel like they were part of that, […] I think that worked really well and saying thank you worked really well as well, local residents really appreciate some feedback. So she [the manager of Smokefree] also made sure that […] all my volunteers knew exactly where this was going, what they were intending to do and she developed a training package as well so

> my volunteers were some of the first people to have the training package so they really bought into the programme." (Minnie, CHDC, area 6)

The Smokefree project was perceived as having a community involvement element which was different from traditional social marketing programmes that promoted a top-down organisational approach to health improvement. However, the CHDC in area 6 concluded that social marketing works as along as it is integrated with a health community collaborative approach that values genuine community involvement.

> "And I think that just shows that that community, yes social marketing alongside the health community's collaborative approach does work." (Minnie, CHDC, area 6)

An explanation is needed here about 'co-production' as the process of engaging customers in the development of the social marketing programme as illustrated by Smokefree. Although the Smokefree team did facilitate involvement of community members in co-developing the programme materials and messages, this was limited to the initial stages of the programme. CHDCs have access to social resources (relationships and knowledge about the community) that could have been better integrated by the Smokefree team to facilitate engagement of the members of the public in delivering Smokefree (e.g. training members of the public to participate in sharing the Smokefree message). The challenges around community involvement and the role of the member of the public as 'user' and 'co-creator' in Smokefree will be explained in Chapter 5.

4. 3. 5 Health visitors

The engagement of health visitors was sought from the early stages of the Smokefree programme. The public health literature highlights the role of health professionals in advocating for healthy environments (Hovell et al., 2000; Ritchie et al., 2009; Tyc, Hovell and Winickoff, 2008; Winickoff et al., 2003). The professional experience involving frequent interaction and relationships that health visitors have with their users was acknowledged and used as a resource in developing the Smokefree programme.

> "I use that [another training DVD] with the health visitors because I think they do have potential to work with their clients. Children's Centres can't work like that,

> I don't think they have the professional skill or the health professional status to do that kind of work in the same way that health visitors have." (Kathleen, manager Smokefree)

Health visitors are qualified nurses or community midwives who specialise in child development and health improvement. They provide advice, care and support to families with babies and pre-school children on issues including: general health, nutrition, behavioural difficulties, child development, postnatal depression and emotional wellbeing, domestic violence, child protection and other social aspects such as housing and finance (DoH, 2011). The health visitors act as a first point of call for services available to children and families. They monitor and promote the health of babies, mothers and families. When asked about their job, the health visitors emphasised the critical role they had in community. They used metaphors to describe their position within the community: as 'the foot soldiers' (Sandra, health visitor, centre 8) and having 'lots of hats on' (Marcia, health visitor, centre 10). The nature of their work requires frequent contact and it often involves long relationships with the families. The health visitors interact with their users at least once a month. The interaction can be direct, face-to-face or by phone. Their role as first point of call, their frequent interaction with families with young Children's and health promotion focus identified health visitors as a potential partner for the Smokefree programme.

> "I think our hit list on our change behaviour is better, but it's because the contacts we have, especially with the one and under one, 'cause it's much more frequent. It's as frequent as the needs of the family and the client are, but also it could be as frequent as that parent decides to bring that child over to us." (Alba, health visitor, centre 12)

However, it was only when Smokefree was promoted at the management level within the health visitors teams that they started to participate in the programme and produce referrals. Similar to the family support officers, health visitors acknowledged that the home visits gave them special knowledge and insight about their users' realities which can be used when aiming to influence behaviour. Health visitors indicated that the Smokefree topic fitted well with their role and they mentioned fewer barriers to having the Smokefree conversation.

> "Of course that is one of the standard questions, 'does anybody smoke?'. If the answer's no, then we tend to say, does anybody come round and smoke in your

house, 'cause we mustn't forget they may have visitors." (Marcia, health visitor, centre 10)

4. 3. 6 Children's Hospital nurses

The Smokefree programme aimed to engage Children's Hospital nurses as a key partner in delivering the Smokefree message. The Children's Hospital nurses were considered a potential partner as they were likely to interact with families who had young children or who had recently had a baby. The Smokefree training was part of the mandatory training programme for children's and neonatal nursing staff. In addition to the training, the staff also received a DVD which illustrates techniques to deliver the Smokefree campaign. Smokefree leaflets were made available in the hospital in waiting rooms and hospital staff were informed about their location in case they needed extra supplies.

However, as the external evaluation (Anonymous Group, 2013a) and training staff interviewed indicated, compared to the number of staff that have been trained, the engagement level has been disappointing with very few sign-ups being produced by nurses.

> "I mean the guys that delivered it [the training] asked people to take some cards and when they'd spoken to parents to put the cards into the post and I think it's fair to say that for the fact that they delivered so many sessions to so many staff the outcome was sort of fairly disappointing…" (Lara, training staff, Children's Hospital).

As the training staff suggested, hospital staff training has become more formalised and more about collecting figures to actually show commissioners they provide specific teaching to their staff in the hospital. Although the Smokefree training was included on the agenda of the mandatory training which outlines what is essential to the job role, the Hospital training staff emphasised that it was not a mandatory element. The smoking cessation training has been on the training agenda in the Children's' Hospital for three years as best practice for midwives. Smoking cessation training is seen as important for midwives supporting their work with referrals to the STOP Service. Perhaps the fact that

Smokefree is not seen as mandatory but as best practice for midwives might make it seem less relevant to the other nurses in the Children's' Hospital.

> "So from a Children's point of view it [the training] hasn't been mandatory it's been […] sort of a quality of best practice […] to improve the health of the parents […] and to be able to give the Children's' staff that quality message. For the midwives as I said it's much more about quality standards and the figures of referrals that the community midwives or the midwives get at that first meeting is measured whereas currently for the Smokefree it's not, I mean it is measured but it's not formally measured…" (Lara, training staff, Children's Hospital)

Nurses seem to have more role support for delivering the medical and nursing aspects rather than health promotion or health education. The change of roles in the health services has led to doctors passing some of their responsibilities to nurses and nurses passing some of theirs to the unregistered staff.

> "…there's lots of changes in the health service […] the doctors are more on a shift pattern so they're not around so much, their training's changed, so a lot of the rules that they used to do have dropped down to nurses, so a lot of the roles the nurses used to do have dropped down to healthcare support workers or health support workers, the unregistered staff…" (Lara, training staff, Children's Hospital)

One member of the Hospital training staff indicated that it may be that health education messages were seen as difficult to integrate within the nurses' job role/practice, particularly because there are too many other 'medical and nursing' things to do.

> "…some staff don't see that is part of their role which is very disappointing because obviously health education is a big part but I think some staff feel, because there's so many medical and nursing elements, that they have to deliver that, perhaps health education has its place at a certain time." (Lara, training staff, Children's Hospital)

Currently clinical practice does not require the Children's Hospital staff to have the conversation about Smokefree or to encourage sign-ups. Although the neonatal nurses have received the Smokefree training, the lack of structures such as management support and health promotion practice to support engagement indicates there appears to be no incentive to add Smokefree to their workload. One of the suggestions was that

Smokefree could be delivered at the point of discharge of the child from the hospital. However, there were concerns about the time required to talk about Smokefree as the staff need to provide already a lot of information about medication and child health.

> "And with the hospital, the problem is I don't have anyone to feed back to, there is nobody at a senior level that says I want to know how we are doing on this and until I get somebody who says how many sign-ups, I don't know […] there's nothing for me to feedback…" (Kathleen, manager Smokefree).

Another factor that was identified as a barrier to hospital staff engagement with the project was the fact that the training was addressed to individuals and not teams as was the case at Children's Centres where the teams included the centre's manager. Not having involved the managers of the nurses meant that the Smokefree team could not report back on staff involvement and the outcomes of the programme. The lack of feedback limited the interaction Smokefree team and nurses to the training only. Another limitation was that Hospital ward organisation makes it difficult to approach one team at a time given nurses' availability.

> "…all of these staff went through this big anonymous training programme, all 500 staff, they all got the input and they all went back but it was just a tick box on a form, yeah you've done your mandatory training. I think it needs to be a team focused thing but how you organise that in a hospital, because when you train a team who is looking after the ward? […] that is a problem so you'd have to do it in several batches" (Kathleen, manager Smokefree)

Despite their low level of engagement with the programme there were examples of neonatal nurses who participated actively in Smokefree. One of the nurses admitted that the Smokefree training changed her practice by increasing her awareness about second-hand smoke and enabling her to use it in her interactions with her patients.

> 'I think it's something [Smokefree] that fits in very well. Cause' like I say, we're already doing about the cot death advice, but this is just sort of an extension of that really.' (Sara, nurse, Children's Hospital)

4. 3. 7 Midwives

Initially, the partner agencies which were actively engaged with the Smokefree programme included Children's Centre staff, health visitors and community health community coordinators (CHDCs). The programme developed over the years to engage community midwives. Midwives were already doing smoking cessation work, including referring people to STOP and talking about smokefree environments. However it was only when the smoking cessation team has delivered the Smokefree training that they were introduced to the Smokefree programme.

Midwives look after and provide support to pregnant women throughout their pregnancy and up to 14 days after the baby's birth. The community midwife's role covers all aspects of care, including health promotion advice, for mother and baby during the pregnancy. Community midwives interact with pregnant women more often and they tend to cover more aspects of health promotion than the midwives based in hospitals. They also do home visits where they can assess the home environment and interact with other members of the family. Assessing the environment during the home visits involves checking for smokers and giving advice about smokefree environments and smoking cessation.

> "We like to ascertain whether they are smoking or whether their partner is smoking, whether the home is a smokefree environment, whether they've smoked during their pregnancy and they've given up during their pregnancy and how soon afterwards and whether they have had input during their pregnancy. […] We give advice on smokefree environments, to anybody that's in the house so very often it can be extended family…" (Paula, community midwife, area 13)

Part of the community midwives' role is facilitating their users' access to support networks. Children's Centres were indicated as the main actor to provide support to mothers of young Children's regarding breastfeeding. Maternity support workers support the midwives within their role. Their work in the community involves health promotion, breastfeeding support and smoking cessation. They also provide emotional support to women after the babies are born.

> "Before we discharge the women we make sure that they've got a good support network for breastfeeding if they are breastfeeding, we give support networks,

like this is the Children's Centre that we are currently in." (Paula, community midwife, area 13)

4. 3. 8. Other actors

Other potential collaborators identified by the Smokefree team included the Fire Service, the Road Safety team, hostels and the City Council Housing Department. As previously explained these actors were not included in this study given their limited involvement. The Fire Service produced a number of sign-ups as they handed out a version of the Smokefree leaflet that was tailored to prioritise the link between smoking and fire risk during their safety talk in schools. The Road Safety team also distributed leaflets that were focused on smokefree cars and vehicle safety. Other sign-ups were generated by the hostels' staff who were promoting the message to their clients – usually single mothers.

Although collaboration with the City Council housing department was sought, their involvement with the programme activities was weak and it did not seem to lead to the desired outcomes. The City Council housing department received the leaflets and a short brief from the Smokefree manager. Although the City Council is part of the Health Improvement Plan and public health is within the City Council it seemed that health was not considered among their priorities at the time. The external evaluation commissioned by STOP suggested that the housing department did not see promoting Smokefree as being part of their role.

> "…the housing partnership didn't work well […] It's partly to do with timing and being the right time and I think there will come a time in the future when I can revisit that, when the City Council is looking for ways of addressing things, that won't need new projects to get them going." (Kathleen, manager, Smokefree).

This section has introduced the actors participating in the Smokefree programme. It described their roles and organisational context as factors that facilitated or hindered engagement (i.e. nurses). The data suggest indeed that staff engagement with Smokefree was seen as performing their role without a noticeable added effort. The Smokefree team indicated they did not expect the low engagement of Children's Hospital staff. Yet, this is not surprising, given the tacit expectations for nurses to take on a health promoter role

and the more pressing priorities of the nurse role. The following section analyses the relationships between the actors and how they shaped actor engagement with Smokefree.

4. 4 Types of relationships

The analysis in this section draws on the concepts identified in the literature review to explain and map the relationships between the actors participating in Smokefree. The literature suggests that a network is defined by the nature of interaction or network structure (dyad or group based, face-to-face, mediated, anonymous), the position within the network (network membership), the degree of familiarity or friendship and the institutionalised rules and norms that guide behaviour (ties) (Gulati, Nohria and Zaheer, 2000; Vassilev et al., 2011). In the case of Smokefree, the networks of professionals dedicated to support families (particularly families with high needs) were heterogeneous including different types of interaction among themselves (dyadic and group) and their clients (dyadic and group), different degree of familiarity and ties (depending on their role but also on the frequency of contact with the families) and different expectations regarding their performance within the network. The following sections focus on these elements to map the interactions between actors.

4. 4. 1 Weak and strong ties

As explained in the literature review Granovetter (1973, 1983) distinguished between strong ties (family and friends) and weak ties (acquaintances). He argued that weak ties provide individuals access to resources other than those from their immediate circle whereas strong ties are more likely to be based on trust and provide socio-emotional support (Granovetter, 1983).

Examining the network around the members of the public in the Smokefree programme indicates that ties tend to go beyond family and friends and the immediate social circle to incorporate relationships with professionals such as health visitors and Children's Centre staff (family support officers, childcare learning and teachers). Within the efforts to develop a network of support around these individuals, weak and strong ties seem to have become blurred. As noted in the literature review, family, kin, friends, neighbours

and colleagues relationships are often difficult to assign to either weak or strong ties within an open system such as health (Vassilev et al., 2011).

In deprived communities, it may be that young or single parents lack family support or that their existing network may act as a counterweight to the desired change. Health visitors, midwives and Children's Centre staff become central players in providing the support needed. They need to develop a 'relationship of trust' operating in a 'non-paternalistic, non-judgemental, friendly non-confrontational manner'. For example, family support workers interacted frequently with their clients in their homes. Developing a good relationship with their client was central to their work.

> "…the [Children's Centre] staff are really good, they're really friendly. And it does make a big difference, I think if the staff weren't quite so friendly, they are really approachable, which means if you do have any issues, questions, queries, you can just ask. […] So that's another reason why I keep coming here, 'cause they are friendly. They've kind of known me coming here with my first child […] They know me, like I know them." (Selena, member of the public, centre 5)

> "More open to actually listen and not feel that it's being dictated to […] plus these people [Children's Centres staff] are there to help you and advise you with the best ways to bring up your children, aren't they? and […] different ways of helping your children develop." (Gilbert, member of the public, area 8)

However, despite the general discourse that highlighted the importance of building trusting relationships and strong ties with the audience, a power dimension has always been present in the relationships staff-member of the public. One manager emphasised that developing a close relationship with the staff may lead to the family becoming too reliant on the staff:

> "Reality is, sometimes staff move around, somebody may go off sick, so where needed, cases can be handed over and also if it was decided that actually they'd become over reliant on the member of staff and the work is not being done as effectively then you may swap somebody, but generally, we try to encourage support through one member of staff." (Mira, manager, centre 6)

> "It's having those skills of listening and sitting back, but we sign an agreement with them where we have to say whatever we hear, if it's obviously child protection we have to take it further, so it's befriending them and getting their trust but on the other hand there's thresholds, you know, we have to make sure the thresholds are not crossed." (Ellie, family support officer, centre 4)

The reliance of users on public services was sometimes perceived as clashing with the idea of choice and assuming responsibility for individual wellbeing. Yet, this reliance was placed in the context of growing poverty and insecurity.

> "I think eighteen years ago we spent a lot of time seeing […] healthy children and educating people who didn't need educating, I think now poverty's a lot more extreme […] there's a lot less family support, a lot less family networks, a lot less money, people are very deprived and poor and people have a resilient, are reliant on NHS and the government so it's everybody else's fault." (Lucy, practice teacher and health visitor, centres 4 & 8)

The blurring of weak ties is illustrated by the case of the family nurse partnership[16] where the relationship professional-client aims to replace or complement a family relationship.

> "And you work intensively and it is about empowering them [young mothers] and delivering messages on all sorts of things, helping them with education, helping them with the relationships with their families, helping them to become independent, raising their aspirations but doing it in a way where you are walking alongside and holding their hand as opposed to beating them with a stick along the way […]. So you are guiding them in a really kind sensitive way and looking at their strengths and it is almost like there is something that was missing in their own childhood that you are having to patch over and re-build that trust, […] and that confidence in them so... It is quite a maternal role I think but they respect you as a professional […]." (Sandra, health visitor who trained to become a family nurse, centre 8)

[16] Family Nurse Partnership is a voluntary home visiting programme for first time young mothers (aged 19 or under) and fathers. The family nurse visits the young mother regularly, from early in pregnancy until the child is two (DoH, 2010b).

As Sewell (1992) highlights, structures may empower actors differently which may lead to actors also acting differently. Health visitors, midwives and family support officers' interactions with their clients are guided by structures (rules and regulations) which draw on a certain power role.

> "…now we refer all women to Stop Smoking and it's up to them to opt out whether they don't want to be referred or not. But we will refer all women regardless." (Celina, maternity support worker, area 13)

However, in practice, they are often put in front of situations that require acting creatively and going beyond their job remit to help people.

> "I think they think you can sort out their benefits for them as well. And what we do in our job, we do do a lot of signposting, so I can signpost them to a lot of people, 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 housing options, to the City Council, to advise them that this family are more needy and need to move sooner, […] probably usually overcrowding or inappropriate, how many people are living in the property, and the ages and sexes sharing bedrooms, things like that. I can deal with pest control as well, I've contacted managers of pest control. So I have sorted out some housing issues, as far as I can, with my influence..." (Marcia, health visitor, centre 10)

4. 4. 1. 1 Ties that hinder engagement and change

Health visitors highlighted that sometimes the social network of their clients shaped their response to the advice and support provided by health professionals. This was experienced particularly in the cases of young parents living with their extended family where issues of control and power challenged the principle of making choices for themselves. As previous research suggests (Vassilev et al., 2011) belonging to an affective network or community means cultural and social norms that sometimes can resist change of lifestyle. Varekojis and colleagues (2011) highlight the importance of involving the networks around individuals within the attempts to recognise and address the role of environmental factors in shaping behaviour. Strong ties (family and friends) may hinder the process of behaviour change acting as pressure factors on the individual who might have engaged with the health programme. Other research has highlighted that

inadequate social support is one of the main barriers to smoking cessation (Amey, 2011; Jones et al., 2011; Stewart et al., 2010).

> "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's 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, […] and if I don't do it that way, then that's not going to be good either for them […] So you often feel as though you're competing with the rest of the world." (Shonda, health visitor, centre 11)

However, as previously stated, some of the communities involved in Smokefree had strong social networks with the extended family living on the same street. Previous research has identified the existence of strong social networks as an opportunity for smoking cessation programmes through word-of-mouth, peer support, and role-modelling (Lavack, Watson and Markwart, 2007; MacAskill et al., 2002).

The concept of structurally transformative agency (Hays, 1994) is useful in examining the factors that may influence behaviour change when existing structures act as a barrier to the adoption of healthy behaviour. As explained in the literature review, 'structurally transformative agency' is linked with citizen participation and community development and encouraged as a way to reshape the structures that may constrain change (Abel and Frohlich, 2012). Through structurally transformative agency individuals can build capacity for change which sometimes may assume reshaping the existing cultural structures. An example is provided by individuals whose social networks act as a barrier to the adoption of the healthy behaviour. However, even in this case, having access to professional advice is key to support their actions and enhance validity of the action to take.

> "I'd need my partner to do it at the same [time], because you know 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 you know like the filter bit of 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 but I don't know, I'll moan at him some more when I go home." (Corrine, member of the public, centre 14)

However, networks can also have a positive effect. As outlined in the literature review, Social Network Theory posits that the 'network effect' is caused by the number and prestige of users in a network influencing the new adopters' value perception (Scott, 2000). The network effect can also be reflected in dyadic networks (i.e. family unit) where the actions of one of the partners (i.e. signing the pledge) are influencing the other partner's smoking habits. This was illustrated by cases where members of the public admitted that their partner's decision to sign the pledge influenced them in changing their smoking behaviour (i.e. some stopped smoking while others started smoking outside).

> "The Children's Centre was already promoting the campaign, everybody seemed motivated…" (Lucy, practice teacher and health visitor team manager, centres 4, 6 and 8)

> "My wife came to me and she was telling me how she brought the Smokefree, she brought a few facts home, so I read through them and I wanted to... so I... and I'd been wanting to stop smoking." (Sal, member of the public, centre 5)

Figure 1 (in the Appendices section) illustrates the actors identified as partners and target audience in the Smokefree programme and the interactions among them. This diagram aims to provide a visual/graphic account of network complexity in the Smokefree context under analysis. The diagram is not meant to provide a generic view of the relationships and actors of community services but a specific 'picture' of a local Smokefree network. The diagram draws on interviews with the staff and members of the public and observation sessions. In addition, documents such as policy and guidance (DoH, 2010a; 2010b; 2011; 2013) were analysed to enhance understanding of the procedures and aims of these institutional actors.

The type of relationship (i.e. developed over time, prolonged and frequent contact and support purpose) is highlighted by the thickness of the line. The frequency of the interaction is marked by the type of dash. Weak ties and less frequent interaction (represented by the red thin dash line) tend to define the relationships between members of the public as the audience of the programme and Children's Hospital nurses, Fire

Service, Road Safety team and City Council housing department and Hostel staff. The relationship is influenced by the frequency, type of interaction (direct/non-direct) and scope of interaction (support/administrative/health). For example, members of the public who are users of the Hostel or Council housing are likely to interact with their staff. However, these interactions will be different from monthly interactions with health visitors and family support workers which include a strong element of support and relationship building.

As the audience of the Smokefree programme mainly consists of families with babies and young children and pregnant women, they are likely to be users of the Children's Centres, health visitor and midwifery services. As such, they are also more likely to frequently interact with staff of these services and build up a relationship (marked in the diagram by a thick red line). The red long dash line is used to mark the ties and possible frequent interaction between members of the public - CHDCs and members of the public – family support officers. Family support officers as part of the Children's Centre staff usually deal with families with high needs. As such, their users represent a segment of the families visiting Children's Centres. CHDCs are involved in door-to-door health promotion and other community development projects. Their ties and interaction with the community members is influenced by the length of time spent in the community and the willingness of community members to participate in the events organised by CHDCs. The potential ties between members of the public in the community are illustrated by the orange line.

The Smokefree team (green line) interacts with community actors to set up partnerships, offer Smokefree training to the staff and provide them with resources (leaflets, freebies and other visual materials, data and feedback). The manager of the programme invested more time and resources in nurturing the relationships with partners that seemed more eager to engage with the programme activities (i.e. Children's Centre staff). Maintaining and cultivating the relationships with Children's Centres required constant feedback and data sharing, rewarding the staff that produced a high number of sign-ups and offering refresher training. The existing collaborative relationships (blue line) between STOP Smoking Services and other agencies including CHDCs, Children's Centres, community midwives and health visitors involved efforts around smoking cessation with Stoptober,

National anti-smoking day, smoking cessation training and STOP smoking clinics run in Children's Centres.

Interaction and collaboration links (light blue long dash line) occur between Children's Centres and other community agencies including health visitors and community midwives which operate within the same facilities and also the Family Nurse Partnership, speech and language therapists and early year specialist teachers. The interviews suggested that collaboration and joint working among local partners and agencies are at the heart of the Sure Start principles (Ball, 2002). As such, Children's Centre staff (family support officers, childcare education and learning officers, managers) were more likely to have frequent interactions (direct or indirect) with health visitors where they would discuss cases or refer families to one another. Midwives can refer families to the Centre and they also attract new users for Children's Centres as they are based within the Children's Centre. They would be also more likely to interact with the same families. Children's Centres may also collaborate with CHDCs on community building projects.

> "The key people for us are the universal services so it is the midwives, it is having those services in our centre which brings them through the doors, [...] so the health visitors will identify families that they feel are in additional need, the midwives identify mothers at risk […] and that is shared with us so pre-birth we get the names of women who have been identified that may need support and so we just make sure that we've got contact with those women and often these are families which live such chaotic lives." (Jessie, manager centres 5 and 8)

> "Yes, I mean we've also got the health team working here, and we've got good links with them, so if you have any reason for concern we'll go and talk to them, and a lot of the families we know, they know, and the referrals come through them anyway." (Kady, family support officer, centre 3)

Health visitors are also part of a health visitor network. As safeguarding is a central area of the health visitors' role, they work jointly with families and other agencies and professionals including midwives, Children's Centres, General Practitioners (GPs), school nurses and social workers. Working in a network was sometimes perceived as both helping and hindering their work

> "Well quite frankly, I'm gonna be honest about this, I personally don't! I don't audit anything myself. I just follow and keep going, day by day, thinking this has got to be done, this has got to be done. We work as a network […] And, of course, sometimes you feel like you're doing more than others. And then you can sort of, you want everybody to be a team player, and yet some people aren't. It's very difficult." (Marcia, health visitor, centre 10)

This section examined the actors involved in Smokefree with a focus on their roles, relationships and positions within the network. Having a variety of organisations and different members of staff participating in the programme (from the receptionists of Children's Centres to midwives and community health workers) reinforces the message and increases the reach. Also, having one actor within the network being a champion at promoting Smokefree (i.e. Children's Centre staff) seemed to have contributed to the programme being adopted by other actors (i.e. health visitors). The findings indicate that certain roles such as health visitors and family support officers assume a more complex relationship with their users compared to other actors such as Children's Centre receptionists or CELOS. Furthermore, in contexts (e.g. Children's Hospital) where management and role support lacked, the staff actors reflected lower levels of engagement with Smokefree. The following section examines in more depth how actors' roles and work practices shape the interactions with members of the public in the Smokefree programme.

4. 5 Interacting – informing – empowering to change?

This section continues the discussion on the factors influencing actor engagement initiated in the first part of the chapter. The aim is to examine how actors' institutional context (roles and practices) may shape their engagement with the social marketing service and their interaction encounters with other network actors.

The main actors engaged in the programme developed by STOP are part of a network that guides, provides information and facilitates access to support services. A central emergent theme in the data analysis indicates that these agencies are operating on an empowerment model. Staff of Children's Centres, health visitors, community health

development coordinators and midwives talked about 'empowering' their clients to make informed choices. However, encounters between staff and members of the public as their users/clients were marked by different power dimensions given by the role the staff played in the community (particularly in terms of safeguarding issues and their responsibility to involve social care when required). As one health visitor suggested: 'they fear us a little bit' (Lucy, practice teacher and health visitor team manager, centres 4, 6 and 8).

> "Empowering people to search for their own problems and then how can we help that but you're gently guiding and then you're there with the information, the support networks." (Lucy, practice teacher and health visitor team manager, centres 4, 6 and 8).

Empowerment was seen as a way for an individual to take charge of their personal development and achieve social goals (Lord and Farlow, 1990; Zimmerman, 1995). Making healthy choices was considered an element of empowerment. Accessing the existing support services was also an element of empowerment which defined the targets of some of the actors involved. For example if health visitors managed to refer people to the STOP Smoking Services this would be a way to measure their success in empowering people to make a healthy decision. It is then STOP Services' responsibility to follow up and make efforts to assist individuals in their journey to stop smoking.

A key theme that emerged is the view that people are responsible for their wellbeing and health. This is in line with the discourse recurring in public health which calls for individuals to assume responsibility for their own wellbeing. The public bodies' role is being defined by an 'approach that empowers individuals to make healthy choices and gives communities the tools to address their own, particular needs' (DoH, 2010a, p. 2). This official line suggests a rational agent approach which responsibilises individuals to take action to change. However, the findings point out that in practice, these individuals may have few options to choose from when they are dealing with other structural and cultural factors that challenge those options.

The approach adopted by health visitors and Children's Centres' staff focuses on understanding empowerment in context although it is dominated by providing information and signposting. Empowering people was seen as a way to inform them and

support them to identify their own problems. It also included a dimension of raising their ambitions – inspiring them – to look beyond their immediate context. Health visitors and family support officers acknowledged the financial and social constraints on taking action to change behaviour:

> "We're just doing our best to promote healthy eating that's cheaper, promoting breastfeeding because that's' very cheap, stopping smoking as we can and just each individual family, just trying to pinpoint the small bits that you can do to make a difference to that family." (Lucy, practice teacher and health visitor team manager, centres 4, 6 and 8)

> "So they've got a lot of social problems, poor education, poor attainment, low aspiration…" (Sandra, health visitor, centre 8)

> "…a family that's involved in domestic violence the last thing you're going to suggest is that they give up smoking, […] it's not a priority and sometimes in fact that cigarette actually, you know with a family where there's anger issues sometimes that cigarette can actually stop that person from battering their child because it's an anti-stress mechanism." (Kelly, senior family support officer, centre 4)

Contextualising the Smokefree message was sometimes challenged by the practice and regulations which suggested they should promote completely smokefree homes. As it has been articulated by previous research (Amey, 2011; Jones et al., 2011; Robinson and Kirkaldy, 2007; Robinson and Kirkaldy, 2009) there were also physical barriers to adopting the desired behaviour. Family support officers and health visitors raised the issue of children's safety when families live in flats or multi-occupancy houses which might make it difficult going out to smoke and leaving the baby alone. In this situation it seemed that staff were in the position to promote a message that might come in contradiction with child safety. Thus, staff needed to consider whether to adapt the message (allow smoking in one room) or to continue promoting the complete smokefree environments.

> "…my only worry with the Smokefree campaign is […] who's looking after their children while they're stepping outside?" (Kelly, senior family support officer, centre 4)

> "I think we were given a bit of a mixed message, because the parents, we'd tell them to go outside to smoke, but equally telling them they'd got to supervise the children while they were outside the window and the children were inside." (Ellie, family support officer, centre 4)

This issue was raised also during the community consultation before launching the Smokefree programme. In these cases, some staff would use the opportunity to discuss smoking cessation as an option to not being able to smoke outside.

> "I remember people saying, well, it's really hard for me to go out and just if it's a baby then you can put them […] but if you've got toddlers that won't stay in a little pen or something while you go out then it's difficult to actually go out and shut the door and leave them to their own devices…" (Karla, CHDC, areas 4 & 8)

The smoking issue – barriers to keeping the pledge and changing behaviour

Empowerment is linked with the concept of informed choice. The idea of informed choice is at the core of the approach of health professionals and Children's Centres staff. It assumes responsible and rational individuals who will make a choice once they have the information. As such, healthy lifestyles seem to be approached as matters of choice (Henwood, Harris and Spoel, 2011). The role of the health professionals and Children's Centre staff was seen as to provide them with the information in order to make 'an informed choice'. Particularly health visitors emphasised this aspect of their job remit:

> "But it's a sensitive area as well, 'cause basically what I'm saying is, 'I can see you're overweight, you want to do something about it'. Where our job is more to empower people, to make informed choices about doing it themselves. But I am there if they need me." (Marcia, health visitor, centre 10)

> "…if you can educate somebody as to, […] and give them all the information about where they can go to and what we can do to help then it's got to be down to the individual's choice […] you can only do so much." (Maris, clinical team leader for health visiting and school nursing, centres 10 and 11)

The staff and members of the public stressed that healthy lifestyles require understanding and fulfilling a variety of social, economic and cultural conditions. Social marketing scholars have called for efforts to go beyond information and communication in behaviour/social change programmes (Andreasen, 2006; Hastings and Donovan, 2002;

McKenzie-Mohr and Smith, 1999; Wymer, 2010). It has been argued that behaviour and social change require an upstream social marketing approach to address environmental factors that influence individual behaviour (Hastings and Donovan, 2002). The need to tackle external factors of behaviour was also reflected in the way staff were approaching their users with healthy lifestyle issues.

Direct interactions between professionals and recipients/users of these services reveal tensions between the notion of support and informed choice. Although choice was the official approach, in practice front line staff (health visitors, CHDCs and Children's Centre staff) admitted that there were sometimes factors beyond individual control that needed to be tackled first.

> "And unless you're going to tackle the bigger, wider determinants of more money so I can go to the gym, so I can go and get fit well then I'll give up smoking, you know, unless you're going to tackle all of those wider determinants, yes it's difficult…" (Karla, CHDC, areas 4 & 8)

Stress was invoked by both staff and members of the public as a main barrier to changing behaviour. Having a stressful life was considered to hinder any attempts to change habits and behaviour.

> "I think if you take them out of the situations they're in. So if you take the stress away and put them somewhere else, it would get them 50% closer to being able to give up smoking. But you can't do that, so it's about finding some solutions, or helping them find those solutions, and managing those stress areas, so they can actually look at...and it's not just smoking, it's everything." (Alba, health visitor, centre 12)

When asked to define stress members of the public mentioned family problems and illness whilst staff emphasised financial problems, unemployment, and alcohol, drugs, tobacco abuse.

> "Well, a lot of upset, you know, family problems, deaths and people being ill. Like at the moment, we've got a neighbour across the road that's dying and my cousin's got a brain tumour and he is dying." (Jessica, member of the public, centre 7)

In the analysis of user/professional interaction Mol's (2008) work was useful to examine the tensions between choice and care. As discussed in the literature review, Mol (2008)

notes that a ‘logic of choice’ tends to dominate the discourse and practice of healthcare. However, the logic of choice is challenged by the practice of disease prevention and social contexts which calls for a ‘logic of care’. Interviews with health visitors and Children’s Centres’ staff suggested that a ‘logic of care’ might be more appropriate when interacting with families with high needs. The staff engaged in the Smokefree programme expressed views that showed movement back and forth between the ‘logic of choice’ and the alternative ‘logic of care’ in their encounters with their users. This finding supports other studies which indicate that the users’ reality challenges the logic of choice through ‘calls for care’ (Henwood, Harris and Spoel, 2011). Although staff talked about targets, procedures and assessments, when facing the realities of their clients sometimes they needed to find different ways to reason with them and go beyond their job role remit to support them.

> “So I’ll give you an example, we had a situation where families, the bank wasn’t giving any money out, the child was on oxygen and they couldn’t get any money to put in their prepaid meter for electricity out from the bank, […] it was like the mother was completely distraught and I can tell you 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, I can’t remember why they couldn’t get the crisis loan and in the end, 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.” (Jessie, manager centres 5 and 8).

These tensions illustrate the interplay between work practices and procedures (as structures) and reflexivity (as human agency). Archer (2003, p. 14) proposed that through reflexivity - as ‘the ability to monitor ourselves in relation to our circumstances’ individuals are able to challenge existing structures and enact change. When having to deal with their users’ problems the staff found that ‘scripts’ and clear information were often not enough to empower. To match this with the SDL literature, engagement of customers/citizens in co-creation requires not only the knowledge and the interaction opportunity, but also the skills and motivation (Grönroos, 2012). It may also be that sometimes users of family support services, health visitors or midwives needed only someone to listen. In those cases, empathy and showing genuine interest in their users’ problems seemed more appropriate than information and leaflets. In this case, a ‘logic of care’ that involves empathy, consolation and encouragement, customised courses of

action and offers of support seems more appropriate to build capacity and enable individual action (Mol, 2008).

> "I think the one to one is better. Because for one thing you can individualise it, certainly what's happening with the baby, you've got a bit of background, and specifically about their baby and what would be significant to one baby might not be to another." (Sara, nurse, Children's Hospital)

> "When you've first gone in their house […] how well you think the first half an hour or so has gone and then you know how to approach it. I mean, if I went in and the mom has started crying and she's really upset, then the paperwork would be the last thing on my mind but the first thing would be to try and get mom or dad obviously sorted and then get them calm and relax before we do anything..." (Kady, family support officer, centre 3)"

Interestingly, when asked about ways to support people in their attempts to manage smoking and healthier lifestyles, members of the public highlighted the importance of personal motivation, educating people about the risks and developing the necessary skills. One did emphasise that having less stress in her life would help. This highlights the importance of understanding the 'customer' in social marketing programmes and working with them to identify ways to support positive change (Stead, Arnott and Dempsey, 2013).

> "I don't know, it's easy to say, like, you need to eat healthier, they need ideas on how to do that because with me when preparing vegetables and that I tend to not have time…" (Corrine, member of the public, centre 14)

> "Yes, it's very hard to stop smoking and once you've stopped smoking you need that willpower to carry on. […] People ... you can have counseling or you can talk to people but then you still need that willpower." (Sal, member of the public, centre 5)

Family support officers and health visitors emphasised the idea of knowing when to discuss Smokefree and smoking with their users. Although tackling smoking was part of the operating procedure for health visitors, sometimes 'calls for care' meant they would avoid talking about smoking.

> "We asked everybody if they're smokers and then you would gage then whether you felt it was safe to go ahead with this, if somebody glared at you or was stomping up and down then you perhaps wouldn't do it." (Lucy, practice teacher and health visitor team manager, centres 4, 6 and 8)

The importance of the 'right time' was also highlighted by members of the public who talked about 'being ready' to change. This finding suggests that an interaction based approach is more conducive for identifying the 'readiness for change' than brief interventions focused on promoting one message for a limited period of time.

> "It doesn't matter what you give out, the information you give out is good but it just depends when the person is ready to stop smoking." (Sal, member of the public, centre 5)

The fear of not alienating their users or make them feel guilty when broaching subjects that were considered of personal nature was a barrier to staff engagement with the programme. This concern was identified in other studies (Gordon, Friel and McGranachan, 2012) examining staff engagement with Smokefree interventions. Staff had to consider the risk of jeopardising the relationship they had with their users when discussing smoking. Given their non-judgemental, supportive approach to their work, Children's Centres' staff decision to manage a smoking related conversation was influenced by the need to maintain the encounter with their user friendly and non-threatening. Interestingly, the staff approach to their work can be considered as both facilitating and hindering their engagement with the programme. Their work routine was a facilitator when dealing with non-threatening situations but a barrier when their work required long term efforts to engage with the family on their main work related objectives. The decision to interact with service users to talk about Smokefree depended on the context of each service user, the existing relationship and the motivation of the staff. This was different for health visitors and midwives where questions about smoking were seen as part of their routine practice.

> "And we refer them [the pregnant women] right at the initial booking for smoking cessation, a lot of them don't realise what it involves until we follow it up with a phone call and smoking cessation team make an appointment to see them." (Paula, community midwife, centre 13)

Adopting a collaborative approach to developing and implementing a health social marketing programme requires not only identifying key actors that may interact with the final user but also understanding their roles and practices in order to facilitate their participation in the programme. This section highlighted how staff actors' practice centred on providing information to enable healthy choices is challenged by the complexity of their users' lives. The 'interaction-information-empower' approach espoused by the majority of the actors involved in the Smokefree network suggests that by adding the interaction element the programme goes a step further than traditional programmes centred on providing information only. The interaction with network actors allows for a dialogue space where actors can 'negotiate' the meaning of information within the attempt to make it relevant for their circumstance. Such an approach also permits oscillating between choice and care in the sense of providing appropriate forms of support. Yet, this fluidity also means that sometimes the goals or value set at the organisational level might not fit with the goals and value of the network actors (the final user in particular). This opens the discussion about the dynamics of the value creation processes which is the theme of the following chapter.

4. 6 Conclusions

This chapter focused on understanding the actors that are part of a collaborative value creation network in a health social marketing programme (Smokefree). The analysis of the actors participating in a social marketing programme suggests complex interactions and the importance of context (networks, professional roles and practices) in the process of value creation. The number of actors involved in this programme and the relationships and complexity of the networks around the 'customer' suggest the relevance of a collaborative model of value creation in social marketing. Most importantly, the existing roles of these actors, their practices and context influenced their overall approach to Smokefree. A critical realist philosophical position emphasises the role of generative mechanisms as factors and deep structures that exert a real power over action (Clark, MacIntyre and Cruickshank, 2007). In the case under analysis, examining how these actors work and the existing networks in the community was essential to understand key factors shaping the mechanisms of collaboration.

Not surprisingly, the manager role was identified as key for supporting staff engagement with Smokefree and for taking action to shape the structures that would enable engagement. In settings such as the Children's Hospital, where the manager was not involved from the start, the level of staff engagement was low. Children's Centres provided the highest number of pledges of all the agencies involved in Smokefree. Their results were linked with a high level of staff engagement. Compared to the health staff (health visitors, midwives, Children's Hospital) Children's Centres had a higher number of staff involved. Furthermore, the Children's Centre staff job role which allowed for more time spent with users, a more relaxed environment (for most of the sessions) and the existing relationships between staff and users facilitated Children's Centre staff engagement with Smokefree.

The importance of actor relationships in shaping the interaction (Jaakola and Hakonen, 2013) and facilitating co-creation (Breidbach, Kolb and Srinivasan, 2013) is reinforced by the Smokefree case. The staff actors involved in the Smokefree espouse an 'interact-inform-empower' approach. However, in practice, the staff sometimes oscillate between a 'logic of choice' and a 'logic of care' to respond to their users' situations. Interviews with staff suggested that constant calls for support and care challenged the formality of 'weak' ties between users and staff requiring the socio-emotional support of 'strong' ties. The focus on relationship building and the need to maintain the non-judgemental and supportive approach sometimes meant postponing discussions about 'delicate' topics such as Smokefree. Particularly actors whose roles assumed a complex relationship of support (i.e. family support workers) and prolonged contact were more likely to negotiate 'the best moment' to broach smoking. Engaging with the Smokefree activities is considered to contribute to value creation. However, actors may engage in practices that do not create value for them simply because of habit or because of rules they need to follow (Gummerus, 2013). For instance, staff might participate in Smokefree activities (i.e. Smokefree training) but consider that it is not relevant for their practice (i.e. staff for Children's Hospital). In addition, some service users would interact with the staff in relation to the Smokefree offering only to maintain an existing relationship.

The analysis of the actors involved in this Smokefree programme highlights that a collaborative model needs to take into account the complexity of the network as a resource in the process of value creation. Following the discussion on the limitations of

social marketing traditional benchmarks this chapter illustrates the multitude of actors and the inter and intra-organisational processes which makes conceptualising relationships as dyads difficult to apply in a social marketing context. Furthermore, examining roles and practices suggests the influence of institutional structures in shaping the response to social marketing action.

Another key finding of this chapter is the emphasis on customisation to accommodate the diversity of users. The interactional approach was considered to enable personalised cues of action for users of different services involved in Smokefree. A service view seems to rethink the traditional targeting and segmentation to integrate approaches based on dialogue, interaction and an extended role for the user as an active co-creator. The Smokefree team emphasised the importance of targeting and segmentation as key instruments for defining their audience. In this case, customisation at the individual level was conceptualised within the boundaries of socio-geo-demographic segments.

In order to understand the process of value creation it is necessary to examine value facilitation (the actions of the focal organisation and other actors), co-creation activities (customers and other actors) and how these actors create value (resource integration) (Grönroos, 2012). The following chapter discusses the process of value creation in the 'Smokefree network'.

Chapter 5: The process of value creation in a health social marketing context

5. 1 Introduction

This study examines the Smokefree case to gain a better understanding of how a collaborative value creation approach is supported and experienced in a social marketing health context. The previous chapter has introduced the actors identified as being part of the Smokefree network with a focus on their roles and overall work approach as central factors in influencing their engagement with the social marketing programme. As explained in the previous chapter, the analysis focuses on health visitors, midwives, nurses, community health development coordinators (CHDCs), STOP Smoking Services and Children's Centres' staff (as staff actors) given their high level of engagement with the programme and members of the public as 'end users' or 'customers' of the social marketing programme.

The discussion continues in this chapter with the analysis of value creation processes in the Smokefree context. As highlighted in the Methodology chapter of this thesis, in addition to understanding the actors who are interacting in a specific context, research requires understanding the factors and processes affecting action (Connelly, 2000). As such the analysis focuses on the factors and mechanisms which shape the dynamics of value creation. The findings draw on semi-structured interviews with staff and members of the public, observation data and document analysis (i.e. Smokefree leaflet, information pack and Smokefree evaluation reports). The thematic framework is guided by the anticipated themes derived from the research questions (i.e. How do actors integrate resources to facilitate and (co-)create value in a health social marketing context?) and the aims of the study (to examine the process of value creation in a social marketing context and actors' roles in this process), as well as emerging themes raised by the data (Ziebland and McPherson, 2006). The chapter is organised in three sections guided by the study aims, including value facilitation, co-creation and resource integration. The emerging themes are linked with SDL theoretical concepts.

There is some debate about the notion of co-creation of value and the SDL proposition that customers are always co-creators of value (Grönroos, 2011a; 2012; Vargo and

Lusch, 2008a). In this study the concept of value creation is used to define the process that includes *value facilitation* (when the firm/other actor acts alone to facilitate customer's creation of value-in-context), *resource integration* by the customer and other network actors (who create value-in-context for themselves) (Lusch, Vargo and Tanniru, 2010) and *co-creation of value* (when the supplier/other actor and the customer act together in a dialogical and interactive process that creates value for both actors involved (Grönroos, 2011b; 2012). Despite these debates there is some agreement that value creation is a customer centred (Hibbert, Winklhofer and Temerak, 2012), relational (Berthon and John 2006; Gummesson 2008; Gummesson and Mele, 2010) and collaborative process (McColl-Kennedy et al., 2012; Vargo and Lusch, 2010; 2012; 2014).

One of the aims of this study is to examine how the process of value creation unfolds in a social marketing context. This chapter explores the process of collaborative value creation, including value facilitation, resource integration, co-creation, and the roles of the actors in the process. Data are examined to search for themes linked with programme processes, interaction between actors, actors' understanding and perception of the interactions and the resources involved. A different chapter will discuss the value dimensions (outcomes) and the motivation for actor engagement in the Smokefree social marketing programme.

5. 2 Value facilitation in a health social marketing context

As illustrated in the previous chapter, the Smokefree programme attracted a number of organisational partners that are part of an existing network in the community. However through the Smokefree offering STOP Services have also managed to act as a connector and integrate the existing network dynamics and relationships to redefine a value network. Lusch, Vargo and Tanniru (2010) suggest that a value network is shaped by interactions between actors which have different competences, relationships and information. The analysis of the Smokefree context illustrates that the roles of actors and their specific aims shape the value network further. Network actors interact through institutions and practices to co-produce the Smokefree offering, exchange offerings, integrate resources and (co-)create value. The next section examines how value

propositions were initiated in order to map the interactions in the Smokefree value creation network.

5. 2. 1 From dyadic exchanges to reciprocal value propositions, initiators and facilitators

The previous chapter has provided insight into how professional roles, work practices and relationships are key elements that shape the mechanisms enabling actors' engagement with Smokefree. Collaboration to facilitate access to and integrate these resources is key to enable value creation. SDL proposes a system approach which considers all stakeholders of the organisation in the process of value creation (Ballantyne, 2003). As Normann and Ramirez (1993, p. 66) emphasise, the focus should be on the 'value-creating system itself, within which different economic actors – suppliers, business partners, allies, customers – work together to co-produce value'. From a health perspective, stakeholder orientation has been advocated as key to balance power (Bovaird, 2005) and deal with the complexity of actors in the public service sector (Osborne, Radnor and Nasi, 2013).

Traditional social marketing is focused on the exchange and dyadic relationships organisation-final user/customer. In the Smokefree programme reaching individuals with the Smokefree offering was mediated by the project team's ability to collaborate with community agencies and facilitate integration of their competences, relationships with their users and information sharing. The value facilitation and resource integration at the middle level (collaborator/intermediaries) was fundamental to reach individuals and support their value creation process.

In the commercial sector the organisation that initiates the value proposition needs to identify the intermediaries (or more recently called 'infomediaries') - which are seen to perform a 'sense and response' function to support the value network - and then work to integrate those actors in the value creation network (Lusch, Vargo and Tanniru, 2010). The growing role of intermediaries in value creation and the fluidity of value networks are highlighted by the Smokefree case. The intermediaries (collaborating staff) become partners that co-produce the social marketing offering – conversation about keeping a

smokefree environment - and facilitate value creation for their users and co-create (i.e. they sign the pledge and accept the social marketing proposition). In the social marketing context under analysis, the social marketing organisation (i.e. Smokefree) and its collaborators assume the facilitation role where interactions with their users provide opportunities for value creation. The social marketing organisation (as the focal organisation) plays the role of the facilitator which needs to identify potential partners and collaborate with them in order to enable individuals to access resources and develop capabilities required for change. Equally, it needs to start by creating the opportunities for its audience's real engagement and value their contributions.

> "[…] in terms of the partnership work […], I developed that far more and I tried to think about how I was going to make the message easy for the partners to deliver and to give them some feedback and some outcomes for them that were useful. So the idea of being able to record exactly who was getting sign ups, I thought I need to know that, otherwise I can't thank them for what they are doing and if I can thank them for what they are doing I can also compare them to other people and so it's a little bit of sort of competition and peer pressure in there as well." (Kathleen, manager Smokefree)

In the Smokefree initiative under analysis, the value propositions initiated by the Smokefree were shaped and modified through knowledge sharing with partners during the training sessions. As discussed in the literature review, the concept of 'reciprocal value propositions' (Ballantyne et al, 2011) is advanced to illustrate how interactions are shaped in a networked value creation context. The authors suggest that stakeholders of the firm change roles as initiators and participants in a value network where interactions between actors go beyond sale/purchase transactions (Ballantyne et al., 2011) to include learning, adapting and co-creating.

> "So I learnt a lot from other people's comments and I realise that they were bringing new ideas to the campaign, it wasn't just mine putting things out there and asking them to deliver that message. They were adding to and tailoring the message to their own circumstance but also adding to the general discussion and understanding of the subject…" (Kathleen, manager Smokefree)

Furthermore, the value proposition for the partners of Smokefree was adapted to each partner's practice context. For example, the Smokefree team needed to adapt their

training and offering to the health professional audience and make it accessible to staff who did not have medical training.

> "[…] I use that [a training DVD] with the health visitors because I think they do have potential to work with their clients. […] You know, family support workers, they could, but your normal Children's Centre staff, the admin and people like that, they are not going to do that more in depth work. So tailoring my training as well is something that I have done over a couple of years." (Kathleen, manager Smokefree)

In addition, the collaborating staff would sometime reformulate the value proposition they would then present to their users (i.e. handing out the leaflet without the 'Smokefree conversation'; using the Smokefree as a tool to support the financial advice they give to their users).

> "The way I found it easier to get into it is as soon as they mention debt and you can see a packet of cigarettes on the side. That's been my way in […] That way you can sort of get in, but it's not an easy subject to approach and people just don't want to know do they? They just say they're stressed. It's just more definitely thinking about how much money you can save is the way they've done it." (Ellie, family support officer, centre 4)

This is an example of co-creation at the intermediary level in a context where partners have a central role in implementation and they are recognised as one of the target audiences of the programme.

> "It might stick as part of a piece of work being done by family support when they're doing some work on money management […] how much you could save if you give up smoking might suddenly make sense because it's from a different context. It's not somebody saying, 'You must do this, you must do that.' They're looking at it purely from a financial sense." (Mira, manager, centre 6)

> "I thought [the training] was very good. Cause when we did the training, she gave like a little leaflet suggesting how you'd approach it. And I did use that, the very first few times. I would just change the wording a little bit perhaps, but I would use her little suggestion for how to introduce the topic. And now I just use my own thing. But I say about this campaign […] in the Children's Hospital…" (Sara, nurse, Children's Hospital)

Some health visitors suggested that the sign ups they produced led to more referrals to the STOP Service. This may be because health professionals tended to target the Smokefree message to smokers only. This is a change from the initial proposition made by the Smokefree team where they would have to target everybody, smokers and non-smokers. The health visitors' approach to the Smokefree referrals is an example of co-creation where the value proposition initiated by the social marketing organisation (i.e. Smokefree) was adapted by the collaborators to fit their aims (i.e. produce smoking cessation referrals to STOP). This was also supported by the indications of the Smokefree manager who emphasised that health professionals were seen as a more effective source of referrals to STOP.

> "…but if the health visitor makes a referral we make the assumption that it is a higher quality referral, that there will have been a conversation, that this is a health professional referral and we phone them straight away. So we will make efforts to contact that person by phone. So that means the health visitor sign-ups are getting better follow up from us and that in a way is a bit more of an enticement for them because that means they are more likely to get an appointment, more likely to get a quit and we can tell them how many quits their work has generated…" (Kathleen, manager Smokefree)

The staff participating in the implementation of the Smokefree programme play the role of both initiators and participants (Ballantyne et al, 2011) in the process of value creation. The staff play the role of participants when accepting the value offering proposed by the Smokefree team. However when interacting with their users and engaging in the Smokefree conversation they become initiators. The process is similar when members of the public who sign the pledge engage in conversation about the Smokefree with their own networks.

> "I actually got her [the ex-partner] a [Smokefree] pack as well that same time […] and I said 'You get a mug' […] I think she filled it in but I don't think she ever sent it off, […], and signed up. I did nag at her to do it but she didn't." (Gilbert, member of the public, area 8)

'Matching' capabilities

The data highlight that the relationships with the organisations showing higher levels of engagement need to be maintained and cultivated through constant interaction and

feedback. Once the value proposition was advanced, the social marketing organisation needed to develop a relationship with their partners and target audiences. Being positive and recognising the help and contribution of the staff has also been a factor in maintaining a good relationship with the collaborating staff. The literature indicates that co-creation of value requires dialogical interaction between actors (Ballantyne, 2004; Ballantyne and Varey, 2006; Grönroos, 2012). It has been suggested that the quality of the interaction influences the process of co-creation (Grönroos, 2011b). As such, the focal organisation needs to have the ability to facilitate opportunities for co-creation and make use of them together with its customers (Grönroos, 2011b).

The Smokefree team designed an offering (i.e. Smokefree conversation, leaflet, training and referral report) that was easy to adapt and integrate with partners' practice. Being able to integrate the Smokefree conversation within the everyday practice has facilitated the engagement of staff with the programme. However, this was not enough to motivate everybody to participate. As illustrated in the previous chapter, this was particularly the case in the Children's Hospital where very few nurses have broached the Smokefree topic. The Smokefree offering for partnering agencies (i.e. leaflet and report of referrals) also provided Children's Centres with data that was integrated in their reports to serve as evidence of making a difference in the community. The Smokefree team also provided the resource to manage and analyse the data supplementing a lack of capacity of the Children's Centres to produce that report.

> "I think it was them [Children's Centres] needing to demonstrate their contribution to the 'be healthy' element of 'every child matters' at the time. They needed to have evidence that they were doing something to contribute to that and this was a readymade piece of information that was going to arrive on their desk, you know every quarter, […] They didn't have the capacity to do that kind of administration of it, all they had to do was send it to me and I can give them that data." (Kathleen, manager, Smokefree)

The activities performed by the Smokefree team to build relationships with collaborators and respond to their needs is one example of 'matching' aims, resources and processes for mutual value (Gummesson and Mele, 2010). As illustrated in the literature review, 'matching' suggests that the value creation potential of an actor also resides in their ability to 'match' and position themselves in a network in order to enable resource

integration (Gummesson and Mele, 2010). Lusch, Vargo and Tanniru (2010) suggest that a value network is defined by actor competences, relationships with users and shared information which are the most valuable resources. The findings of this study indicate that organisational resources also play an important part in shaping the value network. Integrating the capabilities of partners in a value network can be challenging in a social marketing health context. Given the public sector agencies involved in the programme, the organisational changes driven by government policies have also influenced value creation network changes. Thus, the social marketing organisation needs to constantly adapt its value propositions to the changing networks. These challenges will be discussed in detail in the sections on resource deficits.

> "[if she had the chance to ask for something to improve the programme] I'd ask for some half hour slots in some key senior managers' meetings [laughs] no money, the money I've had plenty of money for materials, it is sometimes access to the right ear to be able to present my case. […] And sometimes that is just a matter of timing you know…" (Kathleen, manager Smokefree)

This subsection centred the discussion on the dynamics of value propositions and the implications for the facilitation process. The Smokefree social marketing context illustrates that in a collaborative setting actors shift from participants to initiators of value propositions. Furthermore, value propositions developed by initiators are modified by intermediaries through the process of resource integration to adapt them to their own context. The findings discussed in this section point to the importance of dialogue, including feedback and learning to navigate the networks and shape propositions that have potential for mutual value. The following subsection discusses in more detail feedback and learning as central facilitation processes.

5. 2. 2 Feedback and learning

Examining the 'Smokefree network' suggests that the interactions between various actors enabled resource sharing (Gummesson and Mele, 2010) through feedback and learning. The findings of this study indicate that the Smokefree team, as representative of STOP (the focal organisation), aimed to provide feedback to partners in order to facilitate their engagement with the programme. Staff interviewees from collaborating

agencies highlighted the importance of having feedback about their engagement efforts with Smokefree. Feedback and learning were also identified as central processes by the Smokefree manager, in particular for building and maintaining relationships and adapting the offering to fit their collaborators' needs and context. The offering for partner agencies has a core information component (i.e. the training) aiming to support capacity building.

The literature drawing on SDL indicates that interaction and dialogue are central to enabling co-creation spaces through resource sharing (Ballantyne, 2004; Ballantyne and Varey, 2006; Gummesson and Mele, 2010). SDL views operant resources (and knowledge in particular) as a fundamental source of competitive advantage (Vargo and Lusch, 2004; 2008a; Normann and Ramirez, 1993). As such, feedback and learning are central outcomes next to profit in SDL (Lusch, Vargo and Tanniru, 2010). Learning has been identified as fundamental for organisations in their efforts to innovate and adapt to the collaborative value creation networks (Lusch, Vargo and Tanniru, 2010; Lusch and Webster, 2011). It is important to note that learning goes beyond gathering, using and analysing information to include the ability of organisations to 'sense' the value network and its actors and ways to develop new knowledge (Madhavaram and Hunt, 2008; Lusch, Vargo and Tanniru, 2010).

In the Smokefree context, learning is focused on developing new knowledge for both the social marketing organisation and the collaborator staff. The interactions staff-social marketing organisation facilitated learning about how each agency worked, their operating procedures and practices.

> "So reorganisation can be quite helpful, it gives you a reason to go knocking again, so I think I know what I need to do now. I understand hospital a lot better now. I was quite naïve I thought, if they'd got me in for the mandatory training, they've said it is important, it is mandatory and it is training. And training is about doing your job differently, isn't it? But that was all on an assumption based on what I think training is for […] there was no obligation to put it into practice." (Kathleen, manager Smokefree)

A social marketing public health programme that adopts a collaborative approach requires learning and feedback mechanisms in order to understand and respond to their

partners. Organisational learning requires the capability to 'create, acquire, transfer and integrate knowledge', and to adapt to the new situation in order to improve its performance (Jerez-Gomez et al. 2005, p. 716). The previous chapter highlighted the importance of managers in facilitating staff engagement with Smokefree. Management commitment is identified as a key dimension of organisational learning (Jerez-Gomez et al., 2005). Managers also have a fundamental role in sharing information about Smokefree impact and the relevance of the programme for the staff.

> "Not by email, cause people get so many emails and people don't always look at all of them, but if I can share those numbers at a team meeting and then it's on the team meeting minutes, I think that will keep it on the agenda." (Victoria, manager centres 1 & 2)

In the Smokefree context, learning was also a process of adaptation for both the collaborating staff (i.e. using the training to incorporate new knowledge about second-hand smoke with their practice and/or adapting the Smokefree offering to their users' context) and the social marketing organisation (i.e. learning from collaborators was incorporated in their training). Through interactions with managers and staff (emails and meetings) and evaluations commissioned to an external agency, the social marketing organisation was able to receive feedback from its collaborators.

> "And a lot of the comments from an evaluation, the comments from stakeholders were really positive. […] and some of the meanings that they had taken out of it and sometimes people said things that I hadn't realised about the campaign but they had seen that in the process, like the [CHDCs]. I don't know whether it is T. or Minnie saying that if you ask people to smoke outside that becomes a more conscious act. Well I hadn't thought of that but I tell everybody that now." (Kathleen, manager Smokefree)

The Smokefree manager was flexible in addressing promptly some of the issues that have been raised by the participating staff. CHDCs appreciated the relationships they built with the manager of Smokefree who was always available, sharing data and feedback that was useful and relevant for CHDCs' targets.

> "I think Kathleen's really relaxed as well I think sometimes it's the worker that's managing the project, she's very open to change, she's open to conversations and she always makes sure you're engaged as well…" (Minnie, CHDC, area 6)

Feedback was tailored to respond to what Children's centre managers or health visitors needed. Having access to the information about which members of staff generated more referrals (i.e. the staff had to put their initials and their Centres on the back of the pledge) allowed the manager of Smokefree to acquire information about staff's engagement and reward those who were successful. Other smokefree interventions have highlighted the importance of learning, feedback and praising commitment to support engagement (Alwan et al., 2010; Wildey et al., 1995).

> "I always try and make something personal about their particular achievements, so maybe they've got the highest number of children ever covered by the number of sign-ups in a quarter or a particular high number of men referred to STOP Smoking […] I think the partnership element with the Children's Centres obviously worked best and the bit that worked best was the feedback to them. I think that really consolidated a system that has been able, that's been sustainable and that is what I like." (Kathleen, manager, Smokefree)

However, the findings of this study suggest that feedback was not always provided or that it did not reach the frontline staff. The previous chapter identified the lack of feedback as one of the barriers to hospital staff engagement with the project. The Smokefree team interaction with Children's Hospital nurses did not include the team managers (as the way the wards are organised does not allow for whole teams to be trained at the same time) which meant that the Smokefree team could not report back on staff involvement and the outcomes of the programme. The lack of feedback limited the interaction of the Smokefree team and nurses to the training only. This issue was also raised by some of the health visitors who did not receive direct feedback from the Smokefree team. The manager of the Smokefree indicated that the sign-up reports were being sent to the manager of the health visitor team who might not have shared it with the team. These findings suggest that targeting managers of local services was seen as a way of ensuring access to frontline staff.

> "I mean, I found out how well we were doing from my Sure Start colleague, 'cause she'd gone into a presentation with Sure Start, and they said, well the health visitors have done this, and we didn't know! So it was like, thank you, okay […] But it's about me being motivated to go and keep doing it, it's about getting something back for me as a profession, getting something back saying, actually we've done this." (Alba, health visitor, centre 12)

The distance and sometimes lack of understanding between management and frontline workers also limited health visitors' engagement with Smokefree activities. Keeping the momentum and motivating the team to carry on with the project was found difficult to achieve given the time constraints and their tasks.

> "But it's about translating that to others, so getting my colleagues on board. And it's about the momentum, it's about the motivation, it's about the sustainability. I would love to keep doing it, as robustly as I have been, but I can't see that happening." (Alba, health visitor, centre 12)

The findings suggest that interaction with the managers and staff of the services involved in Smokefree have provided important insight into potential barriers to their engagement and the relevance of the Smokefree offering for their job role. This insight allowed the Smokefree team to adapt the training and the other offerings to suit the needs of their partners. As the manager of Smokefree emphasised, the learning acquired from partners, the consolidation of relationships and the 'network of networks' that developed during the implementation of the Smokefree programme were identified not only as means to achieve but also valuable outcomes of the project.

> "I think the relationships and the networking I've built up, […] I've got very, quite a strong network of people who know about the campaign now and a steady, a steady sort of developing going on, there was a lot of intensive work to start with and now there are, it is still developing, there's still more people coming on to be trained, not as a rush." (Kathleen, manager Smokefree)

The educational component of the Smokefree offering included training of the collaborator staff regarding second-hand smoke. The training was also thought of as a way to involve staff, give them the confidence they could deliver the message but also persuade staff to take on the role of promoting the Smokefree programme. The 'brief intervention guide' or 'how to have the conversation' suggested that staff should 'ask' people if they would be interested in learning about Smokefree; 'advise' people about the effects of second-hand smoke and 'take action' to ask people to sign up.

> "[the aims of the training]…to make people, to challenge myths and stereotypes they might have about second-hand smoke because they [the staff] are as much the target of the campaign […] And also to make them feel part of the campaign

and involved and therefore proud of it and willing to sort of wear the badge and to promote it so they buy into it." (Kathleen, manager Smokefree)

As the previous chapter has shown, depending on the role and their work approach the staff would adapt the conversation to their own context. As such, Children's Centre receptionists/administrators and Childcare early learning officers would usually reduce the 'advise' stage of the conversation and focus on asking and taking action. Health visitors, midwives and family support officers would spend more time explaining and linking the Smokefree conversation with their own agenda.

Some of the staff, particularly from Children's Centres initially thought that participation in the programme required asking people to stop smoking. Before having the training, the staff of one of the Centres were promoting the campaign only by giving away free mugs and asking people to sign up. The Smokefree training and the consequent visits of the manager of Smokefree helped clarify the aims of the programme and address some of the staff concerns.

"…it wasn't going out willy-nilly saying to people, 'Do you smoke?' 'No, I don't,' 'But you did didn't you, have a mug.'" (Ellie, family support officer, centre 4)

The staff who could not attend the training were sent a DVD containing an example of how to engage with people with the Smokefree conversation. The training emphasised that Smokefree was not about the parents, but about promoting a specific behaviour: 'stepping outside when smoking'.

"…she [the manager of Smokefree] did talk through about how Smokefree wasn't about parents, you're not going into parents that you got to stop smoking. It's about me promoting that stepping outside the house and not smoking indoors, so a little bit is coming back to me..." (Kady, family support officer, centre 3)

The training was tailored to respond to the specific needs of the staff from the different agencies participating in the programme such as community volunteers, Children's Centre staff, health visitors and nurses.

"Very relaxed, it was a very, very relaxed approach so in preference to, I mean I've been on smoke cessation training which is very formal, this was very informal, she gave a lot of time for people to have conversations, it wasn't power point heavy or anything else it wasn't text heavy so it was very much having

conversations, talking to people and making sure that they were really clear about what they were expected to do." (Minnie, CHDC, area 6)

The training was appreciated by staff across agencies. Children's Centre staff, CHDCs, health visitors, midwives and Children's Hospital nurses stressed that the training had been informative, well structured, interesting and relevant.

> "…the training was to the point, it was easy, it was knowledgeable and actually it's so needed because you know round here we have so many high numbers of children going to A&E you know there's such a high proportion of children with asthma and things and glue ear and stuff." (Lucy, practice teacher and health visitor, centres 4 & 8)

> "I thought it [the training] was very good. Cause when we did the training, she gave like a little leaflet suggesting how you'd approach it. And I did use that, the very first few times." (Sara, nurse, Children's Hospital)

In the Smokefree context, the learning and education activities were focused at the middle level (collaborating staff). Although 'customer learning' was supported by leaflets promotion and the conversation with service staff, the manager of Smokefree emphasised, that the programme was not targeted at those individuals who would need strong efforts for capacity building. The programme aimed to reinforce a social norm around smoking indoors and to build capacity at the middle level for tackling this issue. The selection of the Smokefree audience may be seen as a limitation of the social marketing programme. This raises the issues linked with targeting and segmentation and the challenge of reaching certain populations which were discussed in the previous chapter.

> "Yes, and so the campaign has been based more at changing a sense of normality and a community acceptability of a certain type of behaviour to pull everyone along together about what is acceptable and what is not and what is normal and what is not, rather than targeting you know, hardened smokers who are always going to smoke inside until their dying day. This campaign has not got the capacity to address those issues." (Kathleen, manager Smokefree)

Staff from the collaborating organisations and the social marketing organisation (the STOP service which included the Smokefree team) appreciated the interaction element

as having particular value in this initiative. Working collaboratively was seen as key for the consistency of the message and for greater audience reach. The close collaboration between the Smokefree team, the STOP service and the partner agencies (particularly Children's Centres, CHDCs and health visitors) facilitated understanding of the value of this initiative and building capacity for staff participation.

> "I think for everyone getting involved and helping that way, it's not just the Cellos [childcare education and learning officers], it's the health visitors, it's the nursery nurses, it's everyone, the family support workers, everyone working together to the same aim." (Clarisse, childcare learning officer, centre 4)

> "Kathleen sending out the figures, city wide, and me sharing them, I think that made the biggest impact on the team." (Victoria, manager, centres 1 & 2)

Feedback and learning were identified as central activities in the Smokefree collaborative process of value creation. Through feedback and learning actors develop the skills and knowledge required in the process of value creation. It is important to point out that feedback does not necessarily involve dialogue and it can be perceived as one way communication. This was particularly illustrated by those cases where the managers did not share the Smokefree feedback with their staff, although it was their staff who were responsible for reaching out to members of the public with the Smokefree message.

The analysis of the interactions between the actors involved in Smokefree highlights the changing roles as facilitators, resource integrators and co-creators in a value network challenging the traditional dyadic relationship (i.e. focal organisation – customer). The staff of the partner agencies who agree to participate in the programme may play the dual role of facilitator (i.e. for their users' value creation processes) and co-creator when they accept the social marketing offering (i.e. Smokefree message & training) and interact with their users to discuss Smokefree. Their roles in the value creation network are influenced by their work roles (i.e. Children's Centre staff, health visitor, midwife etc.), practices and relationships with their users but also their own engagement with Smokefree. Having discussed the facilitation process, the following section concentrates on the role of customer/user in the process of value creation in a health social marketing context.

5. 3 Interaction and co-creation

5. 3. 1 The role of customer/user in a social marketing value network

This section is devoted to the role of customers in the process of value creation. Customer insight and orientation are central principles of social marketing translating into programmes that aim to respond to audience's desires and needs. However, SDL argues for going beyond consumer behaviour research in involving the customer in the process of value creation. As such, customers become co-producers of the offering and co-creators of value (Prahalad and Ramaswammy, 2004; Vargo and Lusch, 2004; 2008a). From a public health perspective, community development models and public sector literature highlight citizen/user engagement and co-production of offerings as ways to improve access to services and empower people to take action for a better life (Osborne, Radnor and Nasi, 2013).

5. 3. 1. 1 Co-producers of programme elements

The Smokefree team aimed to engage the audience from the beginning of the programme in creating the messages and materials. As such they worked with CHDCs and their volunteers in some of the areas with high smoking prevalence to create promotional materials. The involvement of the audience at the formative stages of the programme is not new to social marketing. The manager of the Smokefree project highlighted the importance of interaction with the audience which allowed for feedback and increased understanding of the audience.

> "But talking to someone in the outpatients at the Children's Hospital waiting with their sick child to go in, that is real feedback on how palatable your message is and if you can sit and talk to them for 5 minutes as opposed to 30 seconds because they don't want to talk to you any more then you've got something that they are interested in listening to. So that level of being open to feedback and listening to what is coming back to you all the time has informed the campaign as we've gone along really." (Kathleen, manager, Smokefree)

Community engagement issue: saturation of consultation

The communities targeted by the Smokefree programme are prone to being the focus of community development efforts. Previous chapters have discussed in more detail the features of these communities and the audiences of the Smokefree programme. One of the dangers of such community development efforts is the saturation of community consultation. Especially when such efforts are not perceived as having a real impact in the individuals' life participation may generate feelings of disappointment and discourage individuals from taking part in the future (Attree et al., 2011).

> "They've been consulted to death through, and through that they're quite knowledgeable and they know if it's just lip service so it's not an easy job, 'oh we've been told that before, we've got involved in all of that, we know what you're doing, la, la, la' so it's not an easy thing, but then the average reading age is eleven from one of the studies that I've got…" (Karla, CHDC, area 4 & 8)

CHDCs outlined the importance of developing local partnerships with people in the community to create the setting for engagement and local ownership from the very beginning of a project. However one of the CHDCs noted the challenge of getting a diverse audience to sit in formal meetings that were 'organisationally' led. The danger in this situation was participation of the same community people in all meetings, which did not represent the variety of the community.

The manager of Smokefree project reflected on the implications of community engagement and consultation at the formative stages of the programme. She noted that community consultation can bring creativity and diversity of ideas but at the same time it is sometimes challenging to negotiate between the professional/organisational aims and perspectives and those of the community.

> "… this is the danger of consultation, you have to see where people are coming from and what their own personal agenda is and you have to have confidence in your own experience of […] having a theoretical base and a knowledge about what has been shown to work already in community based work and […] always go straight back to the drawing board, every time. Because then you are disregarding your own professional experience which has got to count for something." (Kathleen, manager Smokefree)

A collaborative community approach can raise tensions between the notion of community members as co-creators and co-producers and social marketers as experts

(Spotswood et al., 2012). Indeed such an approach requires decisions made in terms of the power the community has to shape the programme. Sometimes the community's objectives do not match social marketers' in which case negotiation is required (Stead et al., 2013).

Although community participation is encouraged, one of the CDHCs suggested that too much responsibility given to the local residents might discourage their involvement. She argued for co-planned professional/user projects (Bovaird, 2007) where community residents are supported by professionals in developing and delivering programmes.

> "I don't think we'd ever be at the point where you say to local residents 'here's a hundred thousand pound and go deliver a project', because then that scares people away and it's about saying you shape that project with professional support and then we can guard where that needs to go. I think that's always worked very effectively and that's the way that I work given the job that I do so I think that's definitely the way forward." (Minnie, CHDC, area 6)

Interestingly, although the programme encouraged an active role of members of the public, the focus was to build capacity at the middle level where staff from community based services had the main role in facilitating value creation. The specific collaborator/facilitator role of the member of the public was sought when training community health development volunteers. However, some members of the public adopted an active role in sharing the Smokefree message within their own networks without having received the Smokefree training.

5. 3. 1. 2 Co-creators of value

Co-creation is defined in this study as a customer centred perspective on value creation based on interaction between actors in relation to a value proposition. The focus of the analysis in this subsection is on the members of the public as users of the organisations collaborating with Smokefree.

Members of the public indicated they preferred the interaction based approach when promoting health information. Participants emphasised that having a conversation with someone about a specific health topic made them more inclined to listen whilst making

the message ‘real’ for them. The experience was also enhanced by the fact they were receiving the message from someone they trusted. This was also supported by staff who were smokers themselves and found the training had an impact on their smoking behaviour.

> “Well, just everything really, what she was saying, although I knew most of it but when it’s coming from somebody else it sort of ‘Well, yes, that’s true’ you know? It sort of draws you in more because you’ve got somebody ... it’s all right you saying it to yourself ‘Oh I’m going to stop smoking tomorrow’ or ‘I’m not smoking in the house’ but when somebody else explains it, it comes across a hell of a lot better.” (Jessica, member of the public, centre 7)

> “I mean it’s okay watching something and thinking ‘oh okay’ but then when someone’s actually telling you and they’re telling you facts as well it’s a little bit more different, it sort of sinks into your head a bit…” (Bella, administrator, smoker, centre 1)

The analysis of the data identified co-creation practices of the users. The practices include co-learning (asking questions; providing information and feedback), complying (listening, signing the pledge), adapting (adding their information, changing the Smokefree conversation format) and sharing (take the message to their own networks). Co-creation practices such as ‘complying’ and ‘co-learning’ have also been identified in other empirical work that investigated customer co-creation practices in health (McColl-Kennedy et al., 2012).

Co-learning

The interaction enabled both staff and members of the public to understand the message and what it meant for both of them giving meaning to reality. In this way staff and members of the public participate in shaping the process of value creation (improving knowledge about second-hand smoke and supporting others to change behaviour) and developing practices (having conversations about second-hand smoke and smokefree environments; stepping outside to smoke). The conversation also allows for expanding the education element which came across as central for tackling smoking indoors.

> “Because they could just say they’re not smoking around children isn’t it? And how do you, in people’s own homes, how do you police that? It’s that people do

what they like to a certain degree in their own homes, can't they? Without anyone knowing, they're in their own gardens or whatever. I suppose the only other way is educating them more about it…" (Gilbert, member of the public, ex-smoker, area 8)

For some users, the face-to-face conversation created the opportunity for a better understanding of the message and its relevance to their own lives.

"I think it just depends on the individual because some people respond better to visual things and some people respond better to talking face to face. I think talking face to face they have more of an understanding." (Nadira, member of the public, Sal's spouse, centre 5)

When someone 'comes and says: look, and explains' – seems to trigger people's attention to the message whilst allowing for another interpretation that 'makes sense'. It also enables people to join in and share their own experiences.

"Getting people to […] come and explain it, because you get handed loads of leaflets and you don't read them you just throw them away, but if someone comes and says look, and explains it then you're more like to take it in." (Corrine, member of the public, centre 14)

"…with the media campaigns, you're almost just sitting back and taking in the information, but it's a bit more interactive when you can actually ask someone a question and get a response back. And you have a human perspective, I think. So I suppose different people take information in different ways. So it's just covering the different angles, so it's a good thing." (Selena, member of the public, centre 5)

"And I said 'Well I've given up smoking, I just gave up' and 'It doesn't matter you can still do it' and I talked about ... I talked about my experience what I was having right now. So, yes, we did talk about it, discuss it like that and they do try, they do promote not smoking around children there anyway in the Children's Centres..." (Gilbert, member of the public, area 8)

From an organisational perspective, the conversation element allows for constant customer feedback. Talking to people about Smokefree not only provides the opportunity to reach individuals but also to learn more about their smoking habits, the potential barriers to the change and their views and perception of smoking. However, getting

people to actually engage and respond to the social marketing proposition requires having a relationship that enables that communication. It also requires genuine interest and a real two-way communication.

> "…the way it [Smokefree] was presented, it was quite kind of conversation, chatty informal presentation, which I think always helps. Because you're not being talked to, everyone kind of joins in." (Selena, member of the public, centre 5)

> "That you're interested in them as a person and they're individual, that you're actually not just trying to get the figures down and you're not trying to just work out that people smoke twenty a day and they need to stop, you're actually what does Judy want, why does Judy smoke […] why do you smoke five in a morning […] what's that trigger…" (Lucy, practice teacher & health visitor team manager, centres 4, 6 & 8)

Acting solely as a distribution channel was not enough to generate sign-ups or evidence that the message was getting through. It was the element of interaction and conversation that made the difference in co-producing sign-ups. One of the SDL propositions is the shift to conversation and dialogue as opposed to 'propaganda' (Lusch, Vargo and Tanniru, 2010). Interaction with the final users was at the core of the Smokefree approach. Having a conversation with them about smokefree environments and the effects of second-hand smoke was considered 'planting a seed' or a small step toward contemplating the implications of passive smoking.

> "Well obviously there's some people just sign up for the freebie, but they will have part of the conversation at least, they will take home something with the branding and a few weeks later they will get a pack through the post from me which has more information on it so I am hoping even if it doesn't affect their behaviour in the immediate term, the issue has been raised with them and that is the beginning of the journey." (Kathleen, manager Smokefree)

The importance of the conversation in the Smokefree programme was also underlined by the outcomes of those agencies that adopted the interaction/conversation approach. It has been suggested that the City Council housing department did not include the conversation aspect which was a factor that contributed to very few sign-ups.

> "I think it's [the conversation] absolutely essential and I think of all the aspects of this programme that Kathleen's run this has been the most important that we've seen that if you just put leaflets in a rack they might get picked up, they might get thrown away or be screwed up in somebody's pocket. But for the member of staff for instance at the Children's Centre to have that conversation and make it easier for the service users to understand it all and to answer questions, some very simple questions…" (Lydia, manager, STOP)

Complying

It is important to note though, that the interaction staff-member of the public did not always lead to dialogue and a real conversation and there were instances where staff would only 'inform' people about Smokefree and ask them to sign up. This promotion centred approach to raising awareness is common to many social marketing and public health campaigns (Stead et al. 2007). Where staff adapted the Smokefree conversation to 'informing' and 'asking' reducing the 'advice' element, the opportunity for engaging in a broader conversation was diminished. Data from interviews with users conducted during observation sessions support the findings of the Smokefree evaluation report (Anonymous Group, 2012) which indicate that awareness of the programme tends to be associated with users having had received the information from a member of staff.

As has been discussed in Chapter 4, the relationship staff-user was a key factor that shaped the interaction around Smokefree. Given the safeguarding role of most of the staff (i.e. health visitors, midwives, Children's Centre staff), the interaction staff-member of the public is marked by an asymmetrical power dimension. Therefore, as it will be discussed in more detail in the following chapters, interacting with the staff, listening to their message and complying could be seen as necessary steps to maintain a relationship. In this case, the value of the Smokefree interaction for the service users is not related directly to the benefits of the Smokefree offering but to maintaining a relationship.

Perhaps more than commercial marketing, social marketing requires and has long acknowledged an active individual who needs to take action around behaviour. The active role of the customer is now widely recognised as SDL ideas are adopted in commercial contexts. As such, adopting a co-creation perspective in social marketing seems appropriate. The individual may be at the centre of the social marketing efforts but

they are counterbalanced by the benefits for the society. Although members of the public did not talk about the benefits of the society they did emphasise the importance of their families. In the Smokefree example, the social marketing offering does not emphasise the wellbeing of the target group (i.e. adults who are smokers or non-smokers) but the wellbeing of 'others' (i.e. children, other family members). As such, people are being encouraged to take action to make 'other people better off' rather than themselves. This altruistic aspect of value is explained in more depth in Chapter 6.

Members of the public are present throughout the staff interviews as 'users', 'patients', 'target audiences', and 'clients' but also as 'families', 'mums' and 'dads'. Members of the public identify themselves as 'mums', 'dads', 'non-smokers', 'ex-smokers' or 'smokers'. The manager of the Smokefree articulated the importance of involving the community when developing the programme and integrating their feedback. As opposed to classic social marketing or health promotion programmes, where communication was often unidirectional (i.e. social marketer – audience), the members of the public were expected to actively engage in dialogue with the staff and interact with the Smokefree message (listen/participate in the conversation about Smokefree). In addition, they are asked to sign the pledge, keep the pledge and ask others not to smoke in the house. Although compliance with the latter two was evaluated only based on individuals' self-responses, the former two were opportunities for dialogical interaction and co-creation of value (Ballantyne and Varey, 2006). Observation of group sessions at Children's Centres indicated that some parents engaged in conversation about Smokefree. Sometimes, the topic generated group discussion with some parents being vehemently opposed to smoking. The majority emphasised that they did not allow smoking in the house.

Adapting and sharing

People who sign the pledge are also asked to act and persuade other members of the family or visitors not to smoke in the house. The STOP manager indicated that the aim was to generate a network effect where members of the public would take the message to their own personal networks. This effect was suggested by some of the participants who had conversations about Smokefree with their partners.

> "Yes I told him [her partner] about it. […] He said no it's not that's just people, people just say all that just to get you worried, okay then, I've made it all up

> …[…] No, I keep trying, I keep trying but… He's' stuck in his ways that's what it is." (Corrine, member of the public, centre 14)

> "But it is, 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." (Kalista, member of the public, centre 5)

These findings stress that skills development and capacity building is required to enable members of the public to be effective in the role of educating and persuading others. However, the Smokefree 'offering' to members of the public (i.e. Smokefree leaflet, pledge, conversation, information pack) is designed to provide limited support to 'customers' who lack the resources to inform and persuade other people (friends and family) not to smoke in the house. People who sign up receive a Smokefree information pack that includes a certificate (stipulating their pledge), a Smokefree car tax disk holder and a window sticker that may be used to tell family and friends that their house is smokefree.

Although people are encouraged to 'keep their house and car smokefree' and not allow other members of the family and visitors to smoke in their house or car, the programme does not provide clear strategies for the latter action. The window sticker is aimed to support people in making others aware that their house is smokefree. However, some members of the public adopted the Smokefree offering as an instrument to support their efforts in making others change behaviour (i.e. cut down, stop, or start smoking outside). In some cases participants indicated that simply bringing home the leaflet seemed to have triggered a positive response from their partners.

> "…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…" (Jenna, member of the public, centre 5)

The Smokefree conversation occurred sometimes spontaneously being adapted to the context and the role of the staff. Particularly at the reception, the conversation was brief, condensed in a short presentation of the campaign.

> "[the service users] don't always want to be told all the nasty nitty-gritty parts of it." (Christy, administrator, centre 4)

> "I was at the stay and play […] and they were handing out leaflets and […] the bits you fill in so I filled it in there." (Corrine, member of the public, centre 14)

> "They handed me the leaflet and I think, because I kind of like knew anyway, they didn't feel it was necessary to then explain. But I am sure if I had turned round and said I didn't know anything about it that they would have explained..." (Kalista, member of the public, centre 5)

As highlighted in the previous chapter, actors' roles, networks and work practices influenced their engagement with the programme and their general approach to Smokefree. As explained in Chapter 4, the contextualised approach adopted by the staff often meant waiting for the 'right time' to talk about Smokefree in order not to alienate their users. The Children's Centre staff emphasised the importance of keeping the conversation informal. The idea was to give people the information in a neutral way and ask them if they would like to sign up. However, not being able to identify that 'right time' could mean the interaction would lead to co-destruction (i.e. jeopardise the relationship with the customer).

> "But, yes, just an informal chat really, and I just say 'just give it a go and we'll see how you get on'…" (Sella, family support officer, centre 2)

However, health professionals such as health visitors and in particular the midwives were approaching Smokefree as another piece of 'health information' to give. As findings in the previous chapter indicated the relationship between users and certain staff (i.e. family support workers, health visitors) was marked by power imbalances given the safeguarding element of their role.

> "Never. No, I would always talk about. Because the thing is, because I've got to talk about smoking being the highest incident anyway, of Sudden Infant Death Syndrome, it's part of my role to do that. So I would always talk about it, there

was never, ever an incident where I've not talked about it." (Marcia, health visitor, centre 10)

"…it's evolving where it's not as much voluntary, it's child protection. It's about guidance and support and a lot of listening, a lot of nurturing, but equally watching for the bruises and everything else […] it's lower end child protection." (Ellie, family support officer, centre 4)

Sometimes, the leaflets and promotional items created the opportunity for members of the public to initiate discussion about Smokefree. In these situations, it seems the social marketing initiative under analysis has facilitated users' access to resources they could then link to their life goals and concerns (Arnould, Price and Malshe, 2006) (i.e. children's health, persuading partners to quit).

"I remember spotting the mugs, I think that was the first thing I spotted. […] they explained to me what it was about and, at the time, […] I gave up smoking myself and the mother of my son, who I am not actually with, she was ... I was going through a lot of arguments with her, because she smoked and she was smoking in the house while we was with me and my son was there." (Gilbert, member of the public, area 8)

This subsection focused on the role of members of the public as the 'final users' or the 'customers' of Smokefree. The analysis of the data indicates that users play the roles of co-producers, co-creators and facilitators depending on the position in the network. The findings of this study suggest a limited role for members of the public as co-producers of the actual design of the programme. The involvement of the public in the design of the programme took place at early stages in order to pre-test the leaflet with members of two target communities. The interaction approach emphasised by Smokefree facilitated co-creation spaces between members of the public and staff. Unlike traditional communication (i.e. social marketer – audience) the members of the public were expected to engage in dialogue with the staff and interact with the Smokefree message. 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 follow their own life goals and concerns. Value creation

occurs when actors integrate resources depending on their expectations, needs and capabilities (Gummesson and Mele, 2010).

As the research progressed, participants described the various networks and organisations that exist in the community to promote health and wellbeing, as well as the resources and capabilities necessary to take action to reach and maintain these states. The next section is dedicated to examining the process of resource integration in the health social marketing initiative. The process of resource integration through which customers create value for themselves is extended and analysed at the middle level of the collaborator staff. As collaborator staff interact with Smokefree, they adopt/co-produce the Smokefree offering and/or they sign the pledge themselves, they play the role of both value facilitators and co-creators of value. Collaborators of Smokefree who are the 'suppliers' of the Smokefree offering also integrate their own resources and those provided by Smokefree to facilitate value creation for their users.

5. 4 Resource integration in a health social marketing context

One of the aims of this study is to examine the resource integration process of the actors (staff) involved in Smokefree and of final users (members of the public). As illustrated in the literature review, value-in-context is created through the process of resource integration (Vargo and Lusch, 2008b; Grönroos, 2012). From a service perspective, actors integrate their own resources and, resources provided by the firm and other actors in their network to create value. The literature review chapter discusses how the concepts of capability and resources have been suggested as useful in shifting the discourse from individual choice and behaviour change to structural factors in health programmes (Abel and Frohlich, 2012; Ruetten and Gelius, 2011). Resources are sources of power (Sewell, 1992) that may be activated to reshape the existing structures. Individuals' choice is thus influenced by the capabilities and resources available to them either through personal or network channels (Abel and Frohlich, 2012). Resources and the process of resource integration are also central in the process of value creation in SDL, moving the focus from the firm to the final user (Vargo and Lusch, 2014). Resource integration can be linked in this context with the concept of agency and capacity building. Agency, or capacity to act, is influenced by the control of resources (Sewell, 1992).

The classification of resources in this study draws on the works of Arnould, Price and Malshe, (2006), Vargo and Lusch (2004), and Madhavaram and Hunt (2008) which are accepted in the literature as providing a comprehensive view of resources. The data were examined to identify operant and operand resources which were central to actors' resource integration process. The Smokefree case suggests that in a social marketing context, the actors who collaborate with the central organisation as intermediaries to the final user integrate resources to facilitate the value creation process of their users but also to create value for themselves and their organisation. In the Smokefree programme, members of staff integrate organisational resources (routines, culture, policy, competences/roles), human resources (knowledge, social and communication skills, energy, strength and emotion) and relationships (with other institutional actors and their clients) to build capacity for engaging in interactions about smoking related issues. Members of the public integrate their own human resources (knowledge, social and communication skills, energy, strength and emotion), relationships (with the staff and their families) and resources from other actors (Smokefree and staff of services they use) to create value in the Smokefree context. It may be argued that even if the conversation between staff and user does not lead to sign-up or a positive reaction from the service user, the engagement of the staff in discussing the Smokefree topic is a step towards capacity building. The following section examines the type of resources and the resource integration processes involved in Smokefree. A discussion about resources is important to complete the overview of actors' context and their influence in shaping engagement and the value creation process.

5. 4. 1 Operant resources: organisational resources

As previously discussed in this chapter, collaborating with community actors in developing and implementing Smokefree was considered a way to enable access to a range of resources required to build change capacity. The supportive mechanisms of Children's Centres, health visitors and CHDCs, their health focus, the interactional approach and wide reach in the community provided valuable organisational resources in terms of routines, organisational culture, policies, staff roles and competences that facilitated engagement in the process of value creation in the Smokefree programme.

Children's Centres promote key health messages throughout the year, so within their sessions there will be a specific key message each week. At some point the key message would be about smoking. They promote other health initiatives such as breastfeeding, healthy eating (working with parents to explore creative ways of cooking and making cooking fun), physical activity, No Smoking Day, salt awareness week, immunisations, sun awareness etc. Their managers also strive to implement a healthy eating policy at the centre. Their approach to health promotion does not follow an 'intervention' format but one that uses key messages, 'drip feeding it in all their sessions throughout the year' (Sylvia, manager, centre 7). The 'message drip feeding' which favours a long term approach to health promotion is also used by health visitors.

> "I am not going to change the world with one visit but I know that if I keep delivering the same message and it is just drilled home in a friendly non-confrontational manner you are empowering parents with the information, eventually those messages will go through." (Sandra, health visitor, centre 8)

> "it's not again about preaching it's just about dropping it into their everyday life and making it an everyday life occurrence." (Christy, administrator, centre 4)

As the manager of the Smokefree programme remarked 'campaigns' are meant to be short. They run for a while, create some spark and then they 'die out'. Making health campaigns sustainable has always been difficult. They require a design to enable integration within existing structures and the capacity to do so. The approach taken by Children's Centre staff and health visitors creates the opportunity for the Smokefree message to become embedded in their routine.

> "A national campaign, blitz it for a couple of months and then it dies, you let it go and then you bring it back same time next year or something. To keep it going and to keep people doing it is quite hard." (Kathleen, manager, Smokefree)

For CHDCs, community midwives and health visitors, health promotion is an important part of their job. It involves close monitoring of family health, providing health information about dental health, immunizations, obesity, exercise, vitamin D and smoking. It can also involve addressing isolation, mental health and safety (i.e. cot death). The frequent interaction and the relationships these actors have with their users were seen as a key advantage to facilitate discussion about health aspects.

> "Usually it's limitless [contact], I've worked here for 18 years now so I've seen mums and I'm now seeing babies that are now having babies, so grandparents. I've been their health visitor, mums have children very early in their life in this sort of area and so they can have children for fifteen years and then ultimately some households you've got grandmas who're having babies because they're only in their late thirties when the teenage daughters are having babies […], can be limitless really." (Lucy, practice teacher & health visitor team manager, centres 4, 6 & 8)

Roles are seen as important resources in the process of value creation (Archpru Akaka and Chandler, 2011). Chapter 4 provides an expansive view of the roles and work practices of the actors involved in Smokefree. Specific job roles such as health visitors and family support officers provide them with insight and knowledge about their clients. The family support officers admitted their job makes them gain a special insight about their clients, particularly because they work with people in their homes and they tend to have a longer relationship with them. The family support staff acknowledged the advantages of their position that made them appropriate to engage with the Smokefree message as they are trusted and they can assist their clients throughout the process of change. They emphasised that their approach was based on conversation and being supportive, solution focused work, acting on the basis of their clients' suggestions and not imposing actions.

> "I think we, as family support officers we have access to the homes and whatnot so we can see if a family is smoking, so we have access to that information, so why not try and deliver that message. I think it's about using the positions that we're into to get the messages out." (Sella, family support officer, centre 2)

> "I think if you understand why people smoke then you can understand how they're going to give up and I think that […] with the health visitor, […] you've got that knowledge, you've got that background knowledge, you've got that you know that motivational interviewing technique […]" (Lucy, practice teacher & health visitor team manager, centres 4, 6 & 8)

The findings of this study indicate that in the Smokefree context, organisational resources are key structures to enable the full potential of other resources such as skills, knowledge and relationships which will be discussed in the following subsection.

5. 4. 2 Operant resources: skills, knowledge and relationships

Skills and knowledge of collaborating and STOP Smoking Services staff were essential resources in developing capacity for Smokefree. Staff emphasised the importance of personal skills to engage in conversations about smoking. As previously discussed, learning was a key facilitation process in Smokefree. The training offered by the Smokefree team was tailored for each organisation in order to provide the staff with new knowledge regarding second-hand smoke and delivery techniques relevant to different settings (i.e. health clinic, health visitor, hospital, Children's Centre). The training acted as a trigger for activating staff operant resources and generating value for themselves, their partners and members of the public. The expanding effect of operant resources (Vargo and Lusch, 2004; 2011; Piacentini, Hibbert and Hogg, 2014) in the process of integration had implications for staff's capacity to address other smoking related issues.

> "But when you're dealing with it through work in the way that we do, you need those bits of information that Kathleen was giving us. And they were good, you know, and it wasn't like, some stuff that we get isn't massive, we get lots of complicated information and you just lose the staff on that. And because Kathleen brought it to us and we don't have to download it and print it off ourselves that made it easier as well" (Victoria, manager, centres 1 & 2).

The training was thought to provide some grounding knowledge and tips on how to present the message to their audience. Staff built on the training provided by the Smokefree team and their own resources: knowledge, skills, practice and relationships they had with their clients to adapt and modify the conversation about Smokefree to fit specific interactions with their users.

> "But I think once you've had the training session with for example the staff at [one] Children's Centre, they know the issue for their parents, they know about the Shisha and this, that and the other and they know how to interpret the message of Smokefree to make it suit their client group and that's what I allow them to do because that's what their skills are." (Kathleen, manager Smokefree)

> "I just think it comes down to experience to be honest. Experience and relationships with people and perhaps knowing when to pull back a little bit…" (Jill, support and learning officer, centre 9)

However, in practice some members of staff, particularly from Children's Centres did not discuss the message but only asked people to sign up to the Smokefree campaign or handed out leaflets. In other cases the Smokefree leaflet was added as a 'formal' component of the conversation about smokefree environments. This is particularly the case for health visitors and community midwives who were broaching the smoking topic with their users.

> "I think it might've just made it more formal and more professional maybe, rather than a health visitor or […] a health professional going into a home and just saying […] 'how bad it is for your baby'…" (Maris, clinical team leader for health visiting and school nursing, centres 10 & 11)

The emergent property of resource integration (Peters et al., 2014) is suggested by cases where interaction with Smokefree generated new knowledge which changed the practice of the staff. One example is provided by a neonatal nurse who actively engaged with the programme and integrated the Smokefree conversation within her practice. She included the talk about Smokefree in the basic life support training that is given to parents of babies that have been in the neonatal unit. She admitted that the Smokefree training changed some of her practice where addressing passive smoking had not been a part of the routine before.

> "I don't think it [the Smokefree message] was [part of practice] […] when I went through the reducing the risk of cot death, I didn't actually mention smoking, no. Because, as I say, I wasn't aware that, I suppose I knew somewhere in the background that it would increase the risk of cot death, but I don't think, I'm not sure that it's in the little booklet." (Sara, neonatal nurse, Children's Hospital)

The CHDCs integrated Smokefree with their lifestyle questionnaire that was done door to door in the community. This was a special case as people did not have to fill out the pledge form separately but it was part of the lifestyle questionnaire.

> "…so for example Kathleen [manager of Smokefree] in the end said, 'well it can be a question on your [Be Informed] questionnaire' because previously we were saying […] 'would you like to sign up to Smokefree?' and then we'd get out

another form so she agreed it then became part of the questionnaire which made it much more easier to do." (Minnie, CHDC, area 6)

However, there was the risk of the staff adapting the information and adding their own bits of knowledge which sometimes was not up to date. This may be seen as an example of co-destruction (Echeverri and Skålén, 2011) where interaction and engagement may lead to negative experiences or it may diminish the value of the initial offering. However, the interactional mode between the social marketing organisation and the collaborating staff has facilitated dialogue to minimise co-destruction.

" […] and then they will use all their bits of lay knowledge which some of which is true and some of which aren't, to build on my message and sometimes you get a little bit of a report back that somebody has told them something and you think, 'oh, that didn't' come from me'. But that's always a risk. […] it hasn't happened that often and it's never been anything that I would worry about. But I think once you've had the training session, […] [the staff] know the issue for their parents, […], and they know how to interpret the message of Smokefree to make it suit their client group." (Kathleen, manager Smokefree)

Partnering with these community organisations and their staff facilitated access to the knowledge these organisations have about the communities they serve. This knowledge means rich customer insight that can be used to develop programmes that better reflect their realities and worlds. It may also provide insight generated in real life situations and not the 'pre-set' world of focus groups.

The majority of members of the public interviewed indicated they were aware that second-hand smoke 'was bad', without giving too much details. This is in line with other studies which indicated that children are perceived as being vulnerable to second-hand smoke (Ritchie et al., 2009; Robinson and Kirckaldy, 2007; Robinson and Kirkaldy, 2009; Robinson et al., 2011). Some of them admitted they learned new things from Smokefree which made them change behaviour (i.e. stop smoking in the house).

"…oh no, not second-hand, no I didn't realise how bad it was. I knew it was bad, […] you see it on the leaflets and see it advertised and you know it is bad but you do not know how bad it is until, it was one of the websites, one of the TV adverts…" (Nadira, member of the public, Sal's spouse, centre 5)

Member of the public participants seemed to have the knowledge about the importance of smokefree environments. However, interacting with Smokefree created the opportunity for them to reconsider their habits. When individuals were contemplating quitting smoking, the Smokefree became a reminder that reinforced their beliefs about smoking.

> "No, there wasn't anything [new] that I ... it was just because of the newborn baby and because of my daughter asking me. I think when my wife brought the facts home, I think that was the nail in the coffin for me." (Sal, member of the public, centre 5)

The relationships members of the public have with their families can act as a resource when trying to persuade them to stop smoking in the house. Some of them suggested that going outside to smoke was not as difficult as convincing their partner to do the same. In this case, the challenge was to motivate other people to smoke outside.

> "But it was winter, it was cold and she didn't want to go outside and that kind of thing. It was argument after argument. She's better now, I've got through to her now. But she still will, odd times, […] she'll walk through, say the door'll knock and she's out the back having a fag, she'll walk through the lounge with it in her hand and open the door…" (Gilbert, member of the public, centre 8)

The relationships with staff were resources that members of the public drew upon during the interactions regarding Smokefree.

> "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…" (Carrie, member of the public, centre 5)

The previous section indicated that one of the co-creation practices identified was 'complying'. Interviews and observation suggested that sometimes the relationship members of the public, as service users, had with the staff was a factor that influenced the decision to sign the pledge. Informal interviews also indicated that sometimes people who were not smokers would sign up to 'please' a member of the staff. In the context of Smokefree, relationships between actors (staff-user in particular) were resources that shaped actors' response to engaging with the value proposition.

> "Not really [no new knowledge] because I knew all about it anyway but she was a really nice lady and, […] [I signed up] because the lady at the Sure Start asked us if we wanted to do it." (Jessica, member of the public, centre 7)

The discussion about members of the public's resources suggested that a key element was related to the ability of people to transfer the advice of the support workers into their everyday life and influence their immediate network and motivation. Other studies have pointed out the importance of assessing the context not only in terms of accessibility to resources but also people's capabilities to understand constraints and opportunities for change (Frohlich et al., 2002). Previous empirical work suggested the relevance of physical resources (energy, strength, emotion) (Arnould, Price and Malshe, 2006; Baron and Warnaby, 2011; Piacentini, Hibbert and Hogg, 2014). This study stresses the importance of these physical resources for enabling members of the public to act upon the resources provided by Smokefree.

> "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] less stress…" (Jessica, member of the public, centre 7)

The analysis of the data suggests that the lack of certain resources (e.g. skills, confidence and emotional strength of both staff and member of the public) inhibited the integration of existing resources and the adoption of the desired behaviour. The next section investigates some of the barriers to resource integration in the context under-analysis. The analysis reveals how deficits of resources have an inhibiting effect on actor engagement with Smokefree and the process of resource integration.

5. 4. 3 Operant resource deficits

Conceptual work stemming from SDL emphasise the superiority of operant resources over operand resources and the power of human agency to act upon resources to create value (Arnould, Price and Malshe, 2006; Peters et al., 2014; Vargo and Lusch, 2012). The findings of this study indicate that sometimes operant resources (such as culture - organisational and social norms, roles and institutional support) might also act as structural barriers to human action. Furthermore, the study finds that resource deficits

inhibit the effect of existing resources (e.g. energy and strength of staff being diluted by work conditions). This finding highlights the dynamic feature of resources and the 'socio-cultural' (Gummesson and Mele, 2010) mechanism of resource integration. This section discusses the resource deficits that shaped staff and member of the public interactions with Smokefree.

5. 4. 3. 1 Changes to policy and role competences

The change of role of health professionals was a recurrent issue in the discourse of the health staff interviewed. Health visitors reflected on the societal changes that seemed to bring more poverty and more people in need, more safeguarding issues, less family support and reliance on the state and the NHS. They emphasised they are asked to do more in fewer hours.

> "…people are tired. I've only been back two years and I'm tired, I cannot work at this pace any more. I've told the boss I cannot do 50 and 60 hours a week, which is what it's entailed. And they're saying, well no, you're only paid for 37 and a half. I said, you might only pay me 37 and a half, but how do you think these groups are done, 'cause all the business proposals, I'm doing my admin between half 5 and half 6, you don't pay me those hours, that's why it's getting done." (Alba, health visitor, centre 12)

> "…you try and get your record keeping done that day, and if not, you might come in earlier the next day to do it, 'cause you mustn't get behind, you must stick to your priorities, and you just keep going! And you just think, thank goodness, you get paid, so that you can have a holiday now and again, 'cause that's what you look forward to. But I'm saying that, I do love the job, there's just too much of it." (Marcia, health visitor, centre 10)

One of the changes requires health visitors to do antenatal visits which means they will see more people and presumably this will allow for more prevention work. However, health visitors' narratives suggested a discrepancy between their work realities and the expectations of commissioners:

> "I think sometimes as well, you feel like those at the top commissioning you to do these things, don't really understand about the job, see it as straightforward.

> Where it's unlikely that things are straightforward, 'cause there may be something else that you have to do. And everything takes time." (Marcia, health visitor, centre 10)

The changes of the health visitor role were seen as distracting them from the health promotion role which seemed to be given to other actors in the community such as the Sure Start Children's Centres. At the same time, when Children's Centre staff talked about changes to their services, they revealed anxieties about staff cuts and the increasing role given to volunteers. In this sense, involvement of the users in co-production is seen as affecting professionals in terms of their role and job security.

> "…but more and more we are about a targeted service within an inclusive environment which becomes increasingly challenging because our teams are being reduced so the staff team that we have is being eroded every year, I think there are less and less people there to support the service." (Jessie, manager, centres 5 and 8)

Health visitor interviewees noted they were trained in health promotion and that health promotion should be a part of their job. However, time constraints, the workload and other issues they need to prioritise (i.e. safeguarding, housing) means less focus on health promotion. Generally, health visitors expressed the perception that the actual focus of their work was safeguarding instead of health promotion. Fear has been expressed that the changes in workload would affect the performance of health visitors and that it would dilute their work.

> "It's not appreciated, and it's not recognised. And what they say, health promotion is key and parcel of our work, actually no, it's the safeguarding bit that they really want us to do, to keep them out of court." (Alba, health visitor, centre 12)

> "But a lot of [health promotion] is taken away from you 'cause you haven't got the time, 'cause your time is taken up with the families that concern you, that health promotion isn't top of their agenda, it's more about 'can I get rehoused, I'm not getting any money', there's financial problems, domestic violence, and all those types of things take over people's lives." (Shonda, health visitor, centre 11)

When dealing with these change anxieties, collaboration with other agencies including STOP was not a priority. In addition, safety issues prevent staff from starting the

conversation about Smokefree, particularly during the home visits. When the issues that some families are facing are overwhelming, smoking and health fall down on the agenda.

> "…particularly if you are going into a household where you know that there are concerns regarding child protection and there are far more adults than you in the room with a baby, then you would not, for your own safety, […] you could really be opening a can of worms so there are times when you would not, definitely would not be mentioning anything if you could help it. Because sometimes it just is not worth it." (Sandra, health visitor, centre 8)

Although all health visitors and midwives interviewed admitted that health promotion and smoking (including promoting smokefree environments) were part of their job, sometimes they perceived Smokefree as extra work, another thing to do in addition to the usual tasks.

> "Midwives don't always have time to deal with health promotion so they would refer people to maternity support workers who will visit them in their home." (Claire, manager midwives, area 13)

The changing role of other health professionals such as nurses and doctors has affected the health visitor profession adding to their responsibilities.

> "But I think we've not been as aggressive in marketing it, simply because the workload, it's something else for somebody to do. And I think the professionals health visiting has been dumped on by a lot of professions, 'cause it's the only professional group that is growing, so it's more numbers coming in." (Alba, health visitor, centre 12)

> "We already spend a lot of time talking to parents about health promotion and all sorts of things, it's another thing but it does not take very long." (Patty, health visitor, centre 8)

> "…people are overworked and I understand and respect that but if it's linked in with what they're already doing it's not that much extra work…" (Lucy, practice teacher and health visitor, centre 4 & 8)

Safeguarding was identified as a priority by Children's Centres' family support officers as well. Smokefree was not always a priority, especially when dealing with high level of needs families.

> "It's not a priority to be fair. On something like child protection issues, obviously that's got to come first, so it's not always a priority. It's probably way down the list of about six visits in before we start approaching the subject of, 'Your (house) smells,' or something, cigarettes…" (Ellie, family support officer, centre 4)

> "…but we have to look at the bigger picture about […] sort of than just lifestyle, it's about […] children's safety and if it's case of having, being able to work with a family and […] you have to pick what your battles are and sometimes smoking isn't the priority." (Kelly, senior family support officer, centre 4)

Changes at the policy level and budget cuts were generating anxiety and affecting staff across agencies participating in the Smokefree programme. Particularly CHDCs and Children's Centres' staff expressed the feeling that the government does not appreciate the amount of time and effort required to build up community capacity.

> "…to build up a highly effective team takes quite a few years…so the team here are empowered and they are motivated, highly motivated and highly skilled because they've stayed for a number of years, […] and they've gone off and done so much training now that they are at the peak of their delivery but if it all, […] you go into a reorganisation and there's cuts and you don't know where the team are going to land up, you break that cycle of being a highly performing team." (Jessie, manager, centres 5 & 8)

Changes of policy and decisions at the top level were seen sometimes as undermining local efforts. One CHDC revealed that the community volunteers felt disappointed and discouraged after their contributions to develop a cancer awareness campaign had been dropped in favour of a national campaign. They had been working for a year and a half on materials for a cancer awareness campaign and their formative work was appreciated at conferences. Community involvement without real power sharing in shaping a programme poses the risk of tokenistic participation (Arnstein, 1969). This finding supports the literature which indicates that community engagement can have unintended negative consequences resulting in feelings of disappointment and distress due to the lack of sustainability of programmes (Attree et al., 2011; Bolam et al., 2006). At the same time, acknowledging the relationships and the role of local residents in developing health programmes can be a real asset in terms of capacity building and widening access to hard to reach groups.

> "…yes they [community volunteers] felt very disappointed that we then went to quite a scripted programme with very set targets and it wasn't necessarily what our volunteers bought in for and it changed overnight so it went from one, yes using healthy communities collaborative to then moving straight towards social marketing." (Minnie, CHDC, area 6)

It seems that there is a tension between the 'organisational'/formal view of having a brief intervention that engages the community and the bottom up approach inspired by practice which requires time and capacity building. CHDCs highlighted that it was rather through informal meeting and after trust has been built when community workers learned about the problems of the community.

> "…but it's really from sitting down and talking to people that I hear what kind of issues there are, you know, and that isn't, 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, well for one, 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 a brief intervention with somebody because it doesn't happen, but it's quite nice to know that you can just walk down the road and have a conversation." (Karla, CHDC, areas 4 & 8)

The organisational and policy changes shaped the network of Smokefree collaborators. An important finding of this study highlights that although partnerships between various public services might be in place, staff reductions and refocus of the service, constrained the scope and realisation of these collaborations.

> "So in the old days Sure Starts were really well resourced, probably too well resourced, they didn't need the money they had but had lots of staff and lots of partners that were funded so we paid for extra health visitors, we paid for extra midwives so there was a big team of people and now we're just down to mainstream services which are overstretched, under-resourced and bit by but the service level agreements have gone, the money's gone, they've gone back to mainstream work only. So the partnership working exists but the capacity to work with the families is falling on a shrinking team." (Jessie, manager, centres 5 & 8)

5. 4. 3. 2 Skills, knowledge, relationships

The literature suggests that individual knowledge and skills are valuable resources in the process of value creation (Baron and Harris, 2008; Vargo and Lusch, 2006; 2008a; 2012). The findings of this study support this argument. Having the confidence to approach people about not smoking in the house or car and being well equipped with the right information to counter negative responses were suggested as important elements that facilitated engagement of staff actors.

> "…do you have enough information to counter the arguments that people will put forward as to why they don't want to listen to your advice, they're not going to take your advice, they can't take your advice, whatever. So I think it's that confidence, being really well informed, I think they're [their lack] the biggest barriers." (Callie, manager, centre 4)

The lack of knowledge resources around smokefree environments and second-hand smoke to enable delivery was a barrier to staff engagement with Smokefree. Staff changes and missing the Smokefree training were identified as potential barriers to engagement. Even if staff participated in the Smokefree activities the lack of clarity and misunderstanding about the programme's aims were limiting their engagement. The lack of training has translated into limited activity and scepticism about the effectiveness of the initiative.

> "The other thing that didn't help is that the teams keep changing, so when you work with a group of staff and you know that they're all raring to get the sign-ups, and then everybody gets moved again." (Victoria, manager centres 1 & 2)

> "'Oh, it's another thing, give away mugs, give away whatever,' and we could do it because we could give them all away, but until someone actually came and spoke to us and told us what it was exactly about then it became a lot more serious, but we could explain to parents more. When I first went out it was, 'Do you want some mugs? Fill this form in, you can have some,' because it wasn't explained properly […] at the beginning." (Ellie, family support officer, centre 4)

The lack of feedback and data to show the outcomes of the programme was a barrier to staff (health visitors in particular) engagement with Smokefree. The issue was raised by

some of the health visitors but also some Children's Centre staff who were not aware of the data regarding the programme outcomes. The manager of Smokefree indicated that she had sent the Evaluation report to all managers that were involved in the programme. It may be that in some cases the managers did not share that data with their staff.

> […] What would be really effective is if we had some feedback. Because we can say, yeah the data has gone there, and they can say, well we've had this and that. I want some good, I want some narratives of positive changes, and how it's affected people and their families, so that I can show my other families, well actually it's done this, and it's done that." (Alba, health visitor, centre 12)

The asymmetry of information exchange

The lack of skills based resources was also a barrier for members of the public in understanding and evaluating the Smokefree offering. Language, illiteracy, learning disabilities and misunderstanding about passive smoking were limiting people's capacity to engage with the Smokefree message.

> "…we're making an assumption that people understand what passive smoking is. […] On one particular occasion I spoke to some, […] it was a baby in oxygen at home where I knew the grandparents smoked. So I was going through it [Smokefree] with them, and this grandmother said 'Well I don't passive smoke', and I said 'No you do the real thing don't you?' And she said 'No, I've not had one for four hours'. Passive smoking to her meant chain smoking. So she'd seen the advert on the television about passive smoking and thought it didn't apply to her." (Sara, nurse, Children's Hospital)

> "So, I've not actually gone into whether I can get it in different languages or not and a lot of our mums and dads don't read or write possibly, so they only hear the message. Again, that's, you can't get on the website. I mean we show them the website and tell them how to get on the website, but they've not got the computers…" (Ellie, family support officer, centre 4)

The manager of Smokefree did not see the fact that the leaflet was in English as a limitation. The conversation that should follow the leaflet was supposed to explain it. The leaflet was considered only a tool to support this conversation.

> "I think the leaflet is a tool for a conversation and if I've trained those workers properly they know how to translate the message because it has come up in the training session." (Kathleen, manager Smokefree)

Where staff used the leaflet as a tool that added clear facts to the conversation on second-hand smoke, the risk for information asymmetry was lower as the interaction element provided the opportunity to ask questions and customise the discussion to the individual user's circumstances. However as interviews, observation sessions and evaluation reports indicated, sometimes the staff would limit the Smokefree interaction to only asking people if they wanted to sign up to a smokefree campaign and hand out the leaflet. In these cases, the service users were limited to their own skills to understand the message. The misconception that 'it's NHS/government propaganda' was suggested by the experiences of some of the health visitors and one member of the public.

> "…this grandmother jumped down my throat, and said, "I don't believe in passive smoking, it's something the government have concocted", and the more I go into it about actually, […] what about the baby, how it affects the baby, you've told me the history of asthma in the family, […] exacerbate the baby's condition if they've got it. 'I don't believe in that'." (Alba, health visitor, centre 12)

> "…but those with learning difficulties I don't feel they make the connection that yes, you can see in this picture and it tells you that the smoke is still there but they can't tangibly see it, so not necessarily believe the message and believe 'it's built on a bit of propaganda, this is what the NHS wants you to do, if it wasn't for us the economy, the amount of taxes we pay', but then I would ask 'is it from the black market or do you actually pay the full price?'." (Karla, CHDC, areas 4 & 8)

As discussed in Chapter 4, some of the people targeted by Smokefree were facing difficult life circumstances where 'healthy choices' were not a priority. Some of the member of the public participants stressed the need to be 'ready' to change and that they did not have the energy or the right social support to stop smoking. In those cases the lack of physical resources such as emotion, strength and energy was limiting the effect of other resources such as relationships or knowledge. Unlike previous social marketing programmes using resistance skills approaches to develop individual capacity to change (Botvin, 1997; Flay, 1995; Flynn et al., 1994), in the Smokefree context, sometimes people needed skills to be able to influence others' behaviour.

> "Helpful to me, […], I tried to get him [the partner] to read it but I don't know how helpful it was to him, I don't know how much of it sunk in and how much he just ignores me." (Corrine, member of the public, centre 14)

Time to build a relationship

The foregoing sections identified relationships as a key resource in facilitating the interactions which might lead to value creation. However, the analysis also recognises that in some organisational contexts, drawing on relationships might pose limitations. Relationships require time to build and maintain them. Time pressure has been identified as a key challenge across participating agencies. In the hospital setting, time is particularly limited when nurses are discharging children, as they tend to prioritise information about medication or equipment over health education messages. Lack of time was considered also a barrier to collaborating with other health promotion agencies.

> "I think some people feel it's difficult to deliver a health education message at the very same time that you're discharging a child from hospital when there's perhaps so many other things to tell the parents." (Lara, Training staff, Children's Hospital)

> "…because we go into everybody's home and […] we're probably the only agencies that do that and health [is] targeted care, I think if we started talking to people […] people would jump in and say 'can we do this with you?', it's just purely lack of time…" (Lucy, practice teacher and health visitor, centres 4 & 8)

Compared to health visitors, Children's Centre staff or midwives, nurses in the Children's hospital tend to have less frequent contact with their patients. Sometimes this makes it more difficult to build a relationship and find the 'right time' to talk about Smokefree:

> "I do try and go down there and see certain things. But it is quite difficult to get to know all the parents, certainly before they get to this end. But when they come down here I try and make myself known and try to get to know them a little bit before the baby goes home." (Sara, neonatal staff, Children's Hospital)

Children's Centre family support staff and health visitors had emphasised their prolonged contact with the families and the long term approach allowed them to raise the Smokefree message when it was 'the right time' for their audience. Members of the

public highlighted the need to be ‘in the right frame of mind’ to be able to accept the social marketing offering. The previous chapter explained how complex life situations of their users had required staff to adopt a ‘logic of care’ which sometimes meant postponing the Smokefree message. This approach is more suited to accommodate the fluidity of individuals’ goals marking a change from the standard social marketing approaches to targeting and segmentation. Albeit, situating a social marketing programme within the context of public services requires recognising actors’ diverse organisational culture, policies and routines which might provide different degrees of flexibility regarding the time needed for building relationships with users.

This section identified the main operant resources that were central to actors’ engagement with Smokefree. The findings suggest the interplay between organisational (policy, roles and work routines in particular) and human resources (skills, emotion, strength, energy, knowledge and relationships) in the process of engaging with Smokefree and creating value. Resource deficits affected actors’ engagement with Smokefree and shaped the value network. In particular, organisational changes (policy and roles) had an impact on staff participation in Smokefree activities. Knowledge and skills deficits were suggested by staff as more inhibiting for users’ engagement as it indicated a limited capability to translate health messages into their own lives. Relationships with family members and physical resources such as energy and strength were also seen as potentially limiting users’ reach as they did not feel they had the capability to make the message resonate with their own network (i.e. partners, extended family members). The next section explores the role of tangible resources in the context under-analysis.

5. 4. 4 Operand resources: tangibles

The physical space of Children’s Centres emerged as an important resource that members of the public drew upon in creating value. Members of the public who are service users of Children’s Centres often identified the Centre as a familiar place. The Centre operates as a hub that connects different staff professionals with the users but also users and staff among themselves. Children’s Centres enabled co-creation spaces where families with children could go to access various forms of support and advice (e.g. health

information, baby massage, breastfeeding support groups) or simply have a space to be with others.

> "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 [Children's Centre]." (Corrine, member of the public, centre 14)

> "[Children's Centres] provide information, give opportunity for these guys to play with other children, play with different toys they don't have at home, it's break as well for the mums, or the dads." (Jenna, member of the public, centre 5)

> "…because we don't have any family here so I thought it would be good for [the baby] to go out between other children, not just stay with me or my husband at home because otherwise he will be a little bit shy. So that's why I thought, and also I read on the internet that there's a lot of positives coming from baby massage…" (Denisa, member of the public, area 5)

The physical space of Children's Centres, including decorations and design suggested a focus on health messages (e.g. room doors with hanging fruits; numerous posters and boards with health and well-being information, messages and pictures). Observation sessions were useful to place participants in a context but also facilitated understanding of the 'health culture' of the institutions where the Smokefree actors interacted. The majority of members of the public interviewed in this study learned about Smokefree at their local Children's Centre (Sure Start). This is also reflected by the sign-ups data which indicate the high numbers of pledges signed in Children's Centres (see Table 7).

When asked about the resources available to facilitate their participation in the programme, the interviewees identified physical products as resources (operand): tangibles, free gifts, leaflets, posters and displays. Members of the public highlighted the leaflet in particular as useful.

> "It's the visual aids. Because they're quite costly. Although they [STOP] don't mind giving the resources out, obviously they've got a budget so they're concerned about that. I think if they're asking Children's Centres to highlight and if we're getting more sign ups, cause I know statistically we are getting more sign ups than the health professionals, we're obviously doing something right, so they

need to give us the tools and the equipment and the visual aids, and everything else that goes with it, to be able to deliver those key messages." (Dana, play leader, centre 5)

The free gifts provided by the Smokefree team included coloured pencils, piggy banks, mugs, Smokefree stickers. They were particularly available to Children's Centres' staff as they were thought to have longer interaction time with their users. The free gifts were in general appreciated by the staff as incentives that made people to sign up or a token/a starting point that made the conversation easier.

"I think that [free gifts] engages them […] and obviously they get entered into a free prize draw so again you've got the element of a prize if you do it…so I think they are possibly a big help, some people will do it even if you don't mention a free gift but others 'ooh I'm going to get something out of it'." (Sandy, administrator, centre 8)

However, interviews with members of the public did not highlight the free gifts as an incentive for signing up to the campaign. They rather saw them as promotional items that reminded them about the pledge and the message. The mugs that showcased the Smokefree message were considered particularly helpful in supporting behaviour change.

"That [the free mug] was all right actually, yes. […] I think that [that it had the Smokefree message on it] was brilliant." (Jessica, member of the public, centre 7)

"Yes, that [the mug] I have to say is ... it's very good [because it has the message on it]. And it constantly reminds you." (Sal, member of the public, centre 5)

Health visitors talked about incentives for their clients to encourage them in their change journey. However, some health visitors argued that 'freebies' were not enough to motivate people to change behaviour.

"…they like incentives and the money boxes go down really well because a lot of people aren't ready to give up and one way forward to ease the pain is say let's just try and give up two a day…" (Lucy, practice teacher & health visitor team manager, centres 4, 6 & 8)

"I think they might go for the freebies, but I don't necessarily think they'll sign up to things, if they don't have to. […] I think that person will make their own

informed choice about that they want to give up smoking." (Marcia, health visitor, centre 10)

The free gifts were also seen as tools that would help spread the word about the campaign as people might show them to visitors and they might act as a reminder of the message. The Smokefree manager emphasised that the Smokefree sticker was intended as a strategy/visual aid to help those who had low self-esteem or confidence to address that barrier of actually telling people not to smoke in their house. Confidence has been identified as a key factor needed to move people from the contemplation stage to the action stage (Cismaru et al., 2008).

"I've had a couple of parents say: 'what's that?' and I've then explained about the campaign and they've signed up and then they've got a mug, so I do think that they like to get freebies and then they show their friends as well, 'oh I've got this at Sure Start' and then people come in, […] the freebies help." (Sella, family support officer, centre 4)

One of the CHDCs suggested that incentives were not available to CHDCs anymore whereas the CHDCs from another area indicated that posting out the mugs and free gifts was too expensive in the long run so the Smokefree would occasionally bring them the resources in person.

"They don't send, they don't send the mugs out anymore but I always go and steal their resources so that if I'm signing somebody up you know a mug says a lot […] but then you just think you're just doing it for the mug..." (Karla, CHDC, areas 4 & 8)

"…we had the mugs as well which was really good […] they have them posted out and that was really complicated, really expensive as well so […] Kathleen would come and drop off materials as well… and everybody likes a mug, but the problem is every one of our projects has a mug so people took away with them a bag of mugs. But it's really nice that we see them about anyway..." (Minnie, CHDC, area 6)

The Smokefree team emphasised that the tangibles were not meant to motivate people to change behaviour but to reward them for taking a step – signing the pledge. However, as

staff and the manager of Smokefree remarked, getting the free gift was in many cases a motivation factor for people to sign up.

> "So that exchange of the freebie and signing up. I don't think it's a motivation to behaviour, to smokefree homes behaviour, I think it's a motivation to actually sign it now, the sign up form." (Kathleen, manager Smokefree)

> "I think you have to be careful not to have too many or else it just becomes, you get people signing up just because they want a free whatever it is, so I think you have to keep it in context." (Sylvia, manager, centre 7).

The leaflet

The Smokefree leaflet was provided by the Smokefree to support staff with the delivery of the programme. The leaflet contained images, information about second-hand smoke, strategies to keep the house and car smokefree and a pledge form. Social marketing theory classifies leaflets as part of the augmented product aimed to support behaviour change (Kotler and Lee, 2008). The leaflet was seen as a tool used by the staff to promote the message, good for both users and practitioners. It was in general appreciated as easy to read and something tangible to give to people.

> "…something to give them in their hands, something to make them think." (Patty, health visitor, centre 8)

Most of the members of the public interviewed appreciated the leaflet as being useful and having the appropriate imagery and message. It was also considered that it provided people who do not smoke with a tool to support their confidence in saying no to smoking in their homes. The leaflet confirms some of the knowledge people have about second-hand smoke and may act as a reminder to other members of the family.

> "Yes, it [the leaflet] made me think about it, it made me talk about it and it made me take that pack to her [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'." (Gilbert, member of the public, area 8)

For some of the smokers accepting the leaflet and signing the Smokefree pledge was used as a reminder to help them cut down and incentivise them to try stopping. Smokers would accept the Smokefree offering as something that might provide value in the future

(i.e. hoping they will quit one day). The leaflet was also seen as a reminder that reinforced the decision to stop smoking. The aspect of value will be discussed in the following chapter.

> "I'd been wanting to stop smoking […] Because my daughter keeps on telling me to stop smoking. […] Yes, so... and plus I've got a newborn, so I've been wanting to stop smoking so after she brought that, the stuff home, is when I thought I'd better pack it in. So it's been a month now." (Sal, member of the public, Nadira's spouse, centre 5)

Most of the interviewed staff considered that the leaflet included appropriate, good visuals with 'the lone smoker' imagery reinforcing the social norm about not smoking in the house (Lucy, practice teacher & health visitor team manager, centres 4, 6 & 8). Interestingly, some of the health visitors suggested that leaflets were a key resource that will keep the campaign going.

> "So long as we always have a supply, the campaign is never-ending." (Patty, health visitor, centre 8)

However health staff in particular indicated that the leaflet needed to be explained to their users. One of the health visitors emphasised that solely giving people a leaflet was not going to make a big difference. She explained the importance of having peer support and facilitating access to that support as a key element in the efforts to change behaviour. Being able to facilitate, connecting people that could share their stories and advice was considered more valuable than handing out leaflets and providing professional advice.

> "But mostly a leaflet, like that, realistically I think they need to be talked around, they need to be explained, so people can see." (Shonda, health visitor, centre 11)

> "…if they could have someone they could ring in the local area that they could then talk to them, and if I could have some of those [success] stories to help me keep motivated. Because if all I'm doing is giving this bloody leaflet, it's so soul destroying, just giving them leaflets, or giving them a mug […] So at least it reminds them, I suppose, if you give them a mug, of why they're doing it." (Alba, health visitor, centre 12)

Leaflet limitations

Although the majority of interviewees appreciated the leaflet as a useful information tool to support their Smokefree conversation there were members of staff who noted certain limitations of this resource. Particularly health visitors from multi-cultural areas stressed the 'white feeling' of the leaflet and that the imagery seems to relate rather to 'white middle class'.

> "There's white faces, there's no disabilities, and on this side it's only women who smoke. And then you've got quite a nice household, my families don't look like that. […], leather sofa, who's got money for a leather sofa and a nice cream carpet?" (Alba, health visitor, centre 12)

One health visitor indicated that the leaflet does not capture the whole picture because it does not ask how many adults are in the house and it does not have an option for those who do not allow smoking in the house. The 'tabloid' style of the leaflet was criticised by some of the health visitors as being too colorful and having too much information. However, the manager of the Smokefree emphasised that the 'tabloid' style was chosen on purpose to appeal to the target audience.

> "… the design of everything was decided, intended to be almost tabloid newspaper looking in that it was very pictorial, bold and not too much writing so that you could only look at the pictures you'd still get the message, and the action and our target group if you like is right there on the front of the leaflet, of the poster." (Kathleen, manager, Smokefree)

Most of the members of the public interviewed evaluated the leaflet as useful and appropriate for their context. They were shown the leaflet during the interview as a reminder to help them assess its content and format. Some of them indicated that it had too much information and that it needed more pictures. Informal interviews during the observation sessions indicated that some of the Children's Centres' service users who were not native speakers found it difficult to engage with the content of the leaflet. When they were shown the leaflet some of these interviewees were able to identify the 'don't smoke in your house message'. It is important to note that language remains a barrier particularly when the Smokefree interaction is limited to handing out a leaflet without explaining its content.

> "…it [the leaflet] basically says everything doesn't it? It's got everything on there. I mean it does stick to your curtains and things, I mean, if people make the

promise, they should stick to it really, shouldn't they?" (Jessica, member of the public, centre 7)

"…it's [the image on the leaflet] typical of our street. […] you'll see them like sitting out on the front steps or on a bench in the front, yes and then it's the facts that you don't realise because then you can just see […] well you can't' see but you think of all the smoke that's sticking to the toys, […] it draws your attention to it definitely." (Corrine, member of the public, centre 14)

Other tangibles

Health professionals raised the issue of having practical equipment they could use to reinforce the message. A peak flow meter or a carbon monoxide monitor were considered valuable resources to support health professionals' Smokefree conversation.

"And then to have the equipment, […] I'd like a peak flow monitor, especially that grandmother who said, oh passive smoking and all this, I'd like to show her my peak flow, and her peak flow, 'cause I know mine will be better than hers. And that, just physically showing her that measure will actually reinforce what I'm saying. So I would like a little bit more practical equipment." (Alba, health visitor, centre 12)

People who signed up to Smokefree received a pack by post that included leaflets and further information about second-hand smoke, and Smokefree stickers to post on house and car windows. One member of staff who was also a smoker questioned the value and usefulness of free items and the information pack.

"…there was quite a lot of promotional stuff that came through the post as well and it did make me question how much money they have actually invested into this and was it necessary?.." (Christy, administrator, centre 4)

Their views were contradicting the initial considerations of Smokefree which intended that the big pack would act as a reminder, a conversation trigger point or it would be difficult to throw away.

"…it's not an easy throwaway pack, it's an A4 size, out of cardboard. You feel slightly guilty if you put it straight in the bin I think. It's a nice enough quality, full colour, that you would just leave it around at least for a while and then you do a big clean out it would go in the bin maybe. But in the meantime somebody

> in the house would be going 'what's this you got then'? 'Oh they wanted me to stop smoking indoors, I am not going to do that. Oh yeah somebody spoke' and the conversation starts or they have the mug…" (Kathleen, manager Smokefree)

In addition, members of the public who signed up had the chance to win £ 20 high street gift voucher for every 50th person to sign up. The financial reward is not new in social marketing smokefree programmes indicating relative effectiveness (NSMC ShowCase, no date). Very few people remembered they had received a pack or that they found its content useful. None of the members of the public interviewed mentioned the voucher. However, the interviews took place at least a year after having signed up to Smokefree which made the recollection process more difficult.

> "I remember getting, you know, the pack through the post with the sticker about how bad it is smoking in your house even if like you're in a different room because I used to smoke in the kitchen with the door shut or I used to […] smoke out the window but I didn't realise quite how much the smoke comes back in and sticks to things so that was a big worry." (Corrine, member of the public, centre 14)

Financial resources in relation to smoking and the cost of cigarettes were mentioned by both members of the public and staff. Some of the staff indicated that they were using the financial costs associated with tobacco as an argument to make people aware of the broader consequences of smoking on their well-being. Often the narratives of staff described the context of their users as marked by poverty that expanded into all areas of their lives. Both smokers and non-smokers interviewed recognised that the high financial cost of cigarettes was, along with children's well-being among the factors that made them cut down, or contemplate stopping.

> "He [the husband] does complain [about the price of cigarettes] because it's a lot of money, it's over £ 400, and because I don't have a hobby, one day I came home and said to him, you can have £ 400 a year for cigarettes and I can have £ 400 and spend it on something I can show for, you have nothing to show for after you smoke a cigarette…so we did have this conversation…" (Jarina, member of the public, centre 5)

The findings of this study point to the dynamic interplay between operant and operand resources and the creative effect of the resource integration process. As conceptual work suggests (Gummesson and Mele, 2010; Peters et al., 2014) the integration process may lead to emergence of new properties (i.e. change of practice; creating new relationships etc.). In the Smokefree case, these new properties are associated with mechanisms that triggered the 'power' (Clark, 2013) of the programme to build capacity for change. The main findings of this section highlight that collaborating organisations - which act as intermediaries between the social marketing organisation and the 'end users' - integrate resources from Smokefree (knowledge, skills and tangibles), their own resources (organisational, knowledge, skills, physical) and those from their own network (relationships) to facilitate value creation for their users and create value for themselves. Collaborating staff own resources (organisational, cultural, knowledge, skills and relationships) emerged as essential for engaging in, and facilitating co-creation. Members of the public drew on the resources provided by Smokefree (information, tangibles), the staff of community based services (relationships, knowledge) and their own resources (energy, strength, personal skills, knowledge and relationships with their families) to create value for themselves and others (i.e. children). Organisational resource deficits hindered staff actor engagement with Smokefree. Limited skills and knowledge and inadequate social support limited member of the public engagement with Smokefree.

5. 5 Conclusions

This chapter examined how customers create value for themselves and their families (value-in-context) and how other actors (as resource providers) participate in the process of value creation. Adopting a collaborative approach to value creation requires understanding the actors involved in context, the role of facilitator of the social marketing organisation and its collaborators and of (co-)creator of value of its final audience (i.e. members of the public). The examination of value creation processes suggests that actors of Smokefree change roles as initiators and participants in a value network. The interactions between actors go beyond the actual pledge signing (member of the public) or training (staff) to include sharing, learning and feedback.

Figure 2 (in the Appendices section) illustrates the process of value creation in the Smokefree network. It aims to provide a snapshot of actors' (i.e. collaborator staff, members of the public and social marketing organisation) interactions around Smokefree. One of the key findings of this chapter is that initiators and value creation facilitators (other than the central organisation) can also play the role of co-creators and resource integrators at different stages of the interaction with the social marketing offering (illustrated through the double arrows). In the collaborative model adopted by Smokefree, the collaborator staff who agree to participate in the programme play the role of facilitators (i.e. for their users value creation processes) and co-creators when they accept the social marketing offering (i.e. Smokefree message & training) and interact with their users to discuss the message. The collaborator staff act as intermediaries for the social marketing organisation to reach their users with the Smokefree proposition. This is different from traditional social marketing centred on dyadic exchanges and unidirectional transfer of value (Peattie and Peattie, 2003). Compared to the SDL business contexts where the need to engage with the offering often originates with the customer, a social marketing programme requires additional processes to reach its audiences. This dynamic process requires the social marketing organisation to have well developed learning and knowledge sharing and integration capabilities.

Input from members of the public at the early stages of the programme required a co-producer role to contribute to the design and message of the programme. However, throughout the programme, members of the public were considered to play a co-creator role, where they needed to actively engage with the programme messages, commit to a pledge, take action to keep their homes smokefree and persuade other members in their immediate network to do the same. In particular the study challenges the predominant view in marketing literature that customers are 'empowered, networked and willing' to engage in co-creation (Prahalad and Ramaswamy, 2004; Vargo and Lusch, 2008b; 2012).

Although the Smokefree 'conversation' was a core element of the programme, sometimes staff (i.e. receptionists) would reduce it to 'ask' and 'act' omitting the explanation part. Other staff (i.e. family support workers) whose job role required longer contact and relationships with their users would adapt the brief intervention format to a 'drip-drip' approach which meant prioritising and working to create the right setting and

time for broaching the Smokefree topic. The SDL literature emphasises the benefits of co-creation as most conceptual and empirical research concentrates on customer co-creation processes (Payne, Storbacka and Frow, 2008; McKoll-Kennedy et al., 2012). There is less consideration for co-destruction (Echeverri and Skålén, 2011) and overcoming resistance to the market offerings (Szmigin et al., 2011). Social change contexts often require the need to consider customer resistance to the social marketing offering. A key finding of this chapter is that some actors (i.e. health visitor and family support staff) engaged in the Smokefree network are able to adopt a holistic approach that better matches the 'customer' perspective (i.e. discussing Smokefree when judged appropriate) and might counter potential resistance. This is in line with Arnould, Price and Malshe (2006) who argue that customers see firms – the professionals in this setting- as resources that they can use as they pursue broad life goals – stopping smoking, children's health and/or partner's health.

The findings reveal actors' creativity in adapting and integrating the available resources (Baron and Harris, 2008; Baron and Warnaby, 2011; Cherrier and Gurrieri, 2014; Piacentini, Hibbert and Hogg, 2014) but also the resource deficits which sometimes limit the potential of existing resources. The resources needed to enable and motivate people to transfer the advice of the support workers into their everyday life include operant resources such as knowledge, skills, social relationships, energy and strength but also operand resources such as tangible material goods and financial resources.

The interaction element of the programme was acknowledged and appreciated by both staff and members of the public. The interactions between the Smokefree team and other staff actors strengthened the collaborations which were considered to contribute to the sustainability of the programme allowing for consistent messages over time. The collaborative approach and the education component of the programme acted as mechanisms that contributed to staff capacity building to address smoking related issues.

The following chapter discusses the value dimensions and motivation of actor engagement in a social marketing context. The thesis concludes with a discussion of the main findings of the study, their implications for theory, practice, policy and future research.

Chapter 6: Motivation of actor engagement and value dimensions in a social marketing programme

6. 1 Introduction

Previous work that examined health improvement programmes has been criticised for focusing on agency in relation to biology and behaviour change whilst neglecting individuals' 'meanings, experiences and reactions' to the programmes (Clark, MacIntyre and Cruickshank, 2007, p. 518) as well as the wider contextual factors (Connelly, 2001). The critical realist philosophy that informs the methodology of this research indicates that studying reasons for action is important because it provides insight into the hidden or latent interests, understandings, even false facts that contribute to activating those generative mechanisms that lead to social activities which can 'reproduce, maintain or transform social structures' (Connelly, 2000, p. 267). Therefore, having examined the external contextual factors, the aim of this chapter is to understand how Smokefree actors became engaged with the programme, and the values, and motivations that inspire their action. More specifically, the research questions that guide the analysis in this chapter are as following:

1. What motivates network actors (stakeholder and members of the public) to engage in a health social marketing programme?
2. What value dimensions are present in a health social marketing context?

Drawing on conceptualisations from the marketing and the public service literature this study examines actor engagement as a process centred on interaction defined by relationship experience and the stage of involvement in the social marketing process. The first part of the chapter discusses the motivation (i.e. intrinsic and extrinsic) of the actors (staff and members of the public) to engage with Smokefree. The second part concentrates on the different types of value (i.e. social, altruistic, emotional, functional and epistemic) that emerged from the data.

6. 2 Motivation of staff actors to engage with Smokefree

The study draws upon actors' interviews and observation sessions to identify themes associated with motivation and values. Motivation is associated with internal cognitive

processes (Ryan et al., 2009). Therefore, the study seeks to understand actors' motivation through examining what their reports suggest is important to them and by exploring their behaviours when engaging in interactions in a service context (i.e. Children's Centres and Children's Hospital sessions). The interview protocol was designed to elicit respondents' reflections on why they decided to engage with Smokefree and what form this engagement had taken. The approach to data analysis was inductive being guided by the research questions. The themes associated with motivation were then examined in relation to the literature on motivation and value.

Behaviour may be influenced by psychological (intrinsic factors), or structural constraints (external) such as practices, norms, institutions etc. (Crawshaw, 2012; Hargreaves, 2011; Peattie and Crane, 2005). As illustrated in the literature review, motivation concerns the factors that stimulate and guide the behaviour of one individual (Ryan and Deci, 2000; Moisander, 2007). The study explored intrinsic and extrinsic factors motivating actor behaviour in relation to Smokefree (Ryan and Deci, 2000).

Exploring what motivates actors' engagement with a health social marketing offering is essential to design programmes that are citizen centred and facilitate a collaborative value creation environment. Understanding the cognitive, emotional and behavioural dimensions of actors' engagement is key for organisations within the efforts to support the value (co-) creation process (Payne, Storbacka and Frow, 2008). The study explores engagement as actor (staff and service user) behaviour (i.e. participating in the Smokefree training; giving feedback to the Smokefree team; interacting with their users/clients to discuss the Smokefree message/hand out leaflets/asking people to sign up; refer people to STOP), actor knowledge about Smokefree (i.e. facts about second-hand smoke; being aware of the programme aims and results) and actor perception of the Smokefree programme.

In the context of the collaborative Smokefree initiative, examination of staff actor motivation for engagement has revealed *extrinsic factors* such as job role compliance, management support, personal development and competition. The literature indicates extrinsic motivation is linked with functional and social value (Holbrook, 2006; Zainuddin, Previte and Russell-Bennett, 2011). *Intrinsic factors* included personal beliefs and a sense of accomplishment given by the idea that sharing information about

Smokefree was considered to contribute to protecting children from second-hand smoke. Intrinsic motivation is associated with the notions of emotional, epistemic and altruistic value (Sheth, Newman and Gross, 1991; Holbrook, 2006). The following section discusses the motivational factors for staff and members of the public. A separate section is dedicated to value dimensions in the Smokefree context.

6. 2. 1 Extrinsic factors

Job role compliance

Staff interviewees' reflections suggest their engagement in the programme was a form of performing their job, complying with management requirements and fulfilling their institution's role. Motivation to participate in Smokefree was explained through external regulation – engaging in activities to comply with an external demand and social pressures or to receive a reward (Ryan and Deci, 2000).

> "So I will do whatever my managers tell me to do!" (Dana, senior play leader, centre 5)

> "I just remember being given the, what are they called [...] Just the things that we use, the Smokefree, the little leaflet thing and just asked to target parents as they come in." (Sandy, administrator, centre 8)

The agencies that engaged with Smokefree and committed to the implementation of the programme were the ones where the data produced by their involvement was evidence for their own targets. This was particularly the case of Children's Centres which were the main producer of sign-ups. This study supports previous research highlighting the appropriateness of Children's Centres sites to discuss smoking related behaviours (McEwen et al., 2012). Community health development coordinators (CHDCs) were another significant referrer. Another example is provided by health visitors who started to produce sign-ups once Smokefree was integrated with their community engagement project. Tackling smoking is in the standard operational procedure of health visitors and midwives. Health visitors and midwives emphasised that the conversation about smoking was 'part of their job' and that they could not ignore the Smokefree initiative once they found out about it.

"…we were promoting it even when I started my job three or four years ago, but then […] they re-launched it, tried to make it fresh, tried to promote it so everyone, it is quite hot on the subject. But it was there even when I started so like I said we've always done it." (Celina, maternity support worker, centre 13)

"So it [the Smokefree] shouldn't be you know would you like to, it's part and parcel. So that's how I look at it." (Patty, health visitor, centre 8)

"I'd be wrong if I didn't. I think, as a professional, I need to have that armoury, I need to be able to...even if I say for one person, […] I've given that form to one person, I think, I might have made one person think about their health, or their smoking, or their weight management." (Shonda, health visitor, centre 11)

Manager and team support

The manager's support was also identified as an extrinsic motivational factor for the staff. The role of management in facilitating staff engagement with the programme has been also explained in Chapter 4 which introduced the actors. Some managers stated their centres have been pro-active against smoking.

"…on the topic of smoking we obviously are really proactive here, both centres 5 and 8 are by far the highest referrals to Stop Smoking Services through the Smokefree campaign." (Jessie, manager centres 5 and 8)

The manager's support was essential in making the project part of the job role. Including the Smokefree question into the safety assessment or constant reminders of the project contributed to an increased understanding of the importance of the project. The management support was linked with the transformation of staff motivation from external regulation (i.e. taking action because they are told it is part of the job) to forms of identification and internal regulation (Ryan et al., 2009). Through 'identification' the staff identify with the behaviour to adopt whilst internal regulation takes a step further when the regulations have been assimilated and synced with personal beliefs (Ryan and Deci, 2000).

"So what my line manager did, she devised, we have a safety check list that we do on our first home visit anyway, so she added to that, so when we go to the family's home, we're not just asking them about it, as we are doing the safety check list it comes up in there..." (Kady, family support officer, centre 3)

One of the challenges identified by the actors participating in Smokefree was the difficult conversation about smoking. Both staff and members of the public raised the issue of 'questioning habits' as a challenging conversation. As with most social marketing offerings, Smokefree asks individuals to change behaviour and habits (members of the public) and practices (staff). Motivating actors to engage with social marketing offerings when the activity is not 'interesting' or pleasant requires further efforts to identify external reasons for engagement. Self-Determination studies (Deci et al., 1994) suggest that supporting autonomy and relatedness corroborated with a meaningful rationale may facilitate motivation. Keeping the staff interested and engaged over long periods of time was challenging. This was particularly illustrated by the staff working at the reception where the Smokefree activities may become repetitive, ending up targeting the same people. Receptionist staff indicated that it was difficult sometimes to know who had been already approached with Smokefree.

> "…it's difficult when you've got the same because there's only a certain number of people that you can target for something like that without coming over as being really repetitive and you know." (Christy, administrator, centre 4)

The manager had the capacity to make Smokefree a 'team project'. Working as a team to promote the Smokefree message has contributed to 'normalising' the Smokefree task as part of the job routine. The team element has also exerted peer pressure on individual staff members who were nudged to respond in one way or another to the Smokefree. Generally, each centre had staff members who became 'champions' that would also influence other colleagues in getting involved with the campaign:

> "I've been challenging everybody else to do it as well, 'come on I've got ten, I've got ten today come on the rest of you get going'…" (Sophie, Children's Centre teacher, centre 2)

> "…I think it was because we decided as a team like we really focused on it and, you know, everybody trained up…" (Jessie, manager, centres 5 and 8)

> "And you only need two or three people in the group to really go for it and then everyone tags along because they feel that peer pressure to do it as well. They don't want to be the only one at the Children's Centre who is not signing people up. So they motivate each other through that…" (Kathleen, manager Smokefree)

Members of staff who become champions in promoting Smokefree may act as influencers for other staff within their network. This was illustrated by the Children's Hospital case where engagement with the programme has been low. One of the neonatal nurses who participated actively in the programme has become the main link of Smokefree with the Hospital. Observation of her life support training sessions indicated she had made Smokefree part of her delivery package to parents. As a result of recent Smokefree efforts she has been asked to act as an intermediary between the Smokefree and the Children's Hospital nurses' team in order to encourage their participation in the programme.

> "… we were in the staffroom and somebody said about it [the training], so I said that I thought it was brilliant, I explained and they were like 'Yeah, I suppose.' But I've always, if anybody does mention it, I will always say the way I see it and how I think it's really good." (Sara, nurse, Children's Hospital)

Champions were effective in motivating others to move beyond their prescribed roles and take on Smokefree activities. This study indicates that champions can play a central role in implementation in creating a 'model' to follow. Other research (Hendy and Barlow, 2012) suggested that champions are in particular essential at the pre-implementation stage to promoting a 'vision' that would motivate others.

A duty and responsibility to share the message

When the importance of the programme was internalised by the staff, they saw their participation as a natural task. Some participants (health professionals in particular) emphasised that it was their duty and responsibility to share the information about Smokefree homes and cars.

> "But in my mind it's something that is so important that we have a duty, if you like, a duty to give them that information. What they do with it is obviously still up to them." (Sara, nurse, Children's Hospital)

> "I think, […] we have a responsibility as a health professional, to promote whenever we can, any sort of campaigns such as healthy eating, smoking, obesity, all of those campaigns." (Shonda, health visitor, centre 11)

> "Well it was promoted to us. It is our responsibility now." (Patty, health visitor, centre 8)

The enthusiasm and engagement with Smokefree can be also seen in how staff talked about the competition and the fact they were very good at promoting the campaign. They were also aware of how the campaign was being promoted in other sessions in their centre and made suggestions for other sessions that might be appropriate for having the Smokefree conversation.

Competition

The Smokefree team encouraged competition among the Children's Centres in the city in order to motivate the staff to engage with the programme. The Children's Centre which had the most sign-ups per quarter would receive a trophy and the success would be shared across centres. The competition element was seen as an important instrument to motivate the staff of Children's Centres to participate actively in the programme. The staff who signed people up to Smokefree had to put their initials on the back of the pledge card which was sent back to STOP. This information allowed the Smokefree team to identify which members of staff had been actively engaged in the programme. Occasionally, the manager of Smokefree would reward individual members of the Centre and not only the Centre as an institution by offering them a glass trophy. Recognition and reward of staff contributions to the programme by the Smokefree manager helped maintain their level of engagement.

> "…a bit of a competition, to try and push it as much as we can. The midwives push it, the health visitor push it, and we just put down the admin if it's the admin, if it's the midwives or the health visitors, then we know, who's pushing it." (Penny, administrator, centre 6)

> "But to keep it on the boil, even getting a feel in… so every time I write a report, I say thank you to people for any that have dropped down who I know are quite regular signers, I acknowledge the fact that they are regular and over the year it's been this good, […] I don't tell anybody off for not doing it this time or something, I just try and talk positive all the time." (Kathleen, manager Smokefree)

However, the manager of Smokefree noted that she was reluctant to reward individuals as opposed to whole teams. By rewarding the whole team the aim was to try and motivate also the staff that were not active without highlighting their lack of engagement.

"Hmm, so maybe it is about individual staff, but then that doesn't recognise some of the people who have the conversations but don't get the sign ups or they are not so… […] I feel reluctant to pick off individuals that do well rather than sort of whole teams of people being rewarded as part of the Children's Centre." (Kathleen, manager Smokefree)

"I think they included all the Children's Centres so you could see how well you're doing and they did it personally as well […] on that little form it had an option to have a kit to help you stop smoking, it would tell you all that as well so that was really good as well. Because I think that motivated me a bit more as well…" (Bella, administrator, centre 1)

For other Children's Centre staff, participating in the programme and generating sign-ups represented a challenge to help their Centre meet the targets. Generating referrals became a job related goal which was associated with the Centre's success.

"…when things weren't coming through […] as a centre we weren't like getting really many referrals, I was thinking, oh, this is a bit of a challenge I'm going to take it […] on really." (Sophie, Children's Centre teacher, centre 2)

The competition was also used by Children's Centres' managers who shared the reports regarding the sign-ups recorded at centres across the city in order to motivate their staff to participate.

"And also, I shared the success across the city, or not successes across the city, and obviously if you looked at the numbers of sign-ups we were at the bottom of the list. And then there's all these other Centres that have got hundreds of sign ups. […] there's a bit of healthy competition, to be fair, cause we're not all about competing with the other Centres, but I see that as healthy competition." (Victoria, manager, centres 1 and 2)

However, competition alone, as an extrinsic motivation factor, is difficult to maintain the level of staff engagement over time (Ryan et al., 2009). This was suggested by the fact that after one year the competition element seemed to have worn off at some Children's Centres.

"So, I think yes, the award is great, maybe the award's been around for a while and we need something a little bit different that gets people excited about it again

and thinking about, 'Oh yes, I must remember to do that.' Something that gets them motivated again." (Mira, manager, centre 6)

The literature indicates that competition and rewards, whilst fuelling extrinsic motivation, are in fact seen as undermining intrinsic motivation (Reeve and Deci, 1996; Ryan and Deci, 2000; McDonald, Harrison and Checkland, 2008). The social marketing organisation faces the challenge to find new ways to keep the staff interested and cultivate the relationships created during the early years of this programme in order to build capacity for further developments.

> "…it was about understanding what might motivate my partners to feel engaged with that work and to make it worth their while. So it was introducing both a carrot and a stick so… something to entice them to want to do it and something to kind of make them feel slightly awkward if they didn't do it, to put it the most gentle way […] but also trying to help them understand what they have to gain from it." (Kathleen, manager, Smokefree).

Although the staff actors who participate in the Smokefree homes and cars programme are identified as being part of a network of support, their decision to engage in the programme cannot be motivated solely by their position and roles within the network. The next subsection discusses the intrinsic motivational factors.

6. 2. 2 Intrinsic factors

Personal beliefs regarding smoking were an important factor that facilitated staff actor engagement in Smokefree. Some staff were willing to share their experience as ex-smokers and how they reached a stage where they felt repulsion towards smoking. For example, Laura, a family support manager, had stopped smoking after having lost her sister because of a tobacco associated death. However, she did not like using that experience with everyone, as it was considered too 'extreme'. She had previous training on smoking cessation and advocated for getting involved with Smokefree activities. Her engagement was also illustrated by the steps taken to maintain the initiative on the agenda (i.e. introduced questions about smokefree homes in the assessment that family support officers need to complete during the first home visits).

Personal beliefs are also linked with a sense of competence. Engaged actors suggested they felt competent to have the Smokefree conversation. This is in line with the notion suggested in the literature on social cognition models, that motivation is influenced by self-efficacy beliefs (Bagozzi and Kimmel, 1995; Ryan et al., 2008).

> "I think the staff at the beginning were, 'This is what we're going to do, the mugs are here, sign up,' but I think we realised and could answer the questions we then became more confident to sort of say, 'Well, that's rubbish and think about this'." (Ellie, family support officer, centre 4)

Another ex-smoker emphasises she had special insight that gave her 'the right' to talk to smokers rather than non-smokers.

> "I think can talk about it because I have smoked and I think that helps me sort of have the right to talk about it against someone who perhaps has never smoked because they don't understand what smoking is." (Kelly, senior family support officer, centre 4).

Individuals need to feel competent enough to engage in the activities required by Smokefree. One of the barriers to actor engagement in co-creation is the lack of skills or inability to act (Grönroos, 2012). As discussed in previous chapter, skills development and learning become key processes to facilitate collaborative value creation. Being passionate about the smoking issue and the evidence their work can have an impact helped to maintain interest about the Smokefree campaign.

> "…it depends on what motivates you. If you find something that can have an impact. […] I'm driven by wanting to help children and families, so that's what gets me to get up and motivates me to come into work every day […] I'm passionate enough that if I feel there's something worthwhile sharing with another parent or another family then that's my role and responsibility within the Children's Centre." (Dana, senior play leader, centre 5)

> "I'm very good with people that's why I enjoy reception and for me it I believe in it. I can sell it far better than if I'm just told I've got to do something that I don't necessarily agree with, I think it's brilliant so therefore I can sell it, […] but I believe in the project so I can sell it because I'm selling it from the heart not just speaking it." (Sandy, administrator centre 8)

In settings where the structures to facilitate engagement were lacking (i.e. Children's Hospital), staff needed a very strong personal motivation to take Smokefree on board and get involved with the programme. In this case, participating in the programme was more of a personal project.

> "[in the Hospital] it's just individual staff who might take it on because they feel strongly about it but there's no way of measuring that or feeding back, that's just got to be their personal motivation." (Kathleen, manager Smokefree)

Initially, the nurse from the neo-natal unit who was involved in the programme was not aware of the outcomes of the programme as she was not receiving any feedback from Smokefree. The nurse case might be explained by the fact that she was not asking people to complete the form while she was with them. It may be that people forgot to complete or send off the form to STOP which made tracking her contributions more difficult. However, she continued to broach her patients with the Smokefree message because she considered it important.

> "I'm not sure how many people I've given it out to have actually signed up. But at least they've got that bit even if they haven't taken it any further. I know at least one family who did take it up and they both gave up smoking on the basis of it." (Sara, nurse, Children's Hospital)

As the previous chapters indicated, the lack of management support was a strong barrier to staff engagement in the hospital context. From a critical realist perspective, the nurse case illustrates how a strong belief in the value of the programme combined with a sense of duty enable the power of transformative agency over structural barriers.

A sense of accomplishment driven by positive feedback

Engagement and its results translated into the number of sign-ups and children that were protected from second-hand smoke motivated the staff. Some of the staff who championed the campaign expressed a sense of accomplishment having learned about the high numbers of children who had been protected by second-hand smoke.

> "I've got a picture with me holding it as well! It's just a glass trophy and it's for all the centres in the City [...] It's a shame I didn't get in touch with Kathleen to tell me the results, we've had some good results, especially for the quarter where we won the trophy…" (Karrie, administrator centre 7)

> "It was like I had to prove something and what they said to us initially was 'try and get two before the end of the month' and then as I did more and more I got to quite enjoy it." (Jill, childcare learning officer, centre 9)

As illustrated in the previous chapters, having access to feedback that showed impact from the STOP Services was vital to keep the staff engaged and interested. Feedback was tailored to respond to what children's centre managers or health visitors needed.

> "The report gave you feedback which was really good because it gives you feedback about how many people access the Stop Smoking service, how many children were involved in those families so it was pretty good." (Mona, manager centre 9)

> "But I can tailor it to whatever that manager wants to do […] if she wants to set up a bit of a competition between her staff that is great, I can support that and I can give her that data, as long as they write the names on it…" (Kathleen, manager Smokefree)

The importance of having constant feedback to reinforce their efforts and motivation from the Smokefree programme was highlighted by the majority of health visitors interviewed. In addition to the reporting of sign-up numbers some of the staff indicated they would appreciate examples of success stories that could be shared with their clients.

> "So this is a really good route for us in, of that seven were smoking prior to the pledge and that means in that quarter we protected twenty seven children so that's quite motivating to get that quarterly to give to the team that keeps everybody on their toes." (Jessie, manager, centres 5 and 8)

> "…but what I think we need to do, if we want to carry on this campaign, I need to make it a regular agenda item, every month. And we need to give them some feedback. When we had the first lot of feedback, it was fantastic, and I got an ally, I don't have an ally now." (Alba, health visitor, centre 12)

Staff interviewees stressed the need for evidence of change and ability to track the results, and actually see the journey people went through to change. This study resonates with the general motivation studies (Gagné and Deci, 2005) and organisational behaviour

studies (McDonald, Harrison and Checkland, 2008) suggesting that positive feedback can facilitate intrinsic motivation.

> "…sort of the journey people went along on [Smokefree] and then smoked in the garden and then actually reduced their smoking and then went to Centre 8 to the STOP Service, so people can actually see…" (Lucy, practice teacher and health visitor, centres 4 and 8)

> "…the statistics come back to us and we can pat ourselves on the back by saying how well we've done and how many people have signed this campaign." (Patty, health visitor, centre 8)

The next subsection discusses the motivation of member of the public/service user engagement with the Smokefree programme. Member of the public engagement is defined by interaction (i.e. their willingness to interact with staff to discuss the Smokefree message), actor knowledge about Smokefree (i.e. facts about second-hand smoke; being aware of the programme aims) actor perception of the Smokefree programme and behaviour (i.e. sign up to Smokefree; smoke outside).

6. 3 Members of the public/service users' motivation

The communities identified as target audiences of the Smokefree programme are the ones where smoking prevalence is still high compared to the national average. The previous chapters have described these audiences in more depth.

Member of the public engagement with Smokefree varied from one passive interaction with the staff where they agreed to listen to information regarding smokefree homes and cars to signing the pledge and stopping smoking. Staff indicated that the majority of their users were willing to listen to the Smokefree information even if they did not sign the pledge afterwards. Indeed, the informal interviews conducted during the observation sessions indicated that some people were aware of the programme but did not sign up because they were non-smokers and did not allow anyone to smoke around children. However, observation and informal interviews also indicated that some people were not familiar with Smokefree. This may be because the staff did not discuss Smokefree with

every user; the users might have recently joined the centre; and/or because the Children's Centre would have special Smokefree sessions that these users have missed. Another reason for not signing up may be linked to language barriers as discussed in the previous chapter. Interviews with members of the public suggested a high level of awareness about the basic message that exposure to second-hand smoke has a damaging effect on people. The information that was often recollected by interviewees was that smoke lingers for hours and it sticks to objects and pets. All interviewees admitted they knew 'second-hand smoke was bad' before having received the Smokefree information. Yet, the majority were struck by the amount of harm it could do after having learned the details offered by Smokefree. The Smokefree programmes reinforced some of the knowledge they had about smoking.

> "I used to, you know, like smoke out the window, but I didn't realise quite how much the smoke comes back in and sticks to things so that was a big worry. [Interviewer: So there was some new information for you?] Yes, yes. […] I know you're not meant to smoke in front of your kids but I thought I was alright by shutting myself in the kitchen but obviously I wasn't." (Corrine, member of the publics, centre 14)

Similar to the staff motivation, interviews with service users at different Children's and Community Centres indicated that motivation was driven by extrinsic and/or intrinsic factors. The motivation behind the sign-up varied from simply complying with a request, to using the pledge as an incentive to motivate them to stop smoking.

6. 3. 1 Intrinsic factors

Intrinsic factors were linked to personal beliefs about smoking, the desire to learn more and reinforce those beliefs and the desire to influence others to change behaviour to protect children and other family members from second-hand smoke. *Extrinsic motivational factors* (defined as factors that influence performance to lead to a separable outcome) were defined by the desire to give themselves an incentive for cutting down or stopping and the influence of staff or other members in their immediate network.

Personal beliefs: concern about others' health and the effect of second-hand smoke

Some of the members of the public emphasised they signed the pledge as a way to reaffirm their beliefs about smoking and second-hand smoke. The action of signing the pledge had the symbolic meaning of publicly agreeing with the message of the programme.

> "They don't, they smoke outside, but my issue with that is just because you smoke outside doesn't mean that the smoke doesn't linger on your face, on your hair, on your clothes and on your breath […] when you come in I can still smell it, if I can smell it my child can smell it." (Kalista, member of the public, area 5)

> "…but because I'm not a smoker myself, and I don't like that…I've seen people, I haven't said anything because it's not my place but I've seen people smoking near, […] born new babies…I hate to see it, I hate to see but it's not, I can't go up and…" (Carrie, member of the public, area 5)

There was a common thread in people's reflections on their pledges in the desire to protect others from second-hand smoke. Children's health seemed a powerful argument for people to sign a commitment they would not smoke or allow others to smoke in the house or car. Staff interviewees suggested that some of their users were shocked when learning the facts about second-hand smoke.

> "I've tried to, I don't know, just make them aware of it I suppose, with the kids and all, 'cause I don't think some people are, they're just there and they are blowing smoke everywhere, […] for me I think it's something I feel quite strong about…" (Carrie, member of the public, centre 5)

The desire to influence others to change behaviour

Some of the non-smokers who signed the pledge were hoping to encourage their partners and other members of the family to quit smoking. They would bring the leaflet home and either leave it for their family to see it or engage in conversation with them about the negative impact of second-hand smoke, particularly on babies and young children's health.

> "I actually came to the Sure Start centre and one of the workers asked me if there was anyone in the family who did smoke, to which I replied there was. And she told me that there was this campaign to sign, like sign up for it which I did. I have got family members who smoke, they don't smoke in the house." (Kalista, member of the public area 5)

6. 3. 2 Extrinsic factors

Members' of the public extrinsic motivational factors for engaging with Smokefree were identified in relation to the concept of incentives and compliance with others' requests. As in the case of staff, extrinsic factors influenced members' of the public engagement with Smokefree.

An incentive to reduce or even stop smoking

For some of the smokers signing the pledge was motivated by the need to have a reminder to help them cut down and incentivise them to try stopping. Smokers would accept the Smokefree offering as something that might provide value in the future (i.e. hoping they will quit one day).

> "Yes because you don't smoke as much because you have to keep going outside because you can't really leave your kids to go outside every few minutes so yes I've definitely cut down." (Corrine, member of the public, centre 14)

Compliance with staff and/or other members in their network request

However, some participants admitted they had signed up only to please the staff or in order to avoid a longer conversation about smoking. The relationship the service user had with staff shaped their response to the Smokefree proposition. As some Children's Centres' users indicated in informal interviews during observation sessions, sometimes they signed up because the staff were friendly and sometimes persistent. This was also confirmed by Children's Centre staff.

> "Cause we're so persistent! […] To be honest […] it's cause we're consistently passing that message on all the time. Every session that I know that I certainly do, one of the first things I do is ask parents, 'Have you signed up for this campaign, if you haven't, I'll tell you about it, I'll get you to sign up'." (Dana, senior play leader centre 5)

> "I'm good at charming them, I haven't had anybody that's said 'No, I don't want to do it' and I've had about thirty or forty sign-ups." (Sophie, Children's Centre teacher, centre 2)

This raises the issue of power and the relationship dynamic between members of the public and staff engaged in co-creation practices. The 'consumer' in commercial settings is generally portrayed as empowered, networked and willing to participate in co-creation (Prahalad and Ramaswamy, 2004). However, as it has been explained in the previous chapters, in a public service context, the complex support relationships between users and staff may create situations where the staff roles (i.e. safeguarding) influence a compliance response from their clients. Given the safeguarding role of Children's Centres and health visitors sometimes their staff may be seen as having the power to keep the child in that family and keeping Social Care involved.

> "I think […] because we are health professionals they feel that they can't, they should just go along with what we are saying. So they'd be like 'yeah, yeah' okay we'll do it, […] because they don't want to look like they are not trying their best." (Celina, maternity support worker, centre 13)

> "I'm very nurturing and people will come in and probably see me as a mother figure and they'll listen to me […] my nature is very nurturing. I don't like it myself when I have to report them, because they've crossed that line." (Ellie, family support officer, centre 4)

> "…I mean our families are very astute […] they know how to play the system, […] it's almost like saying 'unless you sign up to this we're not going to give you the support' but we can't do that." (Kelly, senior family support officer, centre 4)

In other cases, the 'network effect' translated into people signing up because someone in their family signed the pledge and persuaded them to do the same.

> "[my wife] brought everything [Smokefree] home to me. So that's when I decided okay, enough is enough, and I went for it." (Sal, member of the public, centre 5)

The 'compliance' factor raises the issue of the quality of Smokefree referrals. One of the issues raised by the Smokefree team was that a high number of Smokefree referrals did not necessarily translate into stop smoking referrals or if they did, they did not always lead to stop smoking appointments.

> "I think we get a good number of referrals through the Smokefree campaign but they are not easy to convert to appointments necessarily." (Kathleen, manager, Smokefree)

Both the partnering staff and the Smokefree manager raised the issue of the quality of referrals or 'insincere' sign ups. Some of the staff interviewees questioned whether some of the people that sign up also follow it through:

> "I mean to be honest, and I know this sounds awful as well and I probably shouldn't tell you but I made the commitment not to smoke in my house but there have been occasions when it's been really cold outside and that temptation to go back in has weighed out." (Christy, administrator, centre 4)

Observation sessions suggested some members of staff used their influence that led to nobody refusing signing up. The participation in the interaction regarding Smokefree may be in this case non-voluntary for service users. Although they might benefit from the conversation and they might even end up signing the pledge and keeping it, they did not necessarily choose to engage with the programme initially. They were targeted because of their position as users of a specific community based service which qualified them as potential audience of Smokefree.

> "But then the same can be said of a lot of referrals that come from the hospital as well, sometimes people might feel under pressure to tick a box and say 'yes I'll be referred' but then don't follow through and won't come to the appointment or whatever but I think we see that across all programmes." (Kathleen, manager, Smokefree)

Non-smokers' action, particularly of those who are already performing the recommended behaviour and have strong beliefs against smoking in the house was perceived as a way to 'reinforce the norm'. However, there was the risk that they would artificially increase the numbers of pledges.

> "The majority of the people who sort of signed up, they told me they do smoke outside, they don't smoke in the house, they don't let anyone smoke in the house, so that's quite good…" (Penny, receptionist/administrator, centre 6)

The reward/gift

Some of the Children's Centre staff suggested that on some occasion their users gave them the impression they were signing up only to receive the free gifts that came with

the pledge. Observation sessions at Children's Centres suggested that the free gifts worked as a considerable incentive particularly when the staff did not go into detail about the aims of Smokefree but only asked people to sign up to a campaign they were promoting. Particularly at the reception where the pace of work allowed for less time for conversation with the users, the interaction around Smokefree was limited to the staff asking the public if they wanted to sign up to a campaign. Some receptionists would also emphasise the free gifts and the chance to win a voucher. However, none of the members of the public interviewed mentioned the free gifts as a reason for signing up.

> "The mug to start with here. Definitely the freebies, they love freebies […]" (Ellie, family support officer, centre 4)

> "…but I keep them here in reception so sometimes people say: 'Oh what are these mugs?' and then I ask them 'Do you want to sign up, and have a free mug?'" (Penny, administrator, centre 6)

> "I think it [what motivates people to sign up] is the free mugs, I know that's awful […] Yes, I mean I would hope that […] a percentage of people will genuinely do it for the actual thing of not smoking in the house and stuff like that but like I said with the fire brigade that was definitely a motivator for me, just having somebody coming out and checking you know your smoke alarms in your home." (Christy, administrator, centre 4)

Member of the public motivation for engaging with Smokefree varied from simply complying with a staff request to holding strong beliefs against smoking, acting to motivate others or themselves to quit smoking and protect children's health. These motivations are associated with different value types which are discussed in the next section of this chapter. This finding illustrates how consumers (who are not necessarily the target audience) are using resources to create value for themselves and others in ways that may be inconsistent with the organisation's goals.

The data suggest that extrinsic factors were an important source of motivation for both staff and member of the public engagement in the Smokefree programme. This is in line with other studies (Ryan et al., 2008; Ryan et al., 2009) which suggest that engagement with health behaviour change tends to be extrinsically motivated. Actor motivation to act

varied from external regulation (i.e. to comply with job/others' requirements) to identification and internal regulation (i.e. assimilating the behaviour required by the programme as resonating with their own beliefs).

The literature indicates that individuals tend to engage in behaviours that are valued by others at different levels (i.e. family, group, society) (Ryan and Deci, 2000). This was also illustrated by the service contexts where producing Smokefree referrals became a team issue. A primary finding of this chapter is that staff become engaged when there is a sense of a team project and there is management support. Participation in the programme may be initially motivated by the simple need to comply with one of the job requirements, but repeated interaction with the Smokefree manager, positive feedback and the management support contributed to normalising the new activity and internalising of the importance of their actions. As has been suggested elsewhere (Ryan and Deci, 2000, p. 64), motivating individuals requires creating a sense of 'relatedness' to the actors that are disseminating a goal. This was also noticeable for some members of the public whose motivation evolved from external regulation (i.e. complying with the requests of another member of the family to sign the pledge) to identification and internal regulation (i.e. signing the pledge and giving up smoking). In these cases, commitment to Smokefree led to internalisation of the cause (Kerr et al., 1997) and a change of attitudes and behaviour.

The next section examines the notion of value in a health social marketing context. Adopting a service-dominant logic lens the study examines value-in-context from the perspective of collaborator staff, the focal organisation (i.e. STOP services as represented by the Smokefree team) and member of the public/service user.

6. 4 Value dimensions in a health social marketing context

Actor motivation for engaging with a marketing offering is generally connected with the notion of value (Zainuddin, Previte and Russell-Bennett, 2011). SDL adopts a phenomenological view on value which can include various benefits (functional, emotional, social, epistemic, altruistic) (Holbrook 2006; Sheth, Newman and Gross, 1991). Based on this view, value is considered a function of experience that comes from

interactions (Prahalad and Ramaswamy, 2004), from pursuing life goals or performing social roles (Arnould, Malshe and Price, 2006). It is important to explore the implications of this perspective on value in social marketing in order to enhance our understanding of the benefits sought by customers and other actors involved in social marketing programmes.

This study makes the distinction between value creation processes and value outcomes or value dimensions in relation to actor perception (Gummerus, 2013). An analysis of the value creation processes (facilitation, co-creation, resource integration) is centred on actors, relationships, activities and resources involved in the process, whilst an examination of value outcomes or dimensions refers to what customers and other actors perceive as value as a result of their involvement. As such, value outcomes are viewed as subjective and as defined by the actors involved in the Smokefree programme. This is different from traditional social marketing literature where value is generally defined from the perspective of the society (Brenkert, 2002).

Chapter 2 reviewed various definitions of value. A proposed definition of value states that 'value for customers means that they, after having been assisted by the provision of resources or interactive processes, are or feel better off than before' (Grönroos, 2008, p. 303). Another definition of 'value-in-use' or 'value-in-context' states value is 'customer's outcome, purpose or objective that is achieved through service' (Macdonald et al., 2011, p. 671). Grönroos (2008) definition needs to be adapted in a social marketing context where value deficits need to be accepted in the short term for benefits in the future. As discussed in the section on exchange limitations, in a social marketing context, overall societal wellbeing might sometimes be a priority over individual benefit. Examples include but are not limited to environment or health applications such as smoking, where customer primary value might mean making themselves 'worse off' (e.g. anxiety and stress; stepping outside to smoke) for the sake of others (e.g. to protect children from second-hand smoke). Given these considerations, in this study, value is defined as actor 'outcome, purpose or objective achieved through interaction with the social marketing offering and other network actors.

The previous chapter has explained the processes of value creation in the Smokefree context. In a value creation network, stakeholders of the central organisation change

roles as initiators and participants (Ballantyne et al, 2011). Given the myriad of actors involved in a social marketing programme a discussion about value needs to acknowledge the various stakeholder perspectives. As such, in a social marketing context, value is understood and explained not only from the 'customer' perspective as the user or the ultimate beneficiary but also from the perspective of the collaborators and other stakeholders involved. Adopting a service perspective in social marketing requires careful consideration and conciliation of the different notions of value of the participants in a value network. As it has been suggested (Gummerus, 2013) adopting a service-dominant perspective requires rethinking what we mean by 'value outcomes' and understanding that value is determined by each actor participating in a value network. In a collaborative context, the social marketers 'co-create' not only with the final user but also with partners and collaborators. The value of the offering is different depending on the perspective adopted (collaborator staff, Smokefree staff, member of the public).

This section explores actor (staff and member of the public) perception of the Smokefree value. Interviews aimed to elicit staff and members of the public/service users' reflections on the value of their participation in the Smokefree programme. The interview protocol was designed to stimulate participants to think whether anything had changed for them as a result of their engagement with the programme (i.e. signing the pledge; knowledge about second-hand smoke; talking about Smokefree and asking people to sign up) and whether their interaction with the programme had helped them in any way. The approach to data analysis has been described in depth in the previous chapters. A thematic analysis guided by Miles and Huberman (1994) was employed to identify patterns and themes related to value. The themes were associated with different value types that were found relevant in the literature. The literature review chapter provides a comprehensive discussion on the different dimensions of consumer value (Babin, Darden and Babin, 1998; Holbrook, 2006; Sheth, Newman and Gross, 1991). The findings of this study suggest that actor value in Smokefree is dynamic and multidimensional. One of the core SDL principles states that firms provide value propositions which can be experiences and/or solutions (Vargo and Lusch, 2006; Winklhofer, Palmer and Brodie, 2007). The experiential view on value shifts from the economic cost/benefit approach to a view where value is "an interactive, relativistic, preference experience" (Holbrook, 2006, p. 751). The data suggest different dimensions that define value as functional, social, altruistic, or emotional depending on the context

(Holbrook, 2006; Sheth, Newman and Gross, 1991). As such, member of the public/collaborator value is examined in relation to the encounter (relationship, conversation and learning), the offering (the pledge, leaflet, training etc.) and outcome (change their own habit or their family's habits; protecting others' health). Social marketing organisation (i.e. STOP) value dimensions include the encounter (relationship, co-learning), the offering (the pledge as a 'customer relationship management' tool, the training) and the outcomes (collaborators network; protect children's health, contribution to shaping the social norm; increased number of referrals to STOP). The following subsection examines the altruistic dimension of value in the Smokefree programme.

6. 4. 1 A salient dimension in social marketing programmes: altruistic value

Engagement with Smokefree to protect children's health

Social marketing definitions outline the altruistic dimension of the value proposition. Social marketing applies marketing concepts to influence behaviour that will benefit individuals and the society overall (Andreasen, 2002; 2012; Dann, 2010). *Altruistic value* is defined as concern for how one's consumption behaviour affects others (Holbrook, 2006). Altruistic value is intrinsic and directed towards others as a self-fulfilment or a sense of well-being (Holbrook, 2006; Zainuddin, Previte and Russell-Bennett, 2011).

The Smokefree initiative was seen as different from previous campaigns against smoking in being open about smoking habits and stimulating people to look at it from the perspective of children's health. The value proposition of the Smokefree programme is centred on an altruistic cause. People are asked to change their behaviour and smoke outside their homes and cars in order to protect others (particularly children) from second-hand smoking.

> "But I think this campaign, I just think it's a good way of just side stepping the actual fact that they are smoking, and just getting them to look at it from a different point of view." (Sara, nurse, Children's Hospital)

> "…it's getting it out in the open really, rather than making smokers feel sort of isolated and unwanted actually saying you know you're not, talk about why are you doing this…" (Lucy, practise teacher and health visitor, centres 4 and 8)

"And it is about parents as well, like motivational interviewing, you get the parent to think about the negative sides of something and then they come up with how they are going to tackle that and in doing that they are then buying into it and they are more likely to succeed so I think actually it is a very good campaign for that reason." (Sandra, health visitor, centre 8)

Altruistic value was identified by the staff participating in the Smokefree initiative. Some of the Children's Centre managers indicated that the Smokefree programme provided them with an instrument to protect their staff from second-hand smoke. Although members of the Children's Centres and health visitors' staff emphasised the functionality of the programme which provided them with valuable data for their own reports, they also admitted the initiative was needed to contribute to the efforts to protect children's health. The Smokefree initiative was seen as a way to educate people about second-hand smoke impact on health.

"And not just, obviously not just being part of my job role but obviously to help the women to […] give them the information about it as well and […] a lot of them aren't very knowledgeable so to just keep reminding them that […] it is something that we do and that it helps and reduces cot death, reduces all these kinds of different things." (Celina, maternity support worker, centre 13)

"I think it's really important [promoting Smokefree], […] and from the information that we're getting back from Kathleen the numbers of children being protected from second-hand smoke are considerable, it's important." (Mira, manager, centre 6)

Children don't have a choice

One of the arguments invoked by both staff and members of the public for participating was the relevance of the initiative to protecting children's health. The key point raised was that children do not have a choice regarding the environment where they live.

"…but for me, it is just I believe that if I want to do something I can do it […] when I am on my own, not to harm my baby. Because that is my baby and he does not have a voice at the moment." (Denisa, member of the public, area 5)

> "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 training." (Karrie, administrator, centre 7)

> "I always say 'it doesn't matter if you smoke, I don't need to know whether you are or not, I'd just like you to perhaps sign up to […] making your home smokefree for the benefit of your children' […] and usually they all sign up." (Sophie, children centre teacher, centre 2)

Children are an important group of direct beneficiaries of the behaviour change in the Smokefree programme. This is also suggested by the identified target audience of the programme (i.e. parents of young children) and the collaborators (i.e. staff from public services whose service users are mostly families of young children). The participants in this study indicated that children were perceived as having a negative attitude regarding smoking but that they were vulnerable and helpless in taking action to change their environment. This is supported by other studies (Woods et al., 2005; Amey, 2010) which emphasise that children react against the practice of smoking in the house but they are often disempowered in changing their circumstances.

> "…she [her daughter] asked me about it [the Smokefree leaflet] and when I told her about it then she said 'oh but daddy smokes' and she will say 'daddy stop smoking' so she's got an input as well because she's seen it." (Nadira, member of the public, centre 5)

> "Yes I've got a fourteen year old that lives with my mum in N. and she's: 'definitely you've got to quit, you've got to quit' but it's not that easy." (Corrine, member of the public, centre 14)

The members of the public interviewed stressed the fact they would never expose their children to second-hand smoke. Those who were smokers had specified they always knew second-hand smoke was bad for their children and they would avoid smoking in their presence.

> "Well, basically she just told us what we already knew about passive smoking […] I've never smoked around children anyway. We, if the children are here, we always go outside and we smoke outside now anyway." (Jessica, member of the public, area 7)

The findings suggest that when the value proposition indicates the benefits of behaviour change are directed to another individual than the one who is taking action, the altruistic dimension of value needs to be strongly articulated to be able to persuade people to engage and maintain the behaviour. The notion of value and exchange has been one of the subjects of debate and criticism in social marketing. As discussed in detail in the literature review chapter, social marketing contexts have challenged the notion of economic value and classic exchange, particularly because of the intangible nature of the social marketing offering, the focus on societal wellbeing and the multitude of actors involved. It is important to note that a discussion about value in a social change context will often include the altruistic dimension. This dimension will often create tensions with self-focused value or the final user notion of value. The study examines value from the perspective of the actors involved (collaborating staff, Smokefree and members of the public). When examining value of the collaborating staff, the altruistic dimension seems to be salient at a general discourse level. Their engagement with the programme is meant to protect children from second-hand smoke. The beneficiaries of their actions are children/non-smokers who may be at risk of second-hand exposure. This observation is also valid for most members of the public. Their actions are motivated by their desire to protect children from second-hand smoke. However, a closer analysis of the data suggests that at the individual level people also seek other value dimensions such as functional, emotional, social and epistemic depending on their goals and objectives. This seems to support the SDL perspective where the emphasis on the final user as co-creator has highlighted the multifaceted dimensions of value (Gummerus, 2013).

6. 4. 2 Functional value

Staff engagement with Smokefree to create evidence for service evaluation

One of the value related themes highlighted that staff and members of the public accepted the Smokefree proposition because it provided them with a specific utility (i.e. evidence for evaluation for staff; a push to cut down on smoking for members of the public). From this perspective, value is functional, defined as a trade-off between costs and benefits (Echeverri, and Skålén, 2011, Sheth and Uslay, 2007). Functional or utilitarian value is associated with a rational economic perspective (Sheth, Newman and

Gross, 1991). It is extrinsically motivated, instrumental, task-related, cognitive and a means to an end (Babin, Darden and Griffin, 1994; Holbrook, 1996).

The sign-ups co-produced with partnering staff and compiled by the Smokefree team constitute important evidence for these actors, particularly for Children's Centres and health visitors. The sign-ups and the number of referrals to STOP generate the evidence required by monitoring agencies. Children's Centres need to provide evidence of their efforts to promote health and decrease social inequality to OFSTED (Office of Her Majesty's Chief Inspector of Schools in England). Thus, the Smokefree referrals were valuable organisational data that were used to illustrate their efforts in tackling smoking targets.

> "The Smokefree project […] worked very well in our centre, it's a top priority for us because we're Ofsteded and we would've been outstanding, we had two health issues, one was breastfeeding and one was smoking […] this is really recording for us because it is resulted, we'd never get ten quick referrals, we'd never get ten people to put their name down ever." (Jessie, manager centres 5 and 8)

For health professionals the Smokefree programme provided them with a 'tool' to approach the discussion about smokefree environments in a more structured way. Smokefree was seen as a more practical and realistic approach to persuade people not to smoke around children.

> "So it's a tool to use to improve the rates of stop smoking and I think it does as well because a lot of people after I'd spoken to them do tick the box for getting extra help and support with giving up smoking." (Patty, health visitor, centre 8)

Health visitors identified the programme as a potential project they could use as one of their community capacity building exercise. They used the co-produced referrals and sign-ups to provide evidence for their community engagement project. As one of the team leaders suggested, their engagement in Smokefree 'paid dividends' (Lucy, practice teacher and health visitor, centres 4 and 8). Smokefree was easy to adopt and integrate with their work. It also provided a good case to help building the team. The practice teacher (Lucy, centres 4 and 8) learned about the programme from one of her students who wrote an assignment about it. Realising the value of the project the health visitor

team adopted it as one of their community capacity building projects. She then played a key role in championing the programme with other health visitors across the city.

> "I think someone came to speak to us in a team meeting, or it was mentioned at the team meeting and then Lucy […] she championed it, […] and she was talking about how we could make a difference and I think someone came to talk to us about smoking within our area […], the amount of people that were smoking and that's when it was triggered..." (Sandra, health visitor, centre 8)

> "…we we've been told to do a project, we're struggling to get our own work done, let alone start a new project off. So we looked at actually how we can work more smartly and more efficiently. So [Smokefree] was one of the things that was in our packs, that we used to give to parents, but we thought actually get smarter, use one or two of those minutes at that contact, just to talk about smokefree homes." (Alba, health visitor, centre 12)

The pledge provided insight about the audience

The pledge offering was a potential source of value for staff, the Smokefree team and members of the public. As explained in the previous chapters, the pledge/commitment approach has been widely used in behaviour change initiatives (Lokhorst et al., 2013). The commitment approach was also used by some of the Children's Centres to engage with their audiences. As staff from STOP indicated, their decision to adopt the pledge approach was guided by the national standard, the existing literature and interventions.

For the Smokefree team, the pledge format provided them with a tool to gather information on the number of smokers and smoking habits and have an immediate measure of the number of people signing up to the campaign. It also generated the opportunity to follow up and track the impact of the campaign in terms of number of people who accessed the STOP services as a result of the Smokefree campaign. The pledge format also allowed for creating a data base of individuals who were smokers or who lived in a smoking environment.

> "…from what I'd read [the pledge] seemed to be quite widely used and you are getting something back from somebody and you can count it and you are getting information off of them that you can then follow up. So what it did was give me

some immediate information from people and in a way the pledge was just a tool for getting that information to start with." (Kathleen, manager Smokefree)

"[the pledge] gave us a data capture tool as well so having a pledge meant that you have […] the number of adults, […] were they smokers before, do they want the help to quit, how many children, how many rooms did people smoke in, so you've actually got a big data set there." (Lydia, manager STOP)

The information obtained through the pledge system also provided data that could be used as evidence for their efforts and as a starting point for the evaluation. The information gathered through the pledge system is an example of customer relationship management (CRM) where the organisation is building a 'data base warehouse' (Urban, 2005) that will create the opportunity for more customised courses of action. However, the data were limited to information about the number of smokers from a specific area with no further insight about those individuals.

In line with other work on commitment (Lokhorst et al., 2013), the promise element of the Smokefree pledge was seen to act as a motivational prompt at the psychological level and a potential instrument to influence people to stick with the desired behaviour.

"…almost allowing the parents to make that decision themselves and they are buying into it by signing something and that will be on their conscience. It is all psychological." (Sandra, health visitor, centre 8)

"I think the actual wording isn't as important as getting people to actually make that declaration because that seems to give people the confidence to actually stick by it and not just let it go at the first sign of, you know, say, Grandma coming to the house and wanting to light up." (Lydia, manager, STOP).

However, both staff and members of the public emphasised that people need to be ready to make that change of behaviour in order for the pledge to work as an incentive. Some of the staff and members of the public questioned the effectiveness of the pledge arguing that this approach is less likely to have an impact on people who are not ready to make this change. This supports previous studies which associate commitment with contemplation and preparation to action as stages of change (Logie-MacIver, Piacentini and Eadie, 2012; Rosen, 2000).

> "I think if people are going to smoke they're going to smoke anyway but I just think it opens that door to think about it." (Lucy, practise teacher and health visitor, centres 4 and 8)

> "Like all these years I've been ignoring the TV adverts and everything but out of nowhere when I got the leaflets and the mug, I just decided to stop smoking. So it depends when a person is ready to stop smoking." (Sal, member of the public, centre 5)

> "I think making a pledge, what are you doing?, you're signing something and saying 'yeah, I will', but how do you know that's working? […] It's a bit difficult to kind of monitor isn't it?" (Shonda, health visitor, centre 11)

Behaviour change outcomes as a result of engagement with Smokefree

As has been suggested elsewhere (Jones et al., 2011) the data indicate that despite a certain awareness regarding the negative health effects of second-hand smoke, the rules around smoking inside the house are fluid. The programme brought new knowledge about the effects of second-hand smoke not only for members of the public but also for the staff involved.

> "I think I had some leaflets about it and it told me a bit more, details about it, […] like from sitting here where we are, you can have your child there and it can affect them, not realising that actually that is a quite a…bad sort of thing…when people think about having a child." (Carrie, member of the public, centre 5)

Most of the members of the public/service users interviewed had a basic knowledge about Smokefree and they were able to recollect some facts about second-hand smoke and the programme aims.

> "I know it was about a year and a half ago. I know it is to not allow anyone smoking around the child, either in the car or, especially in close spaces […] where the child is, basically most of the times at home or car. And it is for the parents, for grandparents and everyone else who surrounds the child." (Denisa, member of the public, area 5)

For some of the members of the public and staff (who were smokers) signing the Smokefree pledge was motivated by the desire to change their own behaviour.

"…it helped my husband, obviously he, […] ignores everything […] ...but no, for him to have that information and read it and acknowledge that […] he's able to see how much he was saving, the money and…and there was this chart as well to see how much he was saving money wise and what it was doing to his health." (Nadira, member of the public, Sal's wife, centre 5)

The staff engagement with the programme has also been reflected in their own change of smoking behaviour. Some members of the Children's Centre staff stopped smoking in the house and car while others recognised that they were able to cut down.

"One member of staff actually gave up smoking, it was one of our admin workers, she wanted to really, cause she was receiving people at Reception, she wanted to obviously promote Smokefree and wanted to give up smoking herself, but she tied the two in together." (Victoria, manager centres 1 and 2)

"A couple of family support officers have said 'well I smoke in the car on the way to visits' and then like we'll get in the car and then they'll be like 'no I've smoked in the car with the window open' so it's made them think themselves what they've done." (Sella, family support officer, centre 2)

Changing smoking related habits

Interaction with Smokefree also meant altering behaviour in terms of the actions taken by smokers to protect their children from second-hand smoke. Some of the interviewees who had partners who smoked indicated that after having been given the information about second-hand smoke, their partners were more cautious not to expose their children to smoke. Actions included washing their hands and mouth after having smoked and going outside to smoke.

"I suppose with my husband, he's more careful. Like I said, he'll have a shower, wash his face, brush his teeth, all of that. Whereas he might have just thought previously, it's fine. […] I mean the kids aren't aware that he smokes anyway." (Selena, member of the public, centre 5)

"It [Smokefree] helped to ... actually it did help to bring up the issue with my [ex-partner]... and to reinforce my arguments with my ex-partner of smoking in front of Chris [the child] and I think it has... and I think at the time, she's a lot better now than she was." (Gilbert, member of the public, area 8)

Some of the smokers who signed the pledge recognised that not smoking in the house was seen as an improvement in their behaviour. Furthermore, the action taken to keep the pledge (i.e. going outside to smoke) has helped them reduce the number of cigarettes smoked per day which will have an impact on their health. One step towards changing the habit may work as a barrier or a disincentive to the old behaviour (smoking). The findings support previous research which indicates a reduction of the number of cigarettes smoked and more quitting attempts as a result of smokefree measures such as the ban on smoking in public places (Hargreaves et al., 2010).

> "Yes, because you don't smoke as much because you have to keep going outside because you can't really leave your kids to go outside every few minutes so, yes I've definitely cut down." (Corrine, member of the public, centre 14)

> "I've not quit smoking, but I do not smoke in the house […] I think if you change someone's habits then they're more likely to give up." (Karrie, administrator, centre 7)

> "Definitely because I don't smoke in my house no more. […] Only, like I say, the odd time." (Jessica, member of the public, area 7)

Those who signed the pledge and kept their promise not to smoke in the house and car also noticed changes as a result of adopting the behaviour: cleaner air, fresh smell, clean walls.

> "…and the house is nice now it doesn't smell smoky, our clothes don't smell smoky once they're, you know, washed and things, yes, so that's nice." (Bella, administrator, centre 1)

> "…because another thing was I decorated my kitchen and I was so disgusted with how much flipping tar and I thought to myself 'that's it, I am not smoking in my kitchen again…'" (Christy, administrator/receptionist, centre 4)

The data suggest that engagement with Smokefree included a functional value dimension given by the benefits of generating referrals for staff and talking about Smokefree and signing the pledge for members of the public. Although the SDL literature indicates that the focus seems to have shifted from economic-functional to experiential, social or emotional value (Echeverri, and Skålén, 2011) the data suggest the functionality or

performance of an offering remains an important dimension for actors involved in a health social marketing programme. The findings support previous studies which identified functional value as a salient dimension in a social marketing context (Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previte, 2013). The functional aspect of value seems to be particularly important within the efforts to encourage various actors to participate as collaborators. In a collaborative programme it becomes essential that the focal organisation (i.e. Smokefree team) articulates the initial benefits of the value proposition (e.g. data for evaluation to show impact in the community). The utility of the Smokefree offering (conversation and pledge) was also important for those members of the public who were smokers or who had a smoker in the family. They sought something that would help them to pursue their personal goal (reducing smoking, an incentive to start smoking outside). This focus on functional value is in line with other studies investigating people's motives for making smoking cessation pledges (Lavack, Watson and Markwart, 2007). The pledge was designed to provide them with strategies to keep their children's environment smokefree but not necessarily on how to manage the change of their habit. From this perspective, the data support the literature (Peattie and Crane, 2005; Wood, 2008; Zainuddin, Previte and Russell-Bennett, 2011) highlighting the need to understand how accepting the social marketing proposition may impact the individual and propose ways to address potential negative experiences.

Having explored the themes associated with functional and altruistic value, the discussion follows the themes that highlighted experiences and emotions as other facets of value in the Smokefree context. The next subsection explores concepts related to emotional value in the social marketing programme.

6. 4. 3 Emotional value

Satisfaction of having done something good

Participants discussed what it meant for them to sign the pledge, talk about Smokefree, ask people to sign up. Their narratives suggested that beyond instrumental and altruistic reasons there was also an emotional factor involved. Emotional value is associated with feelings and affective states such as enjoyment, satisfaction, pleasure, confidence or

excitement etc. (Holbrook, 2006; Smith and Colgate, 2007). The emotional aspect was more present in the narratives of members of the public. Signing the pledge was perceived as an act meant to make them feel good about themselves. Some of the members of the public interviewed suggested that signing up meant aligning themselves to the cause against smoking around children and gave them the feeling they were doing something to support this cause.

> "It's something, I felt good to be honest, I felt good because it is something I did to protect my child and everyone who is in my family, whoever comes here they know they are not allowed to smoke here." (Denisa, member of the public, area 5)

> "If you are just by yourself and you are going on about something and no-one is paying any attention you don't get the same response as if there's like hundreds or thousands of you saying 'right something needs to be done', that's when people tend to like stop and listen and that's when you can get those higher up to listen." (Kalista, member of the public, centre 5)

For staff emotional value was also defined by acting according to their own beliefs and feeling 'passionate' about it. Engagement with Smokefree gave them the opportunity to take action on something they felt strongly about.

> "I mean in some sense, each one can be slightly different depending on whether you've got a person that's a non-smoker, a person that's a smoker, couples where one smokes one doesn't and it's quite an interesting, I quite enjoy doing it really." (Sandy, receptionist, centre 8)

> "I hate it when I drive by a car and I see, anywhere not just in this area, that people are smoking and there's a child in the back and you think […] they haven't got a chance…" (Sophie, Children's Centre teacher, centre 2)

Confidence

Signing the pledge also made ex-smokers feel confident they had defeated the habit and acted according to their own beliefs. Some of the staff also suggested that the Smokefree training provided them with the necessary resources to feel confident about talking about Smokefree with their users.

> "I'd tell them to smoke outside or not smoke at all if possible but to smoke away from the children and not smoke inside, it's selfish and I feel quite strongly about it." (Gilbert, member of the public, area 8)

> "I mean for me, it [Smokefree] works well really...I know what I'm doing, I've got my little, like my little paper work thing going…" (Kady, family support officer, centre 3)

> "Cause the staff are more confident and Kathleen's been a couple of times to the meetings [...] So they had it [Smokefree training] a few times, so it kind of confirmed things or reiterated what it was all about." (Victoria, manager, centres 1 & 2)

The confidence inspired by the training and the experience of talking about Smokefree has also broader implications for building staff capacity to address smoking. The section on motivation highlighted that motivational factors are linked with feeling competent and able to do the task (Ryan et al., 2008). From this perspective the Smokefree training and conversations are mechanisms that facilitate actor's (particularly staff) learning and acquisition of the resources necessary to create value.

Reassurance

One of the common themes that emerged was the staff perception that the Smokefree message was information worth sharing with their users. For some health professionals sharing information about Smokefree was associated with the reassurance that they did everything they could to make sure that children are protected from second-hand smoke. Reassurance was also identified as a value dimension in a study investigating value in a social marketing health service (Zainuddin, Previte and Russell-Bennett, 2011).

> "If they still choose to smoke in the house, then obviously that is their choice. But at least if you told them that their understanding or their belief is actually wrong, […] I think it's important." (Sara, nurse, Children's Hospital)

> "I think it's the knowledge that [having] given that information to parents about keeping the home smokefree, because then other people are not inhaling their smoke and if you've got six children in the home then the children are not seeing

that, modelling that behaviour anymore and I think it's a really strong message, really." (Clarisse, childcare learning officer, centre 4)

"You just do it because you've got the information and obviously you want other people to have it. Ideally you'd hope people would stop smoking." (Jill, childcare learning officer, centre 9)

Negative value

Recent work on consumer value stemming from the relationship and service marketing literature highlights the experiential nature of value (Holbrook, 1999; 2005; 2006; Prahalad and Ramaswamy, 2004; Smith and Colgate, 2007; Sheth and Uslay, 2007; Sánchez-Fernández and Iniesta-Bonillo, 2007; Echeverri and Skålén, 2011). However, in a behaviour/social change context, engagement with the social marketing offering often requires focusing on other types of value (e.g. altruistic, functional) whilst challenging the experiential aspect of behaviour. One of the concerns raised regarding the social marketing approach highlights that the health agenda often neglects the complexity of individuals' 'bodily experiences' (Gurrieri, Previte and Brace-Govan, 2013). Members of the public and staff who responded to Smokefree by changing their behaviour to smoke outside admitted that this was sometimes difficult and it made them feel uncomfortable.

"It's annoying […] having to go outside […], especially in the evening, […] when the kids are in bed and you still have to go outside because it sticks, it lingers and you just want to sit down and just watch the telly so it's another step in making you want to quit because it's annoying having to keep going outside." (Corrine, member of the public, centre 14)

"Just like the odd one I'll have in here on a night-time, you know, before I go to bed because sometimes it's a bit cold, so stand at the window with the window open but nine times out of ten everybody's out there smoking anyway..." (Jessica, member of the public, area 7)

For staff, challenging smoking habits was sometimes considered difficult. This created some anxiety among staff and resistance towards engaging with the campaign.

> "I mean I didn't see all their reactions, but some people think that the parents are stressed enough without mentioning this [Smokefree]." (Sara, nurse, Children's Hospital)

> "So, a lot of staff's anxieties were, 'Oh, you can't tell people to quit smoking, people don't like being told what to do…" (Mira, manager, centre 6)

The activities of the campaign put some of the staff in a delicate position regarding disclosure of the smoker status. Some smokers stated they would not mind telling people they were smokers themselves if they thought that would have been necessary whilst others felt that would have been contradictory to what they were promoting.

> "I did find it a little bit hard though, if who I was speaking to knew I was a smoker because it was a bit like a contradiction, it's like [you?] smoke, but you're stopping me." (Bella, administrator, centre 2)

The emotional value dimension of both staff and member of the public was associated with positive feelings regarding the engagement with Smokefree. By associating themselves with the Smokefree cause, they were acting according to their beliefs and doing something they felt good about. For some participants engagement with the Smokefree offering included less enjoyment (i.e. having to smoke outside in the cold; not being comfortable talking about smoking). The following subsection leads the discussion about social value which emerged as another type of value motivating people to act in the Smokefree context.

6. 4. 4 Social value

The previous chapter introduced the concept of 'network effect' to explain how a certain behaviour adopted by one actor in a network has influenced others in adopting that particular behaviour. The 'network effect' is linked with the notion of social value. Social value is created by association with the profile and imagery of specific social groups (Sheth, Newman and Gross, 1991). It is extrinsic and other oriented as 'one's behaviour is meant to shape the response of others' (Holbrook, 2006, p. 716)

Signing the pledge to reinforce non-smoker status and influence others

By signing the Smokefree pledge, members of the public associate themselves with smokefree environments and/or position themselves as non-smokers. Social value is also derived from the offering's ability to enhance social self-concept (Sweeney and Soutar, 2001). Engaging with Smokefree in signing the pledge was also associated with a sense of reinforcing their identity as a parent and a non-smoker. Previous research highlights the role of self-perception in influencing commitment to a cause (Burger, 1999; McKenzie-Mohr and Schultz, 2014). Social value also links with research drawing upon Social Identity Theory (Hoek, Newcombe and Walker, 2011) which acknowledges the social and psychological factors associated with smoking and identity.

> "I signed it because […] as an ex-smoker and as a mum I think that is the best we can do because if I want to have lung cancer, myself, then that's mine, […] but my child, he is at the age he doesn't have a choice." (Denisa, member of the public, area 5)

> "I don't know whether now being a mum, whether that's caught my attention more. Just how harmful it can be I think. I don't think people realise that, if an individual is smoking, I don't think they realise the impact that it can have on other people. And I think that's what hit home. I don't smoke, so it's different, but now that I'm a mum, if somebody smokes, then it doesn't just affect me, it affects my children." (Selena, member of the public, centre 5)

The pledge not only helps people to identify themselves with the non-smoker status but also may act as an incentive to become pro-active about the Smokefree cause. Some of the members of the public indicated that after having signed the Smokefree pledge they tried to persuade their relatives to do the same and even to nudge them to start thinking about stopping. In this case, commitment to Smokefree worked as a way of activating pre-existing personal norms about smoking (Lokhorst et al., 2013).

> "It's all very well saying yes, paying lip service to the thing, 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 to stop. For me it is not smoking outside for me, just stop, it's not good for you." (Kalista, member of the public, centre 5)

> "I think it [Smokefree] helped him, it gave him information that he would just try to, because if it's on TV he would ignore it and I know that he would, he'd just switch the channel over…" (Nadira, member of the public, Sal's wife, centre 5)

The 'social influencer' role requires closer attention in a social marketing context. As with other social marketing and/or health behaviour change programmes (Kotler and Lee, 2008), Smokefree encouraged people to act as 'messengers' for the Smokefree message within their own networks. However, this role requires people to feel able and competent to have the Smokefree conversation with those in their immediate network. The previous section indicated that the training helped the collaborating staff to feel confident about broaching Smokefree. Yet, members of the public have not received the training. An important finding suggested by the interviews with the members of the public is how assuming the role of the influencer in their family required not only the knowledge but also the skills and confidence to do it.

> "I know a lot because I worked for a cigarette company […] because we had a convenience store and I was representative for a cigarette firm, so I am aware of everything but trying to transfer that to my husband is another thing…" (Jarina, member of the public, centre 5)

> "I'd love to say something, 'what are you doing?' but you don't want to get punched on the nose, do you either?, […] if you see someone, you pull up and you see them smoking and they've got a kid in the back of the car, it would be nice to wind the window down and say 'Oi, what're you doing?'…" (Gilbert, member of the public, area 8)

The previous chapters have suggested that adopting a collaborative approach to value creation requires identifying and understanding the networks around the 'consumer'. A further step is identifying those actors for whom social value is important and the resources required for them to be able to adopt the role of a social influencer in their networks. Interestingly, associating themselves with the Smokefree cause was also seen as contributing to being a good role model for their children. This suggests that the pledge may lead to a change of self-perception (i.e. from ex-smoker to a supporter of healthy environments) and internalisation of the Smokefree cause (Lokhorst et al., 2013).

As was suggested in the interviews with members of the public, becoming a parent might be a good time for change.

> "I've done it [give up smoking] as soon as my child was born, my son and my daughter was born, I did it." (Sal, member of the public, area 5)

> "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, or at least implement things within my lifestyle." (Selena, member of the public, centre 5)

> "I didn't like it round my son, I think that was the most of the reason I gave up anyway […] I was conscious of breathing the smoke on him and things like that and that really made me give up. […] The fact to be around for longer for my son and me wanting to be healthy...or him to be proud of me as well, to be fit and healthy and, […], play sports, do sports, […] and things like that. So I would say that would be my main motivation." (Gilbert, member of the public, area 8)

Children's Centre family support officers and midwives also suggested targeting pregnant women with the Smokefree message as they might be more sensitive to health related issues and willing to take action to protect their babies.

> "…and I think the pregnancy, because the health visitors very much could get the message across I think in pregnancy." (Ellie, family support officer, centre 4)

Seeing themselves as having the ability to influence others' behaviour and the association with the Smokefree cause was also a theme that emerged from staff interviews. The social element of value for staff was identified particularly where competition was used to encourage their participation. This was the case of the Children's Centre staff who mentioned that competing against each other and between centres motivated them to work with Smokefree and raise the number of referrals.

> "I mean, I know that people are really proud when their centre gets that award. It does encourage a little bit of healthy competition and I think it's trying to keep that momentum." (Mira, manager centre 6)

> "I think it does [help the competition], yes the first [time] we got a little trophy […] and that was the first term that I actually started really making an effort I think…" (Sophie, Children's Centre teacher, centre 2)

Smokefree –shaping the norm to change behaviour

Social value is also linked with the idea of shaping the norms to redefine status. A common theme in both staff and members of the public interviews was that the programme was contributing to shaping the norm that it was not acceptable to be smoking indoors, or around children. The staff defined the Smokefree programme as a 'stepping stone' - an attempt to prompt changing habits as first steps towards changing behaviour. The programme encouraged people to take a step towards recognising that smoking is bad for health which might be the first step towards giving up smoking.

> "…it's just a little seed that you're planting…" (Clarisse, childcare learning officer, centre 4)

> "I think as a foundation layer to get people to quit smoking and recognise the damage is passive. Yes, I love the project, I think it's a really good project hence always being engaged in it really." (Minnie, CHDC, area 6)

The majority of the interviewees felt that it was becoming uncommon for people to smoke indoors. However, some of the smokers interviewed indicated that in some areas smoking was still seen as the norm.

> "Most people do smoke outside [...] I don't think that they find the going outside to have a cigarette too bad and if you walk down my street you see people standing outside." (Clarisse, childcare and learning officer, centre 4)

> "I live local and I don't see people standing on the doorstep smoking, I know a few of my friends and some families I work with that do […] take themselves out […], but you think there'd be more of it people standing on their doorsteps having a cigarette." (Kelly, senior family support officer/ex-smoker, centre 4)

The value of Smokefree included a social dimension for the actors involved in the programme. This was most noticeable for members of the public who identified with the non-smoker/ex-smoker status. Signing the pledge was associated with taking action that

was consistent with the image of a role-model for their children. The actions related to Smokefree were perceived as having value potential for the future (i.e. children will grow up having a parent that does what is right). These findings reflect the idea advanced in sustainable consumption studies (Johnston, 2008; Peattie, 2010) that value associated with status and social rewards may be a motivational driver for individual behaviour change. Programmes that aim to tackle smoking would benefit from articulating the social aspects of value. Facilitating the engagement of those individuals for whom smokefree is a worthy cause may create the context for attracting people who could play the role of social influencers in their own networks. However, the data highlight that motivation to engage also depends on individuals' perception about their own skills to influence others. This suggests that facilitating learning and skills development remains a fundamental area for social marketing action. The findings also suggest that the programme was contributing to shaping the norm about smoking indoors. The following subsection explores the epistemic side of value in the Smokefree context.

6. 4. 5 Epistemic value

A 'novel soft approach' to smoking and learning new information

The previous chapter featured actor learning as a central facilitation process for value creation. Examining what value meant for the participants in the Smokefree programme revealed that new knowledge and the novelty of the approach were identified as valuable aspects of the programme.

The novelty of the approach adopted by Smokefree, the change of message and the training component indicate that for some of the participants, who engaged with the programme out of curiosity and desire to learn more, value had an epistemic dimension. Epistemic value is linked in the literature with offerings that stimulate curiosity, desire for knowledge, learning and novelty (Sheth, Newman and Gross, 1991). It is considered that new experiences and even a change of pace can provide epistemic value (Sheth, Newman and Gross, 1991).

The novelty of the approach was appreciated in particular by the Children's Centre staff. The programme was appreciated by the staff for providing them with a soft approach to

reframing the smoking issue. As explained in other studies (McEwen et al., 2012), asking people to sign up to Smokefree was perceived as less threatening than asking them if they were interested in quitting smoking. The staff noted the change of message from 'stop smoking' to 'smoke outside'. The traditional approach adopted by staff to tackle smoking was asking people to stop. However this was sometimes perceived as difficult, especially by some of the Children's Centre staff who felt they did not have the skills or the appropriate status to ask people to stop. The Children's Centre staff stressed the fact that asking people to make a small change in their behaviour instead of asking them to quit smoking was less threatening and easier to integrate with their job role. Some of the interviewees indicated they appreciated the information received which made them share it with other members of the family.

> "And I was really good, I went back home, I told my brother about it because he smokes so he was like 'sign me up', I told my friends that are smokers, wow, I was like [sharing] information, I was 'look guys this is what's happening, this, that and the other' and they signed up so that was really good." (Bella, administrator, centre 1)

For some members of the public, engagement with Smokefree provided epistemic value in terms of learning more about second-hand smoke and satisfying their curiosity about smokefree environments. For instance, one member of the public indicated that he approached the staff first to ask about the promotional items related to Smokefree. The receptivity to the information provided was noticeable in particular for ex-smokers or those living with another smoker who were interested in learning more about smokefree environments.

> "I think when people come one to one, they approach you, and it depends on the person as well, I like to know a lot of information, some people are like 'throw it in the bin' […] it depends on the individual…" (Jarina, member of the public, centre 5)

> "I gave up smoking myself and the mother of my son […] smoked and she was smoking in the house while […] me and my son was there. […] So when I ['ve] seen this campaign I thought 'Oh yes' and […] I talked to the lady behind the counter about it at the Children's Centre." (Gilbert, member of the public, area 8)

For staff, engagement with the programme had a learning component as they were given the Smokefree training which has been discussed in Chapter 5. However, it is important to acknowledge that for many members of staff participation in the training was a means to an end, driven by functional value (e.g. acquire the knowledge needed to be able to deliver Smokefree; comply with a manager request). For example, midwives and health visitors were used to having conversations about smoking with their users. As it has been explained in the subsection on functional value, the programme provided them with a novel and more structured way of talking about smokefree environments with their users.

Epistemic value is associated with intrinsic motivation factors such as the desire to learn and experience novelty (Smith and Colgate, 2007). Some of the members of the Children's Centre staff indicated that their participation in the programme helped them to develop new skills. Participation in the Smokefree programme was sometimes perceived as a personal development and learning opportunity. One member of the staff stressed that the programme gave her confidence to break the barrier of being shy and approaching people.

> "I wouldn't say I found it easy, I wouldn't say it was in my comfort zone, it was a bit out of my comfort zone but then I think that was good for me because it was learning for me and I managed to deliver it." (Bella, administrator, centre 1)

She became 'expert' in promoting the campaign not only when performing her duties but also in other sessions of her colleagues:

> "…and I did a big thing on it so when we had our stay and plays just before it all finished I'd speak about it as well, so if people wanted to sign up they'd come over to me at the end and sign up anyway." (Bella, administrator, centre 1)

For some of the staff interaction with the programme meant learning something that changed their practice:

> "For example, one thing particularly, the doubling the risk of meningitis, I wasn't aware of that, and certainly most people that I've gone through it with them, they weren't aware. And I think that is something very much, people have heard of meningitis and so I think they immediately sit up and listen when you mention that." (Sara, nurse, Children's Hospital)

> "Then someone came and actually did a talk to us about what it was really about and then from that minute onwards I think it was, although the mugs were great

> and the families loved them to bits, it's become more a 'we could explain about the smoke being on the clothes' and it was we didn't understand at the beginning." (Ellie, family support officer, centre 4)

The discussion in this subsection indicates that social marketers should not neglect the epistemic feature of the social marketing offering. Yet, advancing epistemic value propositions that simply provide the network actors with more information is not enough. The staff were exposed to various training events during the year. The staff participants who were given the training could recollect some of the 'new and shocking' information. Members of the public who 'wanted to know more' about second-hand smoke were attracted by the promotional items on display. 'Novelty' emerged as one factor that attracted people's attention and nudged them to make a first step towards engagement. The value proposition needs to articulate an epistemic element that is stimulating and different (i.e. interesting facts, interactive co-creative mode of delivery; strategies for the conversation). Epistemic value appeals may be particularly relevant for engaging collaborating staff by providing them with new ways to perform their role (i.e. talking about smoking). Approaching value from an epistemic perspective acknowledges that actors may be motivated by goals such as learning a new skill, adopting a new method but also changing something in their routine.

6. 5 Conclusions

This chapter explored the notion of actor motivation and value dimensions in the Smokefree context. Examining the motivation of actors to engage with the Smokefree offering indicates different factors for staff and members of the public. Staff motivation for engaging with the programme began as a form of performing their job, complying with management requirements and fulfilling their institution's role. Interestingly, for some members of staff motivation was explained by external regulation which evolved to take forms of internal regulation when the importance of the programme was clearly stated by other actors (i.e. Smokefree team; managers). In these cases, staff were motivated to share the message by a sense of duty and responsibility to their users. Management support was fundamental in making Smokefree a 'team cause' which was associated with generating referrals as an indicator of job performance. Competition was

highlighted as a motivational factor that energised Children's Centre staff attitude towards Smokefree. Nevertheless, the findings support other studies (Reeve and Deci, 1996) which indicate that competition and rewards only are not enough to sustain motivation and that efforts are required to internalise the cause.

Staff were also driven by intrinsic factors such as personal beliefs about smoking and a sense of accomplishment that they did something good. Feeling strongly about smoking made some of the staff determined to champion the programme among their own teams or to engage with the programme despite the lack of support from management (i.e. Children's Hospital). The findings stress the role of positive feedback in facilitating staff motivation to participate in the Smokefree activities.

The analysis of the members of the public motivation identifies themes associated with both intrinsic and extrinsic motivation. Similar to the case of staff, members of the public were driven by intrinsic personal beliefs regarding smoking and concern about children's health. The themes associated with extrinsic factors included incentives to reduce the number of cigarettes smoked per day or stop smoking. An interesting motivational factor that emerged was the influence of staff and/or other members in their network. Although this raises the issue of the power dynamics between staff and service users, the data also suggest that the network effect can work as an extrinsic motivation factor.

The discussion of motivation is connected to the notion of perceived value of the actors involved. The findings of this study support the view that value is multidimensional and dynamic depending on the goals pursued by actors at a moment in time. Although all interviewees invoked altruistic reasons for accepting the Smokefree proposition (i.e. protecting children's health) their perceived value adopted other forms (i.e. emotional, functional, epistemic and social) as a result of different personal goals or aims. This finding emphasises the importance of understanding the subjective and experiential nature of value and its reliance on contextual factors (Flint, 2006; Chandler and Vargo, 2011; Macdonald et al., 2011).

Exploring participants' narratives regarding the value of Smokefree suggested a clear altruistic dimension driven by support for a safer environment for children's health. The altruistic element was stressed by both collaborating staff and members of the public.

Participants also indicated that engagement with Smokefree provided them with functional outcomes such as the data regarding the referrals (Children's Centre staff), information about 'the audience' (Smokefree staff) reduction in the number of cigarettes smoked and a smokefree environment (members of the public). The findings suggest that the functional dimension of value is relevant particularly for engaging organisational actors (in particular those involved in public sector management processes) as collaborators.

Intrinsic motivational factors were connected with the notion of emotional value which was more noticeable for members of the public. Signing the pledge was associated with the satisfaction of having done something good and the confidence of having defeated the habit (for ex-smokers) and the feeling of reassurance (staff) they shared the information meant to keep children safe from second-hand smoke. Another key dimension of value for members of the public was generated by the identification with the non-smoker status and the social influencer role. Signing the pledge to confirm the Smokefree status and build the image of a role model for their children was important for non-smokers and those who lived with smokers. The importance of identity in shaping smoking behaviour has been articulated in many tobacco control social marketing programmes drawing upon social influences theory (Stead et al., 2007). The programme was also considered a step towards shaping the norm about smoking indoors. This was one of the stated objectives of the campaign which encouraged participating staff to reinforce the message also with non-smokers. Promoting the social facet of value was identified as particularly relevant at certain moments in life (i.e. when people become parents).

Staff and members of the public also appreciated the epistemic dimension of value in terms of the novelty of the approach (a change of message) and the information about second-hand smoke. These findings reinforce the importance of learning as a process that facilitates value creation in stimulating actors to participate, develop skills and create new knowledge.

The findings of this chapter suggest that an experiential perspective on value in a social marketing context needs to take into account the negative emotions generated by interaction with the value proposition as being part of the experience. In a social

marketing logic value deficits in the short term need to be accepted in anticipation of other value gains in the long term. In the case under analysis, immediate 'customer value' - for those who were smokers and accepted the Smokefree proposition- was sometimes experienced as negative (e.g. unpleasant experiences of having to go outside to smoke). Therefore, customer value anticipation is a key concept in a social marketing context as changing behaviour can have immediate negative effects and the benefits of behaviour change can be delayed. Staff were also affected by negative experiences associated with adopting the value proposition (e.g. having a 'difficult' conversation about smoking). Social marketers need to anticipate what value might be for their audiences and learn to respond to the dynamic stakeholder and customer value (Flint, Blocker and Boutin, 2011). It is important to note that although all interviewees admitted that Smokefree was promoting an important and needed message, this was not always enough for them to engage with the programme. They needed not only the motivation but also the skills, knowledge (Grönroos, 2012) as well as the appropriate structures to facilitate their engagement in the programme.

The final chapter of the thesis summarises the discussion of the findings in the light of previous studies. It identifies study limitations and implications for research and practice.

Chapter 7: Conclusions

7. 1 Introduction

This chapter provides a summary of the main research findings and their implications for theory and practice. A separate section is dedicated to the implications for social marketing benchmarks. The theoretical contributions to the three areas of literature informing the study including social marketing, SDL and public health and practice implications are also discussed. The chapter concludes with limitations of the study and future research directions.

The study aimed to examine the potential contribution of a service-dominant view to social marketing in addressing social problems. It explored a collaborative health social marketing programme in order to examine if and how a service-dominant perspective can help better explain the process of value creation in a social marketing context. The Smokefree programme was selected as an illustrative case for a social marketing programme that moves beyond the traditional marketing management model to a collaborative model of value creation. The chosen context illustrates a service approach in developing a health social marketing programme. The study focused on the process of value creation and actor engagement as central principles of SDL that may help to better explain the processes of change and the interplay between contextual factors and individual agency in a behaviour/social change context.

The questions investigated in this study were as follows:
Overarching research question:

1. What are the theoretical and practical implications of adopting a service-dominant logic lens to value creation and actor engagement in social marketing?

Underlying research questions:

1. What factors influence actor (stakeholder and service user) engagement in a health social marketing context?
2. How do actors integrate resources to facilitate and (co-)create value in a health social marketing context?
3. What motivates network actors (stakeholder and service user) to engage in a health social marketing programme?

4. What value dimensions are present in a health social marketing context?
5. What are the barriers and challenges of a collaborative approach to value creation in a health social marketing context?

The findings chapters (4, 5 and 6) address question 1 and 5. Chapter 5 (Value creation processes in social marketing) addresses question 2 whilst chapter 6 (Motivation and value dimensions) explores questions 3 and 4.

7. 2 Main conclusions and implications

This study identified a number of important findings which have implications for theoretical development and practice in the social marketing, SDL and public health literatures. This section sets out these conclusions and discusses their implications.

Regarding the primary research question this study examined the potential implications of adopting a service perspective in social marketing. The myriad of actors involved in the Smokefree programme, the relationships and complexity of the networks around the 'customer' suggest the relevance of a collaborative model of value creation in social marketing. Most importantly, this study has suggested that a collaborative approach to value creation poses challenges in addition to the benefits. One of the main contributions of this study is illustrated by the articulation of service-dominant benchmarks for social change programmes presented in section 7. 3 of this chapter.

In line with the critical realist philosophy, the study examined and discussed a number of factors and mechanisms that shape actor engagement in a collaborative social marketing initiative. Study findings pinpoint job roles, practices and institutional support as key factors shaping staff actor engagement with a health social marketing programme. The study also highlights motivational factors and availability of resources as factors necessary to facilitate staff and member of the public engagement.

7. 2. 1 Roles, practices and institutional support

Following the discussion on the limitations of social marketing traditional benchmarks this study illustrates the variety of actors and the inter and intra-organisational processes

which challenge the application of dyadic exchanges (Domegan et al., 2013; Wood, 2008) in a social marketing context. The study indicates that the systems, network based perspective proposed by SDL provides a comprehensive conceptual basis for explaining the processes in social marketing contexts. Examining roles and practices suggests the influence of institutional structures in shaping the response to social marketing action. This case highlights that 'transformative' partnerships (Aveling and Martin, 2013) where partners co-produce the social marketing offering can facilitate value creation but that structures (i.e. institutional rules, practices and roles) play an essential role as contextual factors and the generative mechanisms defining how these partnerships evolve.

Staff actor engagement with Smokefree was influenced by the existing roles of these actors, institutional support, their practices and staff-user encounter context. The findings highlighted that understanding how these actors worked and the existing networks in the community was essential for creating the foundation of collaboration. The study findings suggest that structures such as networks (Granovetter, 1985), roles (Akaka and Chandler, 2011) and practices (Henwood, Harris and Spoel, 2011) may both, facilitate and constrain choices and action. So in order to enable more choices and action, several actors in the network need to be engaged rather than just one actor. Focusing only on the training or the provision of information (Lee and Garvin, 2003) is not enough to encourage engagement with the offering.

As suggested in other studies (Chiu and West, 2007; Rankin, Backett-Milburn and Platt, 2009; McEwen et al., 2012), management support was a central factor in influencing staff motivation and involvement with the Smokefree programme. This is confirmed by previous research which emphasises the role of management in supporting organisational learning and staff participation (Lefebvre, 2006; Jerez-Gomez et al., 2005). The manager ensured that Smokefree was on the agenda and adapted structures (i.e. assessment forms) to incorporate the Smokefree element into the staff job role. The involvement of managers in Smokefree may be seen as a top-down approach. However, the findings suggest that their involvement was required given the institutional context where Smokefree was adopted. The managers' support ensured the legitimacy of the Smokefree activities for the staff and facilitated participation. In settings where management support was lacking staff engagement was lower or it was motivated by personal beliefs regarding the value of the project.

The findings point out the importance of practices in facilitating engagement with a social marketing issue. As previous social marketing studies adopting a cultural-practice view (Hargreaves, 2011; Spotswood and Tapp, 2013) suggested, uncovering actors' practices is essential for grounding interactions and relationships in context. Certain support staff such as health visitors and family support workers were more likely to adopt a comprehensive approach that suited the customer by acting as resources that customers could use to pursue their own objectives (Arnould, Price and Malshe, 2006). This approach may counter the concern that traditional social marketing programmes provide a value proposition centred on information and persuasion techniques only (Crawshaw and Newlove, 2011; Crawshaw, 2012; Langford and Panter-Brick, 2013; Robinson and Robertson, 2010a) 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', the programme makes a step forward in engaging local service staff to provide support, customise and adapt the message to the context of their customers.

As part of a network that guides, provides information and facilitates access to support services the staff participating in Smokefree reported following an empowerment model. Supporting people to make healthy choices was considered an important element of empowerment. Yet, the realities of service users were sometimes challenging this logic of choice. This is in line with other studies (Henwood, Harris and Spoel, 2011; Ritchie et al., 2009; Mol, 2008) which indicate that encounters between health staff and their patients challenge the logic of choice through calls for care. The focus on empowerment poses the risk of neglecting the context and the power dynamics (Rimal et al. 1997; Ritchie et al., 2009). The analysis of the value creation processes pointed out that health visitors and family support officers needed to alternate their choice oriented approach with one driven by care and emotional support. When their users were dealing with difficult circumstances (e.g. families who were at risk of losing their house, lack of resources to keep the house warm over winter; distressed mothers who could not cope anymore) the staff would go sometimes beyond their job role to support them. The support provided ranged from writing letters to the Council and calling pest exterminators to lending money to families. The role and practices of these actors facilitated a customised approach which adapted the value proposition to the context of their users.

The findings of this research suggest that an interaction based approach which responds to the individual realities in the community might challenge the criticism that social marketing programmes aim 'to govern at a distance' rational individuals without taking into account the wider determinants of health (Crawshaw, 2012; Marmot, 2010; Wymer, 2011). The community based services' 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 customer was different, their world conveying multiple challenges to the image of 'idealised rational healthy subjects' (Crawshaw, 2012, p. 206). This approach might be seen as favouring customisation over targets and behavioural objectives which are central principles of social marketing (Andreasen, 2012; Stead et al., 2013). However, it also reflects that understanding and addressing contextual factors means considering the fluidity of individuals' goals (Arnould and Thompson, 2005) and the subjective dimension of value (Vargo and Lusch, 2008a; Chandler and Vargo, 2011) which might challenge pre-set programme objectives. These findings add to the body of research which raises concerns about the difficulty of applying the Stages of Change model in order to assign people to a particular stage of change group (Wilson and Schlam, 2004) given the fluidity of individual states and emotions and the influence of context on behaviour (Logie-MacIver, Piacentini and Eadie, 2012; Luca, Hibbert and McDonald, 2015). The collaboration with staff who interacted frequently with the local families provided the advantage of having more opportunities to discuss Smokefree and customise the offering to the changing circumstances of their users.

The findings suggest that within the local networks of support around these individuals, the distinction between weak and strong ties (Granovetter, 1983) was sometimes vague. This supports other studies (Vassilev et al., 2011) which indicate that family, friends, neighbours and colleagues relationships are often difficult to assign to either weak or strong ties within an open system. Understanding these relationships and the context of the intermediary-user encounter is central to explaining the value creation processes.

The relationship between users and certain staff whose role involved support and prolonged contact (i.e. family support workers, health visitors) was marked by power imbalances given their professional role which also included a safeguarding element.

This was a factor that influenced the users' response to staff requests. As other studies indicate (Crawshaw, 2012; Domegan et al., 2013; Hacker and Wigg, 2010; Ritchie et al., 2009) sometimes members of the public are reluctant to respond to initiatives associated with the government that are seen as paternalistic and interfering with their freedom. As such, the staff work approach was seen as both facilitating and hindering their participation in the programme. Their work routine was a facilitator when dealing with non-threatening situations but a barrier when their work required long term efforts to engage with the family on their main work related objectives. The decision to act depended on the context of each service user, the existing relationship and the motivation of the staff.

7. 2. 2 Value creation processes

The study contributes to understanding how customers create value and how other resource providers participate in the process of value creation (McColl-Kennedy et al., 2012; Payne, Storbacka and Frow, 2008). The study examined value creation as value facilitation (by an actor to another actor), resource integration (to integrate operant and operand resources to create value-in-use) and co-creation (as a process based on interaction between consumers and other actors) (Grönroos, 2012). The analysis of value creation processes included a view on the dynamics of value propositions and factors that influence a value network.

7. 2. 2. 1 Dynamics in a value network: value propositions and facilitation

Adopting a collaborative approach to value creation in social marketing requires understanding the actors involved in context, a key facilitator role for the social marketing organisation and its collaborators and of (co-)creator of value for its final audience (i.e. members of the public). The examination of value creation processes suggests that actors of Smokefree change roles as initiators and participants in a value network. The findings of this study indicate that value creation processes are fluid during the encounter between actors. The findings support the emerging literature (Ballantyne et al., 2011; Frow and Payne, 2011; Frow et al., 2014; Kowalkowski et al. (2012) that conceptualises value propositions as co-created, reciprocal and dynamic. Unlike

traditional marketing centred on dyads (social marketer and target audience), initiators and value creation facilitators (other than the central organisation, in this case STOP Smoking Service as represented by the Smokefree team) can also play the role of co-creators and resource integrators (Grönroos, 2011a; 2012) at different stages of the interaction with the social marketing offering. Staff and members of the public integrate their own resources and resources from other actors to create value-in-context. When staff interact with service users they have the opportunity to shift from a value facilitator mode to a co-creator mode (Grönroos, 2011a). The facilitation and resource integration processes at the middle level (collaborator/intermediaries) were fundamental to reach individuals and support their value creation processes. Participating staff drew upon the resources provided by the social marketing organisation and their own resources to act as facilitators.

Staff whose job required building relationships and prolonged contact with their users spent more time discussing Smokefree and adapted it to their own work conversations. Other actors (i.e. receptionists) who had limited contact with service users reduced the Smokefree interaction to asking them if they were willing to sign the pledge with little additional information. In practice the staff needed to adapt to the encounter situation and the priorities of their users which sometimes meant postponing the Smokefree conversation. Health visitors and family support officers in particular were more prone to change their approach to Smokefree depending on the situations of their users. The findings of this study support the SDL literature (Archpru Akaka and Chandler, 2011; Grönroos, 2012; Lusch, Vargo and Tanniru, 2010) that suggests a value network is defined by actor roles and competences, relationships with users and shared information which are valuable resources. Facilitating access to these resources is required to enable value creation.

Value propositions have a key role in supporting the network of relationships and facilitate resource sharing relationships (Frow et al., 2014). The central organisation (i.e. Smokefree) initiating the value proposition has the role to coordinate collaboration, integrate feedback from the network actors and adapt the proposition accordingly. The value proposition initiated by the social marketing organisation (i.e. Smokefree conversation, leaflet, training and referral report) was easy to adapt and integrate with partners' practice. Being able to integrate the activities required by the collaboration

within everyday practice was one contextual factor that facilitated engagement of staff with the programme. The value propositions initiated by the Smokefree were shaped and modified through knowledge sharing with collaborators (staff and members of the public). Staff collaborators who were allocated the intermediary role adapted the Smokefree proposition to their own practice to reach their audiences. Co-creation unfolded at the intermediary level in a context where partners had a central role in implementation. The case illustrates the importance of intermediaries ('infomediaries') in sensing and responding to the changes of the value networks as suggested in the service logic literature (Vargo et al., 2010).

The interaction based approach adopted by Smokefree facilitated stronger collaborations which were considered to contribute to the sustainability of the programme allowing for consistent messages over time. The collaborative approach and the learning component of the programme contributed to staff capacity building to address smoking related issues. Constant interaction between the social marketing organisation and the collaborating staff had also facilitated dialogue to minimise co-destruction. The findings align to the growing body of research which suggests that active engagement of actors in community development initiatives can contribute to generating a sense of ownership and capabilities that have an impact on interventions implementation (Attree, 2004; Johnstone and Campbell-Jones, 2003; Matthews, 2001; Owens et al., 2011; Waller et al, 2006; Winters and Patel, 2003).

The study pointed out the challenges of integrating the capabilities of partners in a value network. Given the public service context of Smokefree, the institutional changes driven by government policies have also influenced the value creation network. The programme unfolded in a time marked by changes to the health visitors, nurses and community health development coordinators' professions which had implications for their health promotion role. Policy and governance changes and the transfer of authority from NHS to local authorities for community services created an institutional context where engaging with programmes such as Smokefree was seen sometimes as an additional task to take on when new responsibilities were increasing the work load and job insecurities.

7. 2. 2. 2 Key facilitation processes: Feedback and learning

The study identified feedback and learning as central value facilitation processes. Feedback and learning are central outcomes next to profit in SDL (Lusch, Vargo and Tanniru, 2010). Calls have been launched for research on organisational learning to understand how organisations adapt to collaborative value creation networks (Lusch, Vargo and Tanniru, 2010; Lusch and Webster, 2011). Organisational learning is vital for the central organisation to adapt to the changes of the network (Vargo et al. 2010) and keep the partners interested and engaged. However, limited human resources of the Smokefree team were a barrier to maintaining constant interaction and feedback with all the partners involved. The Smokefree team relied on managers to share the feedback with their teams, which sometimes was hindered by the lack of communication and the distance between management and frontline workers. The limited feedback capacity also posed the risk of co-destruction interactions between staff and users.

Learning was essential not only for staff to build capacity for addressing the Smokefree issue but also for users in building knowledge and developing a sense of competence. Learning was also central to avoid co-destruction encounters (Echeverri and Skålén, 2011). The training was a central component of the Smokefree programme aiming to build capacity at the midstream level (i.e. staff). The training was also a way of interacting with potential partners. It made people aware of the programme objectives, and helped to give them the confidence they could deliver the message. Although 'customer learning' was supported by promotion leaflets and the conversation with service staff, the programme was not targeted at those individuals who would need strong efforts for capacity building.

Feedback that included comprehensive data on the outcomes of partners' involvement and recognition of their efforts was fundamental not only to keep them engaged but also to raise awareness about the programme among non-participating agencies. Constant feedback also enabled a more timely response to the changes of the network and helped to address the challenges raised by participation in different contexts. Positive feedback included recognition of and rewarding the staff teams for their contribution to the programme. In line with previous studies (Alwan et al., 2010; Wildey et al., 1995), this was identified as a motivational factor for staff participation. Although the manager of

the Smokefree team avoided rewarding individuals in order not to discourage the less engaged staff, the study suggests individualising staff contributions might be one way of maintaining their involvement and giving them a sense of accomplishment.

7. 2. 2. 3 Active consumers and co-creation

Despite the emphasis on citizen participation within the efforts to extend engagement from consultation to leadership in community programmes (Guta et al., 2014), the findings of this study suggest a limited role for members of the public in the actual design of the programme. The involvement of the public in the design of the programme was sought at early stages in order to pre-test the leaflet with members of two target communities. The approach adopted by Smokefree can be seen as assigning members of the public a co-producer role in co-developing the leaflet. However, this was limited to the community volunteers of two communities that were identified as representative for the target audience. Unlike commercial marketing, social marketing contexts often concentrate co-production efforts on representatives of the community. This raises issues of representativeness (Contandriopoulos, 2004), tokenism (Arnstein, 1969; Craig, 2007), parity and inclusiveness (Woelk, 1992) and community heterogeneity (Larsen and Stock, 2010).

Yet, unlike traditional social marketing programmes, the interaction approach emphasised by Smokefree enabled co-creation spaces between members of the public and staff. As opposed to traditional communication (i.e. social marketer – audience) of social marketing or health promotion programmes, the members of the public were expected to engage in dialogue with the staff and interact with the Smokefree message. Co-creation practices which emerged included co-learning (asking questions; providing information and feedback) complying (listening, signing the pledge), adapting (adding their information, changing the Smokefree conversation format) and sharing (taking the message to their own networks). Making use of the existing support networks in the community facilitated reaching a diverse population. Yet, reach was limited to those who accessed the public services participating in the programme. The programme did not make use of media channels to promote its message relaying entirely on the network of services in the community to reach the audience.

Although interaction with the final users was at the core of the Smokefree approach, the input of these users for the actual design of the programme was limited. Nevertheless, the interaction allowed both members of the public and participating staff to adapt the message to their own circumstances. For staff actors the conversation about smokefree environments and the effects of second-hand smoke was considered a small step toward contemplating the implications of passive smoking. For the members of the public the face-to-face conversation created the opportunity for a better understanding of the message and its relevance to their own lives. The study adds to the body of evidence that supports an interaction based approach to smokefree programmes (Hacker and Wigg, 2010; McEwen et al., 2012; Ritchie et al., 2009). By mediating access to Smokefree through the professionals who were part of existing networks in the community, the social marketing initiative under analysis has facilitated users' access to resources they could then link to their life goals and concerns. This finding is supported by the work stemming from Consumer Culture Theory (Arnould, Price and Malshe, 2006) where customers see professionals as resources that they can use to pursue broad life goals. The Smokefree case illustrates how customers take action as actors that possess 'uniqueness and self-determination' (Bhaskar, 1989) and 'they are not the mere 'bearers' of social structure (Connelly, 2000, p. 266).

This study emphasises that an interaction driven approach facilitates customisation to accommodate the diversity of users. In terms of segmentation and targeting, the Smokefree case indicated that a network interactional approach facilitated individual customised courses of action which were better suited to accommodate the fluidity of individuals' goals than traditional group targeting. The value proposition was tailored to suit the individual user and also the practice of staff engaging in the conversation. A service perspective shapes targeting and segmentation to integrate dialogical approaches based on interaction and an extended role for the user as an active co-creator (Ballantyne and Varey, 2006; Karpen, Bove and Lukas, 2012; Vargo and Lusch, 2008a). The Smokefree team emphasised targeting and segmentation as distinctive social marketing instruments for defining their audience. The value proposition initiated by Smokefree was customised within the boundaries of socio-geo-demographic segments. Segmentation was used in Smokefree in order to select those individuals that were more likely to be affected by health inequality. The literature indicates that careful

segmentation and high customisation to target more 'at risk' groups may help to address health inequalities and the exclusion of difficult to reach groups (Stead, Hastings and McDermott, 2007).

Staff-user interactions assume a power dimension given by the role of the staff. Health visitors and family support workers have a safeguarding role which influences the relationship with their users. Interacting with staff regarding Smokefree may be in this case non-voluntary for service users. Although they might benefit from the interaction, they did not necessarily choose to engage with the programme initially. This is different from commercial contexts where customers willingly engage in co-creation (Prahalad and Ramaswamy, 2004).

Although the programme encouraged an active role of members of the public, the focus was to build staff capacity to facilitate value creation. The programme acknowledged that the final users can play the facilitator role in taking the message to their own networks but it provided limited support for skill development. Yet, some members of the public adopted an active role in sharing the Smokefree message within their own networks without having received the Smokefree training. The findings stress that skills development and capacity building are required to enable members of the public to be effective in the role of educating and persuading others. The study aligns to the view of a 'customer-logic of service' as advocated by other scholars (Cova and Dalli, 2009; Grönroos, 2008; Heinonen et al., 2010) that value creation processes unfold in the customer sphere. Although interactions with the staff were opportunities for 'encountering' the social marketing value proposition and co-creation (i.e. discuss Smokefree, learn, share), members of the public's value-in-use occurs also in their own worlds (i.e. a safe environment for children, using the pledge to convince others to stop smoking). This 'customer-centric' (French, 2009a) view on value creation reinforces the significance of collaborative approaches that facilitate real citizen participation to actively identify their problems and co-develop solutions. However, it also raises the issue of the how far one can go in following community's wants and desires. As it has been noted elsewhere (Spotswood et al., 2012; Stead, Arnott and Dempsey, 2013), community co-creation does involve negotiations between social marketers as 'experts' and community members.

7. 2. 2. 4 Resource integration in a social marketing context

The study extended the analysis of the resource integration process to the middle level of the collaborator staff. The findings suggest that in the social marketing context under analysis, the actors who collaborate with the central organisation as intermediaries to the final user integrate resources to facilitate the value creation process of their users but also to create value for themselves and their organisation. The concept of resources integration is connected to the notions of agency (Kleinaltenkamp et al., 2012) and capacity building which are central to the efforts to understand the context of individual choice in health promotion (Abel and Frohlich, 2012; Ruetten and Gelius, 2011). Individual choice is influenced by the capabilities and resources available to individuals (Abel and Frohlich, 2012; Connelly, 2000). Examining the process of resource integration in a health behaviour change context pinpointed the power of transformative agency (Sewell, 1992) in shaping structures that might hamper participation. Yet, it also highlighted limited resources of the service users targeted to be able to shift the norm within their own networks.

Members of the public drew on the resources provided by Smokefree, both operant (information) and operand (Children's Centres' facilities), the staff of community based services (relationships, knowledge) and their own operant resources (personal skills, knowledge and relationships with their families, energy, strength and emotions) to pursue their own goals (e.g. change partner's behaviour, protect children from second-hand smoke, motivate themselves to cut down on cigarettes etc). This study indicates that the projects and life goals of 'customers' are not necessarily consistent with the social marketing offering but they may adapt it to their own circumstance. Another study that explored vulnerable consumers' resource integration processes (Piacentini, Hibbert and Hogg, 2014) suggests the interplay between operant and operand resources in consumers' pursuit of life goals. This study supports the findings that reveal the consumer's creativity in adapting and integrating the available resources (Baron and Harris, 2008; Cherrier and Gurrieri, 2014; Piacentini, Hibbert and Hogg, 2014) but also the resources deficits which sometimes erode existing resources. One such example is illustrated by those women who managed to change their behaviour as a result of the interaction with Smokefree but failed to have an effect on their partners' habits. Although they used their knowledge, skills and motivation to maintain a smokefree

environment for their children, the deficits in social relationships and lack of confidence diminished the overall value as the partner still smoked in the bedroom.

Archer (1998) emphasises that structure and distribution of material and cultural resources are influential in shaping the social world. The study highlights the resources needed to enable and motivate people to transfer the advice of the support workers into their everyday life (Henwood, Harris and Spoel, 2011) and influence their immediate network. Examples include operant resources such as knowledge, skills and social relationships but also operand resources such as economic resources (income) and physical spaces (house). As smoking rates are higher in disadvantaged communities (Hargreaves et al., 2010) programmes targeting smokers should adopt a broader ecological approach including policies that address social inequalities. The study also suggests that the networks around individuals may facilitate or obstruct action. Belonging to an affective network or community means cultural and social norms that sometimes act as barriers to change (Spotswood and Tapp, 2013). This study reinforces the calls to consider the role of context and the embeddedness of individuals in social networks when developing social change programmes (Hargreaves et al., 2010). Strong ties (family and friends) may inhibit the process of change through the perpetuation of habits and practices but also by not trusting health professionals when their advice was perceived as challenging old beliefs. Although members of the public were equipped with knowledge regarding passive smoking they raised the issue of their inability to persuade others not to smoke. However, the relationships members of the public have with their families also acted as resources when trying to persuade others to change behaviour. The study adds to existing research pointing towards the potential of social networks in facilitating behaviour change through mutual support and word-of-mouth (MacAskill et al., 2002).

Operant resources including organisational resources (routines, culture, competencies), human resources (knowledge, social and communication skills) and relationships (with other institutional actors and their clients) emerged as central to building staff capacity for engaging in interactions about smoking related issues. Organisational resources in terms of routines, culture and competences were essential in facilitating staff engagement. The support role of Children's Centres, health visitors and CHDCs, their health focus, the interactional approach and wide reach in the community facilitated

engagement in the process of value creation in the Smokefree programme. The importance of the organisational resources was illustrated by the Children's Hospital case where the engagement with the programme was low, despite the high numbers of staff trained. The hospital case illustrates the impact of context on implementation and programme outcomes (Pawson and Tilley, 1997). The collaboration model that worked with community based services such as Children's Centres, CHDCs and health visitors had very limited success in the hospital. The lack of explicit rules regarding the health promotion role, particularly around smoking, the volume of work and complexity of the medical information the nurses provide to the patients coupled with a lack of management support were identified as factors that limited engagement.

Roles are identified as resources (Archpru Akaka and Chandler, 2011; Archpru Akaka et al., 2014; Edvardsson, Tronvoll and Gruber, 2011) in the process of value creation. Specific job roles such as health visitor, community midwife, community health development coordinator, and family support officer added rich insight and knowledge of the users gained through prolonged contact and visits to their homes. Their work approach focused on co-developing solutions with their users and providing support facilitated the Smokefree conversation. Children's Centre teachers and play leaders were also able to benefit from informal work environments where health related messages occurred easily in conversation. This study adds to the research stream (Hovell et al., 2000; Tyc, Hovell and Winickoff, 2008; Winickoff et al., 2003) suggesting that programmes to reduce children's levels of second-hand exposure may benefit from engaging health professionals in implementation. However, the study also stresses the need for organisational resources (i.e. management and role support) to facilitate engagement of the staff with the health promotion activities.

Operand resources such as Children's Centre facilities emerged as key in enabling co-creation spaces where customer actors accessed the resources they needed to pursue their personal goals (e.g. find health information, support groups). Tangible resources such as free gifts, leaflets, posters and displays emerged as useful to support the message. The leaflet was a key learning resource for both staff and members of the public. The Children's Centre staff centred the conversation on the leaflet and the information it provided. However, health professionals (i.e. health visitors, midwives and nurses) used it to complement their usual talk about cot death and smoking. The information leaflet

contained the pledge form which was valued by members of the public as a reminder to help them stop smoking or as a way of affirming their identity as a non-smoker or someone who did the right thing for their children. The study indicates that the leaflet only was not enough to have an impact on behaviour and that it needed to be explained and followed by a conversation for people to be able to understand how the message applied to them. This finding stresses the role of interaction and dialogue in enabling co-creation spaces. Overall examining the resource integration processes in the Smokfree programme reaffirmed the need to understand resources in context (Edvardsson, Tronvoll and Gruber, 2011).

7. 2. 3 Actor motivation for engaging with social marketing programmes

Actors' participation in a value creation network is influenced by their work roles, practices and relationships with their users but also their own level of engagement with the social marketing offering (i.e. Smokefree). Understanding the factors that influence engagement required examining actors' motivation and notions of value. Staff actor motivation was influenced by both extrinsic factors linked with their job roles and intrinsic factors related to personal beliefs and a sense of satisfaction/accomplishment given by their engagement with Smokefree activities.

Staff motivation to participate in Smokefree was a form of performing their job, complying with management requirements and fulfilling their institution's role. As suggested elsewhere, role appropriateness was a key factor in influencing staff engagement with the programme (Gordon, Friel and McGanachan, 2012). Although initially externally regulated (i.e. they were participating in the programme because they were asked to do so by their manager) staff motivation evolved in some cases towards internal regulation and identification with the cause (Ryan and Deci, 2000). Interaction with the Smokefree team, positive feedback and peer and management support contributed to internalising the values associated with their actions. The managers played a central role in 'normalising' the Smokefree activities which became a natural part of the staff job role. The social network effect (Scott, 2000) – engaging in behaviours that are valued by others – seems to have an important role in 'normalising' a certain

behaviour. As such a sense of 'relatedness' to the actors promoting the cause (Deci et al., 1994) can constitute a motivational factor for engaging actors in co-creation. However, the findings suggest that staff motivation (health professionals in particular) was also driven by strong beliefs against smoking around children, and a duty of care which sometimes led to engagement without explicit management involvement.

Motivation for members of the public was driven by intrinsic personal beliefs regarding smoking and concern about children's health and other members of the family. Extrinsic factors included incentives to reduce the number of cigarettes smoked per day or stop smoking and the influence of staff. As other studies (Jones et al., 2011) suggested, the desire to stop smoking was an important motivator for members of the public. In common with staff, members of the public indicated the network effect (the influence of staff and/or other members in their network) as a motivational factor.

Motivation to participate was also influenced by self-efficacy beliefs (Bagozzi and Kimmel, 1995; Ryan et al., 2008). Participating actors (staff and members of the public) suggested they felt competent to talk about smokefree with others. In addition to motivation and knowledge people need to have the skills to participate in co-creation (Grönroos, 2012). Thus supporting skills development and learning are central processes to support individuals' feeling of competence. The training provided as a part of the Smokefree offering helped to build staff confidence they could talk about smoking with their users.

This study highlights the importance of extrinsic factors in motivating staff and members of the public to engage with a health social marketing programme. This is in line with other studies (Ryan et al., 2008; Ryan et al., 2009) which indicate that engagement with health behaviour change tends to be extrinsically motivated. The predominant extrinsic motivation reinforces the need to consider the influence of structures on individual behaviour when seeking to develop social marketing programmes.

7. 2. 4 Value dimensions in social marketing

The findings of this study contribute to a better understanding of the different value dimensions of actors involved in a health social marketing programme. The scarce research on value in a social marketing context has focused on functional and emotional value only (Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previtte, 2013). Future research directions have been proposed to further investigate altruistic value as a commonly accepted dimension in social marketing programmes (Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previte, 2013).

The study investigated the Smokefree actors' perception of the value created through their participation in the programme. This is one of the few studies (Zainuddin, Previte and Russell-Bennett, 2011; Zainuddin, Russell-Bennett and Previtte, 2013) exploring value as experiential and contextual in a health social marketing context. Furthermore, this is the first study, to date, to have examined value from multiple perspectives (i.e. customer, intermediary, focal organisation) using SDL lens (Gummerus, 2013). The notion of altruistic value (taking action that will benefit others) was recurrent during the programme. Members of the public and staff articulated the importance of their actions to protect children from second-hand smoke. However, the findings highlight that both members of the public and staff sought an offering that could be easily adapted to their own goals, projects and contexts (Arnould and Thompson, 2005) which do not necessarily match the ones identified by the Smokefree team. For example, members of the public narratives suggested that signing the pledge was seen as a symbolic act of reinforcing their identity as a non-smoker. The focus on social value supports previous research pointing towards the role of self-perception in securing commitment to a cause (Burger, 1999). Staff in particular highlighted the functionality of the programme in providing them with evidence for their own evaluation efforts. Thus, the study indicates that a service perspective allows for understanding the multifaceted dimensions of value in a social marketing context. From this perspective, being able to use the social marketing offering to learn, perform roles and reaffirm non-smoker identity whilst providing a positive experience indicated epistemic, functional, social and emotional value dimensions (Sheth, Newman and Gross, 1991) in the Smokefree context.

Recent developments in the marketing literature on consumer value emphasises the experiential nature of value (Holbrook, 1999; 2005; 2006; Echeverri and Skålén, 2011; Prahalad and Ramaswamy, 2004; Smith and Colgate, 2007; Sheth and Uslay, 2007; Sánchez-Fernández and Iniesta-Bonillo, 2007). However, in a behaviour/social change context, the social marketing value proposition often promotes an altruistic or functional dimension whilst neglecting the experiential aspect of the behaviour. This study suggests that value in a social marketing context has a strong anticipatory dimension in that actors may accept a proposition knowing that the benefits might occur sometime in the future and that the immediate experiences might be negative. The findings also suggest that each actor participating in a value network makes its own assessment of value and that sometimes value at the individual level might not be reflected at the organisational level (i.e. staff of the Chidren's Hospital). Furthermore, multiple actors' value perception might be asymmetrical (Gummerus, 2013) and negotiating a value proposition that is equally appealing to all actors participating in the programme might be challenging.

This section has set out the main conclusions of this thesis. The following section summarises the contributions to the three main streams of literature that this thesis has drawn upon.

7. 3 Contributions

7. 3. 1 Contribution to social marketing

This study is one of the few (Domegan et al., 2013; Lefebvre, 2012; Russell-Bennett, Previte and Zainuddin, 2009; Russell-Bennett, Wood and Previte, 2013; Zainuddin, Previte and Russell-Bennett, 2011) to contribute to the efforts to examine the implications of SDL and value creation for extending social marketing theory (Hastings, 2003; Peattie and Peattie, 2003; Gordon, 2012) and for going beyond the individual level in addressing well-being and health improvement (Wymer, 2011). The thesis makes an important contribution towards integrating SDL concepts with social marketing theory. The study proposes service informed benchmarks as a starting point for further development and refinement of a novel approach to social change programmes. The study also contributes an empirically informed account of the application of concepts

such as value, networks, actor engagement, co-creation, that have been less explored in the social marketing literature (Domegan et al, 2013; Russell-Bennett, Wood and Previte, 2013; Zainuddin, Previte and Russell-Bennett, 2013).

Domegan and colleagues (2013) argue that co-creation is an alternative to the goods-dominant logic but that it poses the risk of narrow conceptualisations confined at the individual level. This study indicates that in a social marketing context co-creation unfolds as a collaborative network based process (McColl-Kennedy et al., 2012) where actors interact at different levels to integrate their own resources and resources from other actors to create value. The analysis of the resource integration process of different actors in a behaviour/social change context is a unique account for social marketing research. The study extends previous work focused on co-creation at the customer level (Domegan et al., 2013; Russell-Bennett, Previte and Zainuddin, 2009) by exploring value creation process in social marketing as a network based process that moves beyond exchange thinking. In so doing, it contributes to understanding the value creation processes in a social marketing context with a focus on the midstream level of collaborating staff and their interactions with final users.

The study contributes to the efforts to answer the call for research on the implications of SDL as a 'network of networks approach' (Domegan et al., 2013). It provides a novel account on examining multi-actor perceived value in a social marketing context, highlighting the complex interactions between actors' goals. The study supports the recent calls (Brennan and Binney, 2008; Gordon and Gurrieri, 2014) for greater integration of 'stakeholder reflexivity' in social marketing in order to develop sensible and context sensitive programmes. This study reinforces the calls articulated elsewhere (Frohlich, Corin, and Potvin, 2001; Frohlich et al., 2002) for understanding the context as both a physical 'space' and collection of human meanings and significance. Whilst the SDL systems approach provides a comprehensive framework for understanding the complexity and the 'multiplicity of views' (Gordon and Gurrieri, 2014) it also indicates challenges of negotiating between 'subjective' and shared meanings of value.

The thesis makes also an important step towards considering context oriented theories (Gordon and Gurrieri, 2014; Hastings as quoted in Dibb and Carrigan, 2013) that are needed to support social marketing action at the midstream and upstream level. Grier and

Bryant (2005) emphasise that although social marketing should integrate concepts from other disciplines and approaches in order to improve its tools for behaviour change, this 'openness' may undermine its 'marketing' core. Examining the synergy of social marketing with SDL key principles and underpinning theories, this study reflects on different models of marketing that appear more appropriate for social contexts. In pursuing this aim it contributes to the efforts to refine the core principles of social marketing and its affirmation as a discipline for social change. The SDL concepts grounded in Network Theory, Resource Theory, Consumer Culture Theory emerge as better suited to explain and operationalise the processes occurring in social change management. The study contributes a much needed empirical account of how processes are negotiated and performed in open systems such as social change programmes (Gordon and Gurrieri, 2014).

This research makes a contribution to the efforts to bridge the knowledge gap regarding midstream social marketing (Gordon, 2013) by examining the dynamics and processes unfolding at the community level. It adds to the limited body of knowledge on partnerships and stakeholder participation in social marketing programmes (Andreasen, 2006; Bryant et al., 2001; Hastings 2003; Lefebvre, 2006; 2011). Examining the value creation processes at the midstream level contributes to the few studies focused on capacity building (Faulkner et al., 2009; Whitelaw et al., 2010) in a social marketing context. The study emphasises the need acknowledged elsewhere (Polonsky as quoted in Dibb and Carringan, 2013) for developing integrated inter-agency solutions in order to address the fragmented application of social marketing and build capacity for change.

As indicated in the literature review chapter, social marketing research has been dominated by the positivist approach found in mainstream marketing (Brennan, Voros and Brady, 2011). This study contributes a qualitative approach to understanding the implications of a service perspective in social marketing. This approach allowed for capturing insights from different actors and uncovered the dynamics of value creation and engagement in a health social marketing context. In doing so it contributed to understanding motivation for engaging with social marketing offerings, an area under-explored in social marketing (Zainuddin, Previte and Russell-Bennett, 2011).

The following section takes the discussion further to propose service-informed benchmarks for social change programmes. Theoretical and practice implications of these proposed benchmarks are discussed.

7. 3. 1. 1 Service informed benchmarks for social change programmes – implications for theory and practice

One of the aims of this study was to examine the implications of SDL for the theoretical core of social marketing as defined by the social marketing benchmarks. As illustrated in the literature review, social marketing benchmarks (Andreasen, 2002; French and Blair-Stevens, 2007) were introduced to clearly define core social marketing principles and distinguish it from other approaches to change. They also provided practitioners and funders with a framework to guide development of social marketing programmes. As social marketing benchmarks emphasise the reliance of social marketing on the traditional model of marketing, integrating service thinking requires re-examining and identifying new principles to guide social change programmes.

This study argues that service informed benchmarks are necessary in the light of the changes in society and the developments in marketing to update and expand the foundations upon which behaviour and social change programmes are developed. Drawing upon different literature streams including SDL, public service management and social marketing and examples from the case study under analysis, this study proposes a set of service informed benchmarks for social change management. The benchmarks are seen as a reorientation of the traditional social marketing principles as defined by Andreasen (2002) from marketing management to a service perspective. The discussion is organised around social marketing benchmarks (Andreasen, 2002; French and Blair-Stevens, 2007) connecting with the debates of traditional social marketing that were introduced in the literature review chapter. Table 8 in the Appendices provides a summary of these debates correlated with SDL principles and the proposed benchmarks. Social marketing contexts are more complex and difficult than commercial marketing contexts due to the nature of behaviour change, the complexity of the stakeholder networks, the lack of resources and the costs involved for changing behaviour (Andreasen, 2012; Domegan et al., 2013; Hastings and Saren, 2003; Peattie and Peattie, 2003; Niblett, 2005). As such, SDL is not simply transferred in a social context but

examined, translated and adapted to non-commercial realities. This project is intended to propose initial service based principles for social change programmes but further research will be needed to develop deep understanding of how SDL concepts apply across different social issues. Section 7. 5. 2 which is dedicated to recommendations for future research will propose some areas for further theoretical additions to the development of these benchmarks.

Benchmark 1- behaviour change and structural change

Social marketing interventions are guided by a clear focus on behaviour change. However, the focus on individual behaviour and agency without addressing contextual and structural factors has been one of the most prominent criticisms of social marketing (Wymer, 2011). Structures can be social (e.g., norms, values, ethical standards), institutional (e.g., management support, staff training) and physical (e.g., indoor and outdoor spaces, technologies). Recent social marketing research emphasised the need to complement downstream approaches with midstream and upstream action that will address the structural factors that influence behaviour (Brennan and Binney, 2008; Dibb, 2014). Strategic (French, 2009b) and critical social marketing (Gordon, 2011) has emphasised the importance of considering structures in social change programmes. It has been suggested that adopting service thinking can facilitate the shift from downstream to midstream and upstream in social marketing (Domegan et al., 2013; Russell-Bennett, Wood and Previte 2013). SDL is systems oriented, emphasising the importance of processes, context and networks. Thus, learning from service logic reinforces the principle of *structural change* as equally important as individual behaviour change.

Structural change requires understanding of the context that influences individuals and identifying ways to address that context. Arnould, Price and Malshe (2006) point out that individuals' physical resources (emotion, strength and energy) combined with different socio-cultural contexts shape their goals and life projects. Contextualising social marketing programmes requires understanding individuals' goals and value, identifying existing resources and facilitating access to those resources. The Smokefree case highlighted that resource deficits have an impairing effect on available resources. Thus, more efforts are required to understand the potential of existing resources to counter the deficits. A service perspective considers consumers, firms and organisations as integrators of their operant resources (skills, knowledge, competences, values, and

ideologies) and operand resources for value creation (Baron and Harris, 2008). Resources are assessed depending on the social context where they operate. This means that social marketing value propositions need to take into account both consumer and collaborator available resources. Recent critiques of SDL (Campbell, O'Driscoll and Saren, 2013) challenge the hierarchal relationship between resource types and call for recognising the role of operand resources in the marketplace. Indeed, social change contexts seem to suggest that it is the interplay between operant and operand resources rather than the superiority of one resource to another that needs to be better understood (Piacentini, Hibbert and Hogg, 2014).

Social marketing programmes should aim to build capacity for change by addressing both internal (knowledge, skills and motivation) and external factors (social & cultural: family, peers, community and institutional). Collaboration with various stakeholder is required to reach individuals and address the social issue at micro, meso and macro levels. Adopting a systems approach can facilitate understanding and collaboration with the networks that have potential to shape the structures around individuals. Adapting the value propositions to different contextual levels (i.e. individual, family, community or societal) can be achieved through network collaboration, customised support, knowledge and skills development. Examples of illustrative actions may include engaging actors in the community to develop support services (i.e. free gym passes; walking groups) provide learning opportunities (cooking classes) working with existing local services to improve access to social marketing services (i.e. STOP Smoking Services) and reach people (i.e. lay workers to have conversations about health issues).

Benchmark 2 – customer orientation and engagement

Social marketing's customer orientation marked a change from traditional expert driven approaches. Traditionally, customer orientation in social marketing involved using market research to understand the audience and pre-test intervention elements with the target group (Lefebvre and Flora, 1988; Andreasen, 2002). Recent reviews of Andreasen's work (2002) added 'audience insight' to social marketing benchmarks (French and Blair-Stevens, 2007). Audience insight is considered to complement a customer orientation and emphasise the need to develop a deep understanding of the 'audience' of social marketing programmes (French and Blair-Stevens, 2007; French et al., 2010). However, traditional social marketing drawing on the managerialist view of

goods-dominant logic often implies a limited role for customers and a promotion oriented approach wherein social marketers need to target individuals with carefully crafted messages (Brenkert, 2002; Gurrieri, Previte and Brace-Govan, 2013). Examples from social marketing programmes - for example programmes aiming to reduce alcohol consumption (Piacentini and Banister, 2009; Szmigin et al., 2011), encourage physical activity (Spotswood and Tapp, 2013) - illustrate that a deep understanding of the socio-economic-cultural factors is needed in order to identify barriers to engagement with social marketing offerings.

SDL shifts the focus from the firm to the customer who is active, competent and empowered to co-create value (Vargo and Lusch, 2008a; Ramaswamy, 2011). The service perspective in social marketing moves the focus from the actual offering to the process of creating that offering (Vargo and Lusch, 2004), a process where the public is no longer only the potential receiver but also the creator. A co-creation approach has deep implications for the customer's role in social marketing programmes. Social marketing contexts require active individuals who need to take action around behaviour. A co-creation approach in social marketing seems relevant in articulating the need for transparency, dialogue and citizen participation in programmes aiming to bring about social change. Collaborative efforts are needed to increase participation of citizens in social marketing programmes and address the asymmetrical relationship social marketer-customer (Gurrieri, Previte, Brace-Govan, 2013). The key implication for social marketing is a shift from a 'top-down' to a 'bottom-up' approach where the public is engaged in all phases of a programme from defining the problem to implementation and evaluation. Value co-creation, implies a change in the dominant logic for marketing from 'making, selling, servicing' to 'listening, customising and co-creating' (Payne, Storbacka and Frow, 2008, p. 89). Customer orientation shifts from learning about a passive audience to co-learning with an active audience. It requires interaction to create audience encounters and provide engagement opportunities. Adopting a co-creation perspective indicates potential for creating the space for public dialogue, reflexivity and debate which is critical for social change (Buchanan, Reddy and Hossain, 1994; Domegan et al., 2013; Gordon and Gurrieri, 2014; Gurrieri, Previte and Brace-Govan, 2013).

The new media and new information technologies show potential in reaching groups that are engaged with such technologies (Bernhardt et al., 2009; Dibb, 2014; Lefebvre, 2012).

However, reaching individuals who live in deprived communities and who may not have access to these technologies requires customised approaches driven by interaction and dialogue. Maintaining interaction and dialogue with customers throughout the development of the social marketing programme is required in order to create offerings that respond to real needs. This continuous interaction can be problematic in the context of social marketing due to limited access to the target audience and the short life span of social/behaviour change programmes. An interactional capability requires built in feedback mechanisms, integrating the offering within existing services to maintain support, and creating opportunities for dialogue.

Benchmark 3 – value creation

The concept of exchange was considered the core of social marketing (Bagozzi, 1975; Kotler and Lee, 2008) although it generated conceptual debates and confusion among practitioners around its applicability, especially in the health field. Inspired by relationship and service marketing Peattie and Peattie (2003) propose 'interaction' and Hastings (2003) argues for 'relational' as alternatives to the exchange principle in social marketing.

The traditional economic exchange view holds that value is embedded in the products or services of the organisation being added during a non-interactive production process which does not include the customer (Echeverri and Skålén, 2011). The service view holds that value for users does not emerge from the core offering only, but is created with the customer and other actors in their network (Grönroos, 2012). In this view, transactions are only one form of interaction in marketing (Ballantyne et al., 2011). The view of value-in-context and value creation - as a network based process where actors interact to integrate their own resources and resources from others - marks a fundamental change from the view of value-in-exchange. The economic exchange view on value is difficult to apply in a social marketing context especially when there is no physical product or service provided (Andreasen, 2012) or value is not created at the moment of consumption. The value of a social marketing offering is often not created at the time of consumption for the audience as the benefits of behaviour change can be delayed and the perceived costs high. Furthermore, changing behaviour can have immediate negative effects (e.g. cravings, anxiety, fear, social isolation). The value concept which includes the idea of value facilitation (by an actor to another actor), resource integration (to create

value-in-context) which can also occur in the future and co-creation (as a customer centric process based on interaction) (Grönroos 2012) accommodates the circumstances of behaviour, in which value deficits in the short term need to be accepted in anticipation of other value gains in the long term. Further, the view that value is created within a network legitimates a stakeholder orientation and supports the idea of a shift of power from 'social marketers' to other actors (e.g. customers, their peers and family, services etc.) in the network. The concept of 'value-in-underuse' (i.e. value of resource conservation) (Campbell, O'Driscoll and Saren, 2013) can be particularly useful within the efforts to engage in sustainable marketing practices and promote ethical consumption (Peattie and Peattie, 2009).

The phenomenological view of value adopted by SDL (Gummerus, 2013; Vargo and Lusch, 2010) provides a more comprehensive framework for understanding the role of experiences in social marketing. As illustrated by the Smokefree case, acknowledging that value is subjective and created in context has implications for construing value propositions that are not 'provider defined.' Adopting a value creation perspective also allows for more actor reflexivity (Cherrier and Gurrieri, 2013; Gordon and Gurrieri, 2014) on how value is defined from different perspectives (i.e. customer, social marketer, funder, service provider staff, community and society more broadly) and how value propositions are negotiated in a social change context. The challenges caused by operating in an exchange mode in social contexts, particularly the difficulties of applying exchange in health contexts and, the altruistic nature of social marketing value support the adoption of value creation as a key principle for social marketing.

An experiential view of value requires acknowledgement that the change process can bring both positive and negative experiences and work needs to address factors that would create a negative experience (e.g. facilitate individuals' access to constant support once they committed to make the change). One key implication for social marketing organisations is to develop an interactional capability and provide opportunities for the audience to engage with the offering. Another important implication is to define value in the social marketing context, acknowledge the different types of value (i.e. social, altruistic, emotional, epistemic, functional etc) (Holbrook, 2006; Sheth, Newman and Gross, 1991), seek opportunities for personalisation and co-create value propositions to reflect network actors' needs and preferences. Equally important, social marketing

organisations need to consider the resources required for change and make use of multichannel delivery mechanisms (e.g. collaborate with other network actors that interact with the audience).

Benchmark 4 – competition, networks and collaboration

The main source of competition in social marketing was usually defined by the internal factors that prevented the individual from changing their behaviour (Andreasen, 2002; MacFadyen, Stead and Hastings, 1999). More recently, scholars emphasise that competition includes an analysis of both internal competition such as psychological factors (pleasure, desire, risk taking, addiction etc.), and external (other influencers) forces competing with the behaviour change (French and Blair-Stevens, 2007; Gordon, Carrigan and Hastings, 2011; Hastings and Saren, 2003). Thinking in terms of competition requires creating strategies to remove or minimise the competition. Adopting a systems view on change requires examining the context of behaviour and the competing systems that shape the environment. Rethinking competition requires more critical social marketing (Gordon, 2011) to acknowledge the impact that various structures (e.g. commercial marketing and advertising) have in reshaping the environment to favour certain behaviours.

While a competition analysis can be useful to identify internal and external barriers to change, adopting a collaborative stakeholder approach is also essential to greater reach and sustainable action. One of the reinforced cues for action in social marketing is sustained research efforts to understand and build on stakeholder insight (Brennan and Binney, 2008; Domegan et al., 2013; Dibb, 2014; Gordon, 2013). Indeed, one of the SDL implications for managers is engaging in collaborative marketing where the management model becomes one of interaction (Ballantyne and Varey, 2006). SDL acknowledges the growing role of stakeholder marketing (Gummesson, 2008; Gundlach and Wilkie, 2010) and value creation as a collaborative process (Frow and Payne, 2011) where stakeholders of the firm change roles as initiators and participants (Ballantyne et al., 2011). This is different from traditional social marketing centred on dyadic exchanges and 'unidirectional transfer of value' (Peattie and Peattie, 2003).

Relationships with network actors are a key to extend access to resources (i.e. other organisations), remove barriers to action (i.e. peer support and family) and build capacity

for further support (i.e. integrated services). Thinking in terms of value-in-context, collaboration means identifying key network actors (that can interact with the audience) and understanding which value propositions are relevant to them. Most importantly, the existing roles of these actors, their practices and context influence their engagement with social change programmes. Understanding how these actors work and the existing networks in the community is essential for creating the foundation of collaboration. Organisational learning is required to understand and respond to potential collaborators. SDL places learning and dialogue as central processes in developing knowledge, sensing and reacting to the collaborative networks (Lusch, Vargo and Tanniru, 2010).

However, collaboration is often challenged by institutional factors, (Barnes, Newman and Sullivan, 2007) and conflicting priorities of stakeholders (Fawcett et al., 1994; Stead, Arnott and Dempsey, 2013). Collaborating with public service staff whose roles assume a complex relationship of support (e.g. family support workers, health visitors) and prolonged contact may raise issues of power given by the expert-layperson dynamic. Collaboration with commercial partners challenges reaching those reciprocal value propositions and poses ethical concerns (e.g. alcohol, tobacco industry partners). There is also the risk of co-destruction when collaborators adapt the information and add their own knowledge. Identifying, reaching and engaging stakeholders in social marketing programmes require interaction, dialogue, transparency, enhanced 'stakeholder reflexivity' (Gordon and Gurrieri, 2014) and complex negotiation processes to co-create value propositions that resonate with each group.

Benchmark 5 – Segmentation, relationships and customisation

Segmentation and targeting were encouraged in social marketing as a way to efficiently use scarce resources for better impact (Andreasen, 2002). Their application involves using segmentation variables to select the intervention target group and tailoring the offering for selected segments. Despite the benefits, the application of segmentation to social marketing has aroused criticism because it reinforces the concentration on individuals, neglecting broader structural factors that influence social problems (Brenkert, 2002; Dibb and Carrigan, 2013). In particular, concerns have been raised about its use to select those individuals ready for change while neglecting vulnerable or hard to reach populations (Brenkert, 2002; Langford and Panter-Brick, 2013; Newton et al., 2013).

Recent developments from relationship and service marketing emphasise that customers are relationship partners and not isolated targets (Ballantyne and Varey, 2006; Vargo and Lusch, 2008a; Karpen, Bove and Lukas, 2012). As such, segmentation and targeting need to be rethought to accommodate an approach based on interaction, dialogical learning and contextualising. The view that consumers are active agents underpins the shift towards one-to-one approaches and customised experiences informed by the type of value sought by audiences (Zainuddin, Previte and Russell-Bennett, 2011), their resource integration processes, their contexts (Karpen, Bove and Lukas 2012) and their engagement levels with the offering. To develop these individualised insights (French, 2009b), interaction and learning from dialogue become important processes, while service design and new technologies are particularly important areas to explore in order to implement customisation and one-to-one approaches (Bolton and Saxena-Iyer, 2009; Lefebvre, 2012).

The SDL consumer is networked, empowered and willing to participate (Prahalad and Ramaswamy, 2004). One of the key issues in social marketing programmes is developing capacity for change, particularly of vulnerable and hard to reach populations. Often, social change programmes deal with consumers who face a severe lack of resources (e.g. financial and skills, knowledge and motivation) (Crawshaw, 2012; Stead, Hastings and McDermott, 2007). In deprived communities, it may be that individuals are isolated, lacking family support or that their existing network may act as a counterweight to the desired change (Vassilev et al., 2011). Thus, the community based services become central players in providing the support needed. To respond to inequalities, there is a particular need to facilitate co-creation of customised offerings for disadvantaged communities (Stead, Hastings and McDermott, 2007). Collaborating with these services becomes essential to facilitate individuated approaches to reach people.

Benchmark 6 – service driven framework

The marketing mix is a core tenet of traditional social marketing, drawn from the classic goods-dominant marketing framework (Kotler and Lee, 2008). As previously discussed in the literature review chapter, changes in marketing and society and evidence from social marketing practice have questioned the application and relevance of the 4Ps. Its linear process and ‘firm focus’ were challenged by the complex dynamics and the variety

of actors of social change programmes (Peattie and Peattie, 2003; Gordon, 2012). As illustrated in the literature review chapter, social marketers suggested updating and extending the social marketing mix (Gordon, 2012) to broaden the methods (French and Blair-Stevens, 2007) and connect new psychology models with social marketing action at different levels (Tapp and Spotswood, 2013).

A service perspective means expanding the scope of marketing beyond traditional frameworks (Grönroos, 2011b) towards a more holistic approach to social change. The Nordic School distinguishes between conventional marketing mix and service marketing which is oriented towards interaction, relationships and networks (Grönroos, 2008; Gummesson and Grönroos, 2012). SDL emphasises a radical shift from the 4Ps marketing mix towards engaging, collaborating, facilitating, integrating resources and co-creating with customers and other value network actors (Vargo and Lusch, 2008a; Lusch and Vargo, 2006b). A service oriented framework for social change is citizen-centred seeking to integrate different types of value, operating in a collaborative and dialogical mode, creating opportunities for audience encounters throughout the social change process, and facilitating the creation of value.

Facilitation and resource integration: In commercial settings suppliers need to provide consumers with the necessary resources to facilitate their value creation processes (Grönroos, 2008). Further, co-creation requires actors' motivation, capability and willingness to interact (Grönroos, 2012; Picentini, Hibbert and Hogg, 2014). This orientation involves a facilitator role for social marketing organisations to identify relevant resources and actors as potential collaborators. Particularly in a social change context, collaboration is needed to support audiences in gaining the knowledge, skills and motivation required to be able to take action for change. A social change context may also pose significant structural barriers to engagement with the social marketing offering. Supporting citizen learning and skills development is essential to build capacity for change. However, a facilitator role requires acknowledging the external barriers and the operant and operand resources necessary to address those barriers. Further, a facilitator role needs to develop learning capabilities to adapt to the changing value networks. It also involves a resource integrator role as it collates resources from the network to reshape the offering. For example integrating knowledge and experience from

consumers and other collaborators may result in new offerings (e.g. a service initially designed for quitting smoking could be transformed in a holistic well-being service).

Engagement and co-creation: A service orientation assumes also the co-creator role for organisations that interact with their audiences (Grönroos, 2008; 2012). Engaging consumers and other network actors through interaction and dialogue opens opportunities for co-creation through sharing, learning and relationship building. It also means understanding actors' practices and seeking ways to support (e.g. breastfeeding support groups) or change those practices (e.g. stop smoking counselling). Perhaps even more than commercial contexts, social change programmes are bound to follow ethical principles of transparency and democratic dialogue. Co-creating conversations and dialogue is needed to allow for public debate and real participation of consumers, citizens and other stakeholders in the process of change.

This section has proposed service informed benchmarks for social change programmes. The following section discusses the contribution to service-dominant logic.

7. 3. 2 Contribution to service-dominant logic

The study contributes an empirical account to the growing literature on SDL and value creation (Archpru Akaka et al., 2014; Breidbach, Kolb and Srinivasan, 2013; Jaakkola and Hakanen, 2013; McColl-Kennedy et al., 2012; Mele, 2011; Payne, Storbacka and Frow, 2008; Piacentini, Hibbert and Hogg, 2014; Woodruff and Flint, 2006; Zwick, Bonsu and Darmody, 2008), a domain still dominated by conceptual work (Gummerus, 2013; Frow et al., 2014; Vargo and Lusch, 2014). The social marketing programme under analysis provides an interesting case of how value creation processes unfold, the factors underlying co-creation, the networks and roles of the actors involved in a non-commercial context.

The current study has not only attempted to apply SDL concepts to social marketing, but also explored the practices of co-creation across a range of different public organisational contexts providing new insight into the process. By doing so, the study makes a valuable addition to understanding the interactions among organisations, their

customers/users, staff and other stakeholders in value networks (Akaka and Chandler, 2011; Frow et al, 2014; Grönroos, 2012; Jaakkola and Hakanen, 2013; McColl-Kennedy et al., 2012; Mele, 2011; Vargo and Lusch, 2006; Lusch, Vargo and Tanniru, 2010). The study supports the findings of other empirical work in different contexts (i.e. value creation in business solution networks) (Jaakkola and Hakanen, 2013, p. 55) which indicates that value processes between various actors are 'iterative and inherently interlinked'. One of the key findings of this study is that initiators and value creation facilitators (other than the central organisation) can also play the role of co-creators and resource integrators at different stages of the interaction with the social marketing offering. The study suggests that users - in addition to the role of co-producers and co-creators – can also be facilitators for other actors, depending on the position in the network and their goals and capabilities. The case illustrates how value propositions are shaped through interactions between actors and actors and their context in a health improvement network. Compared to previous empirical work which indicated that knowledge brokerage and dialogue can both enable and constrain reciprocal value propositions (Truong, Simmons and Palmer, 2012) this study suggests that value propositions are also shaped by the practice and interaction context of the actors involved.

The research provides better understanding of actors' perceptions and experiences of co-creation as the organisational perspective on the advantages of these approaches prevails in the literature (Gummesson, 2008; Heinonen et al., 2010; O'Malley and Prothero, 2004; Peñaloza and Venkatesh, 2006). Participants' accounts suggest that staff and user encounters facilitate dialogue and the pursuit of goals which may lead to co-creation of value. The social marketing context which assumes a societal value dimension and the general subjective character of value indicate that actors (staff and users) might have a different perception of their interactions as value creation opportunities. In particular the study challenges the predominant view in marketing literature that customers who interact to co-create are 'empowered, networked and willing' (Prahalad and Ramaswamy, 2004; Vargo and Lusch, 2006; 2012) to do so. The study also supports the emerging literature noting that not all interactions between actors lead to creation of value (Maglio and Spohrer, 2008). The findings indicate that the interactions around Smokefree between staff and service users that were initiated by staff were also opportunities for 'co-destruction' (Echeverri and Skålén, 2011). The study also advances

the literature on the distinction between value creation processes and value outcomes (Gummerus, 2013; Zainuddin, 2013) in a social change context. Examining value creation illustrated the dynamic processes unfolding at the individual and network level. The analysis of value dimensions from the perspective of members of the public (as service user), collaborator staff and staff of STOP (as the focal organisation) provides a unique account of multi-stakeholder value.

The study also adds to the literature on customer and stakeholder resource integration (Grönroos, 2012; Hibbert, Winklhofer and Temerak, 2012) in a public service context and the facilitation processes involved. Examining the resource integration processes at both, user and intermediary staff levels suggests the role of operant resources (knowledge, practices, skills, relationships) in enabling existing resources to facilitate and create value. The expanding effect of operant resources (Vargo and Lusch, 2004; 2011; Piacentini, Hibbert and Hogg, 2014) activated in the process of integration has implications for developing actor's capacity to participate in future co-creation practices. The study points out that similar to value, resources need to be understood in context and that deficits of specific operant resources such as relationships, skills and practices and job roles but also operand resources (such as physical space) might in fact hinder the potential of other resources such as motivation and knowledge. Further, the study challenges the SDL view of a hierarchal one way relationship between operant and operand resources (Campbell, O'Driscoll and Saren, 2013) indicating the interplay of operant and operand resources in the Smokefree context.

7. 3. 3 Contribution to public health

The social marketing contribution to public health is now acknowledged (Andreasen, 2012; Lefebvre and Flora, 1988; Hastings and Saren, 2003; Peattie and Peattie, 2009). As explained in the literature review, the application of social marketing in health has changed the design of public health campaigns. Social marketing is associated with introducing pretesting and ethnographic research to understand the audience in public health (Hastings, 2003). In addition, social marketing applications in health also stimulated critical approaches to investigating commercial marketing practices and their impact on society in areas such as tobacco (Hastings and Saren, 2003; Gordon, Carrigan

and Hastings, 2011), nutrition (Wymer, 2010) and alcohol (Gordon, 2013). Social marketing is also linked with adopting a managerial planning approach and a focus on profitability to develop behaviour change campaigns (Hastings and Haywood 1991).

However, as explained in the literature review chapter, the application of social marketing in public health has been critiqued for its 'behavioural approach' which limited the attention to contextual factors and wider determinants of health (Buchanan et al., 1994; Crawshaw, 2012; Wymer, 2010). Further, the neo-classical economics perspective of the exchange (Buchanan et al., 1994; Domegan et al., 2013) and the managerial approach (Gordon and Gurrieri, 2014; Lefebvre, 2012) were critiqued for being inappropriate in health where collaborations are required at different levels for developing context sensitive programmes.

This study contributes to the efforts to answer the calls launched from scholars and practitioners in the public health area to revise and update social marketing frameworks. The study suggests that a service perspective with its focus on networks, interaction, processes and collaborative value creation provides a framework that resonates well with the complex relationships and variety of stakeholders in the health social marketing context.

This study is one of the few focused on the process of participation of local services staff and community members in health social marketing projects (Charlier, Glover and Robertson, 2009; Butterfoss, 2006; Ritchie et al., 2008; 2009; Stead, Arnott and Dempsey, 2013) and the experiences and motivations of individuals that engage with these programmes (Baker et al., 2011; Fotaki, 2011). It highlights how implementation of a collaborative social marketing programme is shaped by the practices of the actors involved and the existing capacity for health promotion efforts.

Previous research (Ritchie et al., 2009) emphasises the role of health professionals in advocating for smokefree environments, and the need for continuing training and education on second-hand smoke. The literature notes contradictions regarding members' of the public reactions to receiving smokefree messages from health professionals (Hacker and Wigg, 2010) and the professionals' attitudes to taking up this role (Whitelaw et al., 2010). Exploring different actors' perspectives on their motivation

and value for engaging in social marketing programmes provides rich insight into some of the limitations of this approach. This study indicates that people were likely to listen and engage in conversation about Smokefree with health visitors and staff from Children's Centres. Examining networks, roles and practices the study provides an innovative conceptual framework to explain and understand the processes occurring in health behaviour change programmes when partnerships are required.

The study also provides an important empirical account on the health promotion practices of actors that are part of an existing support network in the community. Previous work advocating service driven marketing approaches in the public sector (Osborne, Radnor and Nasi, 2013) suggests that such approaches would enhance interaction between public sector organisations and citizens facilitating co-production at the micro (individual) and meso level (public sector organisations) whilst supporting service integration for better use of resources. This research identified key actors and job roles that show potential in engaging with members of the public and supporting community co-creation practices. By adapting the social marketing offering to fit their own objectives, these individuals exhibited active agency rather than behaving as passive recipients (Gulati et al., 2000). Previous community action research studies (Ozanne and Anderson, 2010) suggest that working in close partnerships with the community has the potential to build capacity for change. However, the variety of actors involved in the study allowed for a comprehensive view on some of the challenges and limitations of collaborative practices in a health context. Collaborative work requires careful coordination and constant interaction between the actors involved. It also assumes an understanding of how structural factors (i.e. changes to the profession, management, policy priorities) might hinder or facilitate collaboration. The next section discusses a number of findings which have practical implications for social marketing, health behaviour and social change practitioners and policy makers.

7. 4 Implications for practice and policy

This study drew on SDL to examine engagement and collaborative value creation in a health social marketing context. It considered the factors that influence actor engagement in a health social marketing programme and the processes involved. The study also

provides additional understanding of actor motivation and value dimensions in a health behaviour change context. The findings of this research provide useful insight for practitioners and policy makers working in the area of behaviour/social change and health services management. The section on service informed benchmarks provided additional insight for practice. In this section, the main implications for health policy, social marketing and health services management are discussed.

A service approach

Adopting a service-dominant approach in social marketing programmes does not mean disregarding the traditional approach. A number of authors argue that the service-dominant logic did not bring a paradigm shift (Ambler, 2006; Brodie, Sels and Saren, 2006; Sweeney, 2007) and it is more appropriate for some contexts than others. Indeed, Vargo and Lusch (2014) stress that goods-dominant logic is nested within SDL. Thus, some social marketing programmes may operate better on a marketing management model if the focus is on promoting tangible products on a short term basis and the audience is more easily reachable via conventional promotion channels such as media and/or online technologies (i.e. informed and skilled customers). Some of the actors (both staff and members of the public) interviewed in this study mentioned media campaigns promoting smoking cessation or smokefree environments. Furthermore, some even recommended that the programme incorporates some elements of media promotion (i.e. TV adverts) to increase reach. The case examined in this research provides a specific context where the audience comprises mostly vulnerable customers who are more difficult to reach via traditional social marketing strategies. However, these are the individuals which illustrate the health inequality gap. These individuals deal with various health issues and are hard to reach with information and media messages alone (Crawshaw, 2013). Despite the progress made regarding tobacco management and control at the UK level, the individuals belonging to socio-economically deprived groups exhibit above average smoking rates. High customisation to target these ‘at risk’ groups may address the challenge faced by social marketing programmes which tend to target easy reachable groups (Stead, Hastings and McDermott, 2007). A service driven approach focused on dialogue, interaction and capacity building resonates well with efforts to reduce health inequalities by engaging with hard to reach individuals.

Building capacity for midstream, upstream and sustainable social marketing

The need for midstream and upstream social change programmes has been long acknowledged (Andreasen, 2006; Brennan and Binney, 2008; Hastings and Donovan, 2002; McKenzie-Mohr and Smith, 1999; Wymer, 2010). This study stresses that an 'actor-to-actor' stakeholder approach (Chandler and Vargo, 2011) is required to go beyond the consumer to address the social context and target upstream change. The findings of this research suggest that social marketing might not be incompatible with a structural approach as it has been previously argued (Crawshaw and Newlove, 2011; Crawshaw, 2012; Crawshaw, 2013). Adopting a service orientation and a collaborative value creation approach indicates potential in contextualising social marketing programmes, building capacity at the community level and adopting a long-term approach which better suites the realities of individuals.

This study reinforces the findings reflected elsewhere (Ritchie et al. 2008; Whitelaw et al., 2010) that sustainability of health programmes requires long-term planning, management support and on-going resources. In addition, this study highlights that sustainable health programmes require a design that enables integration within existing structures and the capacity to do so. Other smokefree programmes in the UK have used 'employed referral liaison advisers' to refer people to Smokefree homes and/or cessation services in Children's Centres settings (McEwen et al., 2012). The Smokefree programme under analysis has the advantage of working with existing staff who may carry on having the Smokefree conversations even after the programme ends. In order to develop sustainable collaborations with community based services and other public sectors organisations time commitment is required to build long-term relationships through face-to-face communication (Charlier, Glover and Robertson, 2009).

The Smokefree programme indicates that concentrating on developing capacity at the middle level may also influence behaviour change of the collaborator actors. The Smokefree findings indicate that integrating the Smokefree message within collaborators' work routine shows potential for avoiding the 'project focus' which tends to dominate health interventions (Whitelaw et al., 2010). Collaborating with community services such as Children's Centres' staff, health visitors, community midwives and community health development workers may facilitate the integration of the message in their routine but also creates opportunities to learn from their rich insight and

experiences of working with those communities. These actors gained rich insight about the community wherein they operate through their work experiences. Often, as they live in the same communities they serve, they gain grassroots experience that is invaluable for developing programmes that are context sensitive. Non-medical roles such as Children's Centre staff and CHDC's might be seen as less intimidating than health professionals and creating informal encounters with their users. Identifying and building relationships with key actors who have the potential to act as leaders in the programme is central for the sustainability of the programme. Furthermore, encouraging and facilitating sharing experiences and best practice with the actors involved would support learning in particular for new staff and innovative strategies to address change.

This study focused on the collaborations among public and non-profit organisations. Collaboration between social marketers and for profit, commercial companies remains a challenging area, given the ethical implications in a social marketing context (Hastings as quoted in Dibb and Carrigan, 2013; Wood, 2012). Given the considerable power and resources that the corporate sector organisations hold, avoiding such collaborations might seem counter-productive (Vock et al., 2013). However, when engaging with potential commercial collaborators maintaining ownership of the social marketing programme and interaction with partners is vital to avoid creating conflicts of interest and diluting the social marketing offering.

Choice, skills and customisation

The consumerist choice logic borrowed from the private sector raises challenges in a public service context where individuals have fewer choices given the various constrains (e.g. financial, social, self-efficacy) (Fountain, 2001; Crawshaw, 2012; 2013; Jones and Needham, 2008; Jung, 2010). Engagement of customers/citizens in co-creation requires not only the knowledge and the interaction opportunity, but also the skills and motivation (Grönroos, 2012), physical and emotional strength (Arnould, Price and Malshe, 2006) and other operand resources such as appropriate facilities to enable participation. The individuals targeted by behaviour and social change programmes are often vulnerable, lacking the necessary resources (Piacentini, Hibbert and Hogg, 2014) for participating and actively engaging with the value proposition. Building collaborations with community based services is essential to understand individuals in context, customise offerings and support skill development.

Although the idea that people are responsible for their own well-being tended to dominate staff participants' narratives, when confronted with families with high needs, some of the staff admitted the choices were limited by financial, social constraints and that they needed more than just information to be able to make a change. Approaching healthy lifestyles only as matters of choice brings limitations in terms of understanding the impact that external factors have on behaviour (Crawshaw, 2012; Robinson and Robertson, 2010a). Having to interact with their users (often in their own homes) enabled the staff to situate them in context and understand the barriers to healthy choices. The findings of this study suggest that a 'logic of care' (Mol, 2008), showing empathy, encouragement and customised courses of action and support helps to build capacity and enable individual action.

This study highlights the salience of understanding the many spatial contexts within which social change is sought. Yet, it suggests that sometimes smoking and/or healthy lifestyles in general are not a priority when dealing with other issues such as domestic violence, unemployment, extreme poverty and vulnerable people who are lacking the cognitive abilities or even the emotional energy necessary to make sense of healthy lifestyles. In this context, it emerges that focusing on choice is simply not a solution as wider determinants of health need to be addressed first.

Denormalising smoking

The Smokefree programme aimed to denormalise smoking indoors and around children. Other research indicates that social marketing programmes focused on anti-consumption need to be integrated with efforts to change the norms and the culture around the object of consumption (Piacentini and Banister, 2009; Peattie and Peattie, 2009; Spotswood and Tapp, 2013). The pledge aims to encourage individuals to take a public stance on smoking. Examining the perceived value of individuals who signed the pledge indicates cases where signing the pledge had an effect on their behaviour (i.e. smoking less) and that of others within their immediate networks (e.g. partners that stopped smoking, changed habits). It would be interesting to explore the effects of such a pledge when people were asked to become champions of the programme.

Participation in Smokefree influenced changes of collaborator staff behaviour (smokers' behaviour in particular). The Smokefree training and activities created the opportunity for them to reflect on their own smoking habits and the potential tension between their role as promoter of Smokefree and the smoker status. Efforts to engage and develop capacity of collaborator staff in social marketing programmes require understanding their own position and beliefs regarding the behaviour promoted in order to address potential contradictions.

Policy changes, restructuring and collaboration

One of the key institutional barriers to staff actor engagement was policy changes which consequently had implications for job roles and professions. Policy changes which led to the restructuring of community based services affecting Children's Centres, CHDCs and health visitors in particular were disruptive to the established collaborations and networks. Although the partnerships between various public services were in place, the lack of staff resources inhibited the effectiveness of these collaborations. The literature highlights that staff attrition and turnover are key barriers to implementation (Gillies, 1998; Laverack, 2001; Lefebvre, 2006; Ritchie et al., 2008; Smith et al., 2001). Other studies examining smokefree initiatives (Ritchie et al. 2004; 2008; 2009) emphasise that community-based programmes relying on partnerships need to consider the impact that stakeholder change might have on implementation and sustainability of these programmes.

This research indicates that changes were affecting the health staff in particular, with nurses taking on more from the doctor's responsibilities and passing on some of their duties to health visitors and other community-based services. Health visitors emphasised their job role changed to include more responsibilities in fewer hours. Children's Centre staff were also being affected by changes to their services and budget cuts which translated into anxiety and job insecurity. Given these circumstances, collaboration with other agencies - if not essential for their aims - was not a priority.

Social marketing programme managers need to make sense of these policies and changes of the network and take action to maintain collaboration by reassessing the initial proposition and finding new ways to make it relevant for the collaborating staff. Understanding what those changes mean for their practice and work priorities is needed

to be able to reshape those propositions. Maintaining communication throughout these changes is a first step towards keeping the relationships which have already been built and even initiating new contacts with new staff in key positions. Having a dedicated individual who acts as a connector and network facilitator is essential for maintaining and reviving collaborations. Such an actor also plays a key role in facilitating knowledge and expertise integration (Ritchie et al., 2008) to support development of future collaborations. However, this is a considerable challenge given the short life span of social marketing programmes and the time required to rebuild partnerships. This research re-emphasises the need for long-term planning and capacity building in social marketing (Whitelaw et al., 2010) and public health (Potter and Brough, 2004) and its significance for sustainable programmes.

Community involvement and ownership

The policy reorientation from top-down to bottom up approaches driven by consultation and co-production of public services (Bovaird, 2005; 2007; Needham, 2008) supports the shift towards community driven social marketing initiatives. The partnerships health literature indicates that involvement of partners at early stages is essential for developing a shared vision and understanding of the programme (Gillies, 1998; Ritchie et al., 2008). Co-producing with communities is a source of creative solutions and resources which complement the 'expert' knowledge of professionals (Smith and Henry, 2009). However, in practice it seems that social marketing programmes initiated at the national level are still dominated by a top-down approach which fails to resonate with the diversity of local communities. Examples of community driven social marketing initiatives indicate that blending community development principles with marketing principles generates positive outcomes not only in terms of behaviour change but also of empowering individuals (Domegan et al., 2013; Stead, Arnott and Dempsey, 2013).

The community workers appreciated the programme under analysis because it strived to work with community volunteers and create a campaign that resonated with the locals. Despite being consulted at the initial stage of the programme regarding the message design, involvement of members of the public in the actual development and implementation of the programme was limited. The collaborating staff (except for the CHDCs who participated at co-designing programme materials) were engaged at the

implementation stage which meant their contribution to the actual design of the programme and framing of the issue was limited.

The participants in this study emphasised the importance of community ownership for initiatives that encourage citizen participation. Tokenistic participation (Arnstein, 1969; Bovaird, 2005) remains a real issue despite the general discourse advocating co-production and citizen participation. Collaborating with community based services may create the conditions for co-creation as long as real participation is encouraged and supported through a bottom-up approach which values and integrates partners' contributions. It is important to note that engaging people to actually respond to the social marketing proposition requires building a relationship that enables two-way communication and real dialogue. Actors such as CHDCs, family support officers, health visitors and community midwives are essential for community based initiatives as they are often trusted and may facilitate participation of other members of the community. However, in order to facilitate their participation more role support for health promotion is required.

Evaluation

Community based initiatives require time to develop collaborations and build capacity for sustainable change. Pressure from funders for evidence of effectiveness in the relatively short term poses a considerable challenge to such collaborative programmes. In addition, the traditional social marketing focus on behavioural goals (Andreasen, 2002) might not fit community development approaches in which communities and individuals are encouraged to determine their own priorities (Stead, Arnott and Dempsey, 2013). Furthermore, empowerment, social networks and capacity building outcomes (Middlestadt et al., 1997) go beyond behaviour change outcomes and are more difficult to assess (Stead, Arnott and Dempsey, 2013). The programme analysed in this study commissioned an evaluation which concentrated on measuring awareness and behavioural outcomes of Smokefree, including a stakeholder consultation. However, the Smokefree team emphasised that building staff capacity and developing networks were equally important outcomes.

SDL operates in a value network, where various actors have a role in the process of value creation. Operating in a network environment brings up questions concerned with

accountability, governance and collaboration management (Barrutia and Echebarria, 2013; Domegan et al., 2013). Tracking partners' involvement and results might be challenging if mechanisms are not in place from initial stages of the programme. The Smokefree team managed to track collaborators' participation by using the pledge form as a tool to capture data. However, other collaborations which encourage co-production with partners and members of the public might be more difficult to assess without process evaluation and constant feedback and interaction between the central organisation and the other collaborators. Working within a collaborative network also requires attributing contributions to specific partners and acknowledging their role in the programme (Lefebvre, 2006). Public recognition of their efforts does not only act as a motivational factor for the staff but also contributes to a network effect which might influence other actors to participate.

Previous literature indicates that social marketing needs to develop a strong evidence base for behaviour change (Balch and Sutton, 1997; Hornik, 1997). Another perspective highlights that evaluation in social marketing should focus on the process and take into account that interventions are not 'fixed' but changing (Doner, 2003). The later perspective is particularly relevant for initiatives that adopt a service orientation and a collaborative value creation approach. Such a perspective understands that sometimes there may be unexpected benefits as a result of social marketing efforts, and that not obtaining specific behavioural results does not necessarily mean that the programme has failed (Hastings, 2003; Spotswood et al., 2012).

Furthermore, the financial return on a social marketing programme aimed at a public health issue (e.g. obesity, smoking) may be visible after decades only (e.g. lower chronic disease rates when the audience hits a certain age) but this long term effect often clashes with funders' desires for immediate results (Spotswood et al., 2012). Evaluation of service driven social marketing programmes needs to go beyond behavioural outcomes to look for capacity and relationships building indicators. Critical realist evaluations (Connelly, 2001; Clark, MacIntyre and Cruickshank, 2007; Cruickshank, 2012; McEvoy and Richards, 2003; Pawson and Tilley, 1997) provide a useful such framework to examine social reality as an open system in which there are many different factors, contexts and generative mechanisms that can affect outcomes. A critical realist approach

to evaluation explores ‘what works for whom, when and why’ (Pawson and Tilley, 1997, p. 220) taking into account people, contexts, successes and failures (Clark et al., 2007).

7. 5 Limitations of the study and recommendations for future research

7. 5. 1 Limitations of the study

Although the study makes contributions to the social marketing, service-dominant logic and public health literature, there are a number of research limitations that need to be taken into account. This section outlines these limitations. Another section suggests directions for future research.

7. 5. 1. 1 Methodological limitations

Qualitative research poses limits regarding the interpretations and the applicability of the findings. As discussed in the Methodology chapter, qualitative research and case studies in particular do not allow for statistical generalisation. However, the current research acknowledges these issues and has addressed them in relation to the case study that was conducted. The study aimed for ‘analytical generalisation’ to theoretical propositions (i.e. SDL) and not populations or cases (Yin, 2003). Section 3. 7 (of the Methodology chapter) outlined the wide range of definitions and perspectives (Golafsani, 2003; Guba and Lincoln, 2005; Maxwell, 1992; Silverman, 2000; Yin, 2003) on the quality of the research, and the steps taken to ensure the research meets the criteria for objectivity; reliability; credibility; transferability and application (Miles and Huberman, 1994). The interview protocol did not act as a script but sought to elicit broad discussions on central topics and allow for new themes to emerge. The process of data analysis was described in detail to ensure transparency and the objectivity of the research.

Although Smokefree’s features make it a typical case for smokefree homes and cars programmes that facilitated this study - given the wide range of participating stakeholders, the nature of behaviour change (i.e. stop smoking inside one’s own house), and the different value dimensions of the actors present in this context - the generalisability of the results cannot be claimed before further research has been carried out in other behaviour/social change contexts. The health context is particular given the

existing interconnectivity of services and the extensive organisational structures at the heart of service delivery. From this perspective, the health context is different from other social change contexts which might lack this infrastructure (e.g. environment protection).

In addition, the smoking and tobacco control context of this study is a special one in public health. Smoking and tobacco control is one of the areas where public health has made significant progress over the years. Policy and upstream interventions have supported a trend towards denormalising tobacco use and smoking indoors (Jarvis et al. 2009; Hastings and Saren, 2003; Holliday et al., 2009; Priest et al. 2008; Simms et al., 2010). It can be argued that collaborations around smoking related issues are becoming part of the governance reality but this might not be the case for other health topics. Smokefree targeted families with young children who were likely to be users of those community support services. From this perspective, it may be argued they were considered a 'captive' audience and that they were easily reached through the network of professionals operating around them. Furthermore, as with other smokefree programmes (Amey, 2011; Allmark et al., 2011; Hacker and Wigg, 2010; Ritchie et al., 2009) the target audiences were mostly women, raising the issue of assigning responsibility for children to this group only and neglecting other key groups such as fathers and grandparents. As traditionally men are seen to engage less with health services (Courtenay, 2000; Robinson and Robertson, 2010a; White, Oliffe and Bottorff, 2012) concentrating on women as the main target is a limitation of this programme. The findings also highlighted that in many families it was the men (parent or grandparent) who were smokers.

Adopting such an interaction based approach might be difficult when the audience is isolated or avoids interaction with such services. The planning for the Smokefree programme acknowledged the time commitment and the long term approach required to build partner capacity which sometimes is lacking in social marketing programmes. The policies, public services structures and practices around social marketing which characterise this case may not be relevant for other non-UK contexts. However, the aim was to provide deep understanding of the phenomena of actor engagement and value creation in a specific context. The study discusses the case in relation to theory and research contributing new knowledge on a service approach in social marketing and its implications in a social change context.

The laborious process of data generation and the analysis of this type of qualitative research require drawing limitations in terms of time and scope. The study focused on the actors who were main contributors to the programme and excluded others who had a limited involvement. Regarding the data generation methods, interviews have their limitations as they depend on the availability of the participants and their readiness and skills to share their story. Although the study included interviews with different stakeholder groups (Children's Centres' staff, health visitors, community health development coordinators (CHDCs), midwives, Children's Hospital nurses, Stop Smoking Services staff and members of the public), the group size varied. This was due to the number of the actors from each group involved with Smokefree (e.g. there were seven CHDCs across the city but only three of them have been actively involved in the programme as they were based in target areas of the city).

The Children's Hospital nurses indicated low engagement with Smokefree (despite the high numbers of staff being trained by the Smokefree team) and this influenced their availability for this study. Additional interviews with Hospital staff would have provided valuable perspectives on the nurses' participation in health promotion programmes and the barriers to their participation. Midwives' participation in Smokefree started towards the end of the data collection stage which limited the number of interviews with this group. Policy changes (e.g. the transfer of public health from the NHS to the local authorities) and the changes of the community services had an impact on the structure of the network involved with Smokefree. As such, community health development coordinators who initially agreed to support this research by creating links with their volunteers had to reapply for jobs which meant lower engagement with the programme.

The interviews with members of the public were restricted to five different geographical areas of the city. This was due to a self-selection process (interviewees were recruited based on their willingness to participate in the study). The study did not focus on those who refused to sign the pledge as the aims were to understand how actors engage to create value. The informal interviews during observation sessions were instrumental in understanding some of users' reasons for refusal to participate. Future research could focus on those who do not participate in order to investigate actor resistance to social marketing offerings. This research started a year after the Smokefree programme had been initiated which had implications for the availability of community volunteers who

participated at the early stages of the programme. Despite these limitations, the diversity of the stakeholder groups and agencies involved in the research provided insight from a wide range of contexts, helping develop more robust theoretical insights (Miller and Tsang, 2011). In general this study aimed to look for trends and themes within each participating agency.

Observation sessions were limited to four Children's Centres, the training sessions in the neo-natal unit and Smokefree promotion at the Children's ward (Children's Hospital). Being able to attend only certain sessions that took place at different centres meant that it was not possible to follow the same group for a certain period of time. Due to confidentiality concerns, the researcher was not able to accompany family support workers or health visitors to people's homes. Extended observation of health visitors, family support officers and CHDCs practices and interactions with their clients would have added valuable insight into the 'everyday' and helped triangulate the findings from the interviews.

7. 5. 1. 2 Service-dominant logic and social marketing

A potential limitation of this study is given by the fact that it draws upon the service-dominant logic – a mainly commercial perspective - which is still growing and establishing itself in the marketing/management field - to suggest benchmarks for social change programmes. However, as stated in the previous section of this chapter, the study acknowledged the novelty of SDL and the need to adapt and/or complement its set of theories to suit social change contexts. The service based benchmarks are guiding principles that need to be researched in different contexts and complemented by other theories. The following section proposes some key research areas for further theory development in social marketing.

7. 5. 2 Recommendations for future research

This section builds upon the limitations of this study and the section introducing service benchmarks to outline recommendations for future research. This study advocates that the psychological and behavioural theories that dominate social marketing need to be

complemented by other theories in order to better understand and address the interplay between context and individual. This study suggests that future research should consider examining the potential of theories underpinning SDL and other context oriented perspectives for extending social marketing theory. The discussion is organised around key research areas for development.

Other empirical contexts

Given the health context of this study, further empirical work is needed in other contexts. For example, such research could examine the application of a service perspective in the area of environmental protection where the diversity of stakeholders' agendas and the dynamics of the networks pose additional challenges to reaching mutual value propositions. It is also important to investigate the implications of a service perspective in social marketing applied in other cultural contexts where the integration of services may be lacking.

Structural change

Challenging structural factors requires a long term approach and building capacity for supporting change over time. Unlike commercial settings, social change programmes are facing more limited resources, institutional and cultural barriers to their efforts. Changing structures might mean challenging traditions (e.g. diet norms that pose tremendous risk to public health), racial stereotypes (e.g. promoting non-discrimination), institutional/organisational structures (i.e. practices and processes) and working against governmental agenda (e.g. subsidies for cultivating Tobacco). Drawing upon marketing and public policy (Wilkie and Moore, 2012) and Consumer Culture scholarship (Arnould and Thompson, 2005) may provide additional sources for understanding actors in context in order to articulate the approach to structural change.

This study highlights the roles of community based services in implementing a social marketing programme and supporting capacity building at the midstream level. However, it also reveals challenges of such collaborations which are influenced by the fluidity of actor priorities and policy changes. Community action research (Mendenhall and Doherty, 2007; Ozanne and Anderson, 2010) and critical realist approaches to evaluation (Connelly, 2000; Connelly, 2001; Clark, MacIntyre and Cruickshank, 2007; Cruickshank, 2012; McEvoy and Richards, 2003; Pawson and Tilley, 1997) indicate

potential in supporting collaborative work and understanding the hidden mechanisms that influence action.

Customer engagement and co-creation

A primary challenge for future research is the active role of the citizens in co-creation and the facilitation processes in social change programmes. In commercial marketing, firms often target customers that already have the information, knowledge and competence to take the lead in co-creation. Social marketing contexts often need to target those segments of the audience (especially in the health context) which are disadvantaged and lacking expertise and knowledge. These individuals require more interaction and facilitation from the social marketing organisation and its network partners. Future research examining citizen involvement in public health programmes should follow the process from the early stages of first contacts between organisation and citizens. A longitudinal design could contribute a more comprehensive view on the evolution of relationships and the changing dynamics within the value networks.

As has been acknowledged elsewhere, more research is required for a better understanding of the subjective experiences of those actors involved in social marketing (Gordon and Gurrieri, 2014) and who benefits from co-creation (Peñaloza and Venkatesh, 2006). Examining dynamic relationships between the audience's actions, the marketplace, and cultural meanings can contribute to understanding the audience from a cultural and social perspective (Arnould and Thompson, 2005) rather than an economic or psychological one. A limited number of studies has adopted a critical (Gurrieri, Previte and Brace-Govan, 2013), cultural (Spotswood and Tapp, 2013) and social practice perspective (Hargreaves, 2011) in social marketing research. Ethnographic research will be useful to observe interactions and relationships between the audiences of social marketing programmes, the organisation developing the programmes and any other value network actors. Such research would provide a better understanding of the 'lived experience' (Gurrieri, Previte and Brace-Govan, 2013) of those who are the target of social marketing programmes. In addition, other qualitative methods such as diaries could provide interesting findings.

Although this study has emphasised the importance of interaction in facilitating engagement and value co-creation, it is important to recognise that organisations

operating in the area of social change face the challenge of limited resources to maintain and manage all the required interaction channels. Whilst certain groups may be more easily reached through new media and information technologies (Lefebvre, 2007; Robinson and Robertson, 2010b), other individuals (particularly low-income, illiterate) may not have the necessary resources (financial, skills) to use these technologies and may prefer traditional or alternative channels for interaction. Previous research has indicated the potential of new media for engaging with young men on health issues (Robinson and Robertson, 2010b). Further causal research could focus on investigating which technology and media types are more favourable to facilitate engagement and co-creation with individuals belonging to different socio-economic-cultural groups in various social marketing contexts. It could also investigate the role of such technologies in engaging individuals belonging to various communities of interest (Robinson and Robertson, 2010b) in co-creating social marketing offerings (i.e. developing online support groups, supporting learning).

Non-profit and public organisations involved in social marketing programmes are required to democratise the processes of change providing equal opportunities for participation and dialogue. Scholarship on citizen engagement/participation (Cooper, Bryer and Meek, 2006) and dialogue (Deetz and Simpson, 2004) may help complement SDL concepts so that they are appropriate for relationships and interactions in different social change contexts.

Value creation

SDL suggests an experiential perspective on value (Prahalad and Ramaswamy, 2004; Ramaswamy, 2009; 2011) where value is subjective (Echeverri, and Skålén, 2011; Grönroos, 2012), based on the personal judgement of the beneficiary (Holbrook, 2006). Yet, often the setting of social marketing priorities requires social value judgements. Social marketers are facing the challenge to define value from a society perspective not necessarily a customer perspective. The process of reaching those social values is duty bound to meet criteria of transparency, accountability, and participation (Brenkert, 2002; Clark and Weale, 2012; Gurrieri, Brace-Govan and Previte, 2014). This is where the importance of dialogue, open processes and citizen participation is reaffirmed.

Future research is required to explore value creation as a socio-cultural process in social marketing. Designing social marketing offerings that emphasise the notion of altruistic value may not be enough to motivate people to engage in action (e.g. environmental programmes). Understanding what motivates people to engage with social marketing offerings requires exploring the complex dynamics between individuals and their environments. Social practice theories (Hargreaves, 2011; Reckwitz, 2002) may complement SDL in helping to explain motivation and action in relation to common and shared practices. A social practice approach seeks to change practices and behaviour by altering structures and choices. This approach would also fit well with environmental causes. For instance, one of the limitations of environmental campaigns is the focus on value (often framed as altruistic – saving the planet for the benefit of other people; taking action for a good cause etc.) (Peattie and Peattie, 2009). A social practice approach to environment protection programmes would take action at the level of structures, focusing on the 'everyday' practices, grounding action in individuals' realities.

Collaboration and networks

A research priority is to understand the process of resource integration and the type of resources required in creating value in a social marketing context. As suggested elsewhere (Sweeney, 2007) a service view on value creation requires a reconfiguration of roles and relationships among network actors to create value. The role of the organisation in creating the context for co-creation in social marketing and the resources to support knowledge, skills and motivation building require further attention. Despite the stakeholder approach advocated by SDL, research on stakeholder value creation is still limited (Frow and Payne, 2011; Frow et al., 2014).

Scholarship on collaborative governance (Ansell and Gash, 2008; Emerson, Nabatchi and Balogh, 2012) and organisational learning (Jerez-Gomez et al. 2005) could provide additional insight into integrated frameworks for co-creating with stakeholders in a social change context. Examining the strength of ties between various actors in a community becomes central to understanding the existing networks and their influence on behaviour. As illustrated by SDL principles, Network theories (Granovetter, 1983; Latour, 2005; Scott, 2000) could provide the concepts and methodology for deeper analysis of such factors.

7. 6 Conclusions

This chapter discussed the main theoretical and practical implications of the thesis. The discussion was centred on articulating the central findings related to the themes investigated in this study, namely: factors influencing engagement, value creation processes, motivation and value dimensions in social marketing. A special section was dedicated to conceptualising service informed benchmarks for social change programmes and their implications for theory and practice. The main contributions to the three literatures - social marketing, SDL and public health - were also considered. Practical implications of the research highlighted in section 7. 4 concentrated on ways in which practitioners (social marketing and health service managers) could manage collaborations and interactions. The study also underlined implications for policy on issues related to empowerment and choice, community collaborations and role support for health promotion. The section on limitations of the study focused on the methodological issues, in particular the limited generalisability of the study because of the qualitative nature of the research. The final section of the Conclusions chapter advances suggestions for further research.

As a final note, it is important to understand that a service orientation centred on interaction and collaborative approaches does not guarantee value creation. Nonetheless, it facilitates an open process based on communication and direct encounters between the actors of a value creation network. Theory development in social marketing has been concentrated on how to influence the 'consumer'. Service-dominant logic, with its focus on processes, resources, systems, value networks and interaction suggests that social marketing should also focus on other actors to address issues of capacity building and structural barriers in social change programmes. Service-dominant logic informed benchmarks are proposed to stimulate research, development of social marketing theory and support practitioners in adopting an approach which recognises the social, cultural and collaborative practice dimensions at play in the process of social change.

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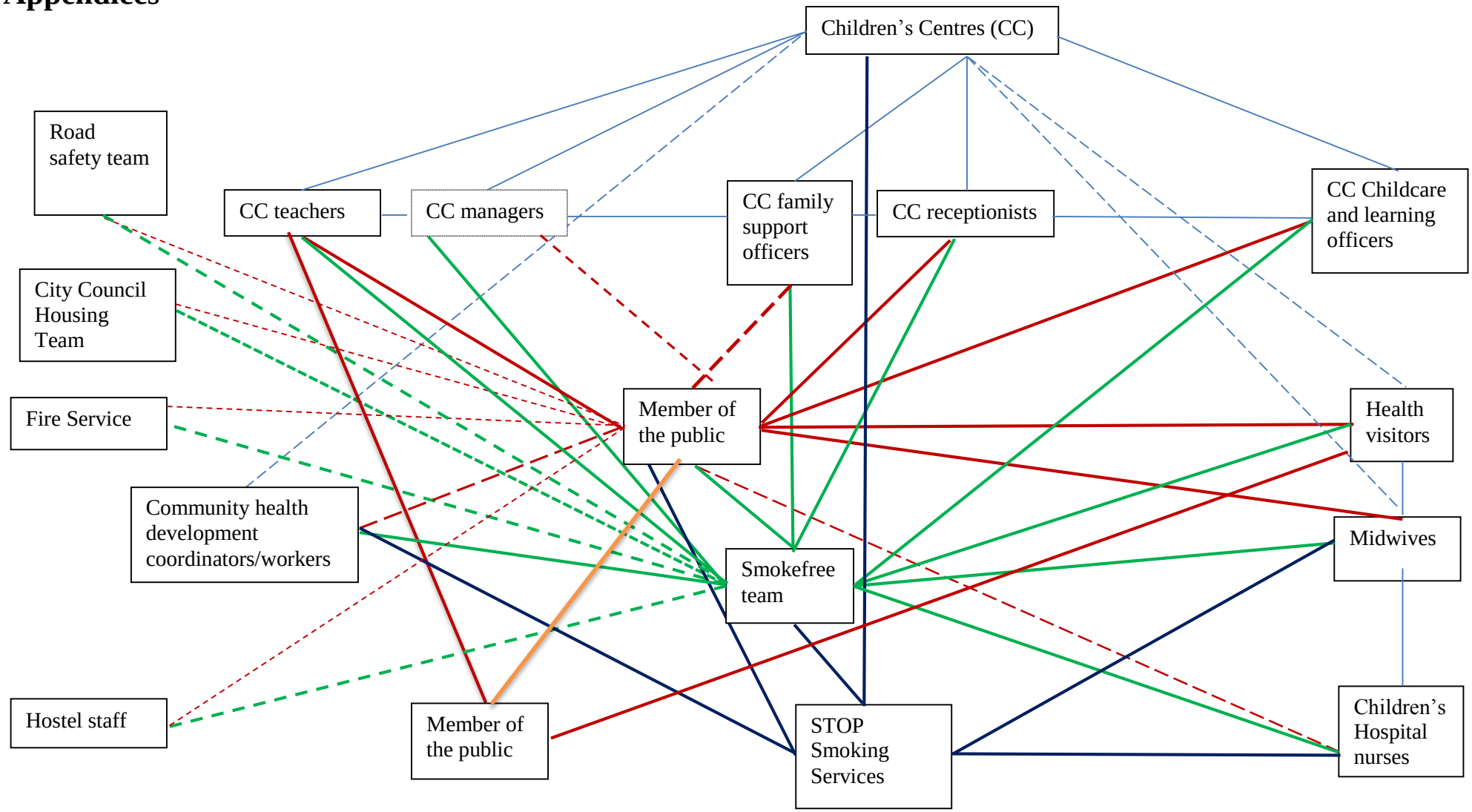
Appendices

Figure 1: The Smokefree Network: Actors and interactions



	Frequent interaction and developed relationship member of the public - staff		Less frequent interaction, member of the public (as user)-staff
	Frequent interaction Stop Smoking Services – staff/members of the public		Frequent interaction and collaboration Smokefree team – staff/member of the public
	Less frequent interaction, low level collaboration Smokefree team -staff		Less frequent interaction and collaboration Smokefree team –staff
	Frequent interaction staff -staff (collaboration)		Possible frequent interaction and developed relationship staff –member of the public as user
	Less frequent interaction, developed relationship, member of the public (as user)-staff		Less frequent interaction staff-staff (collaboration)
			Possible frequent interaction and developed relationship member of the public – member of the public

Figure 2: Value creation processes in a social marketing context

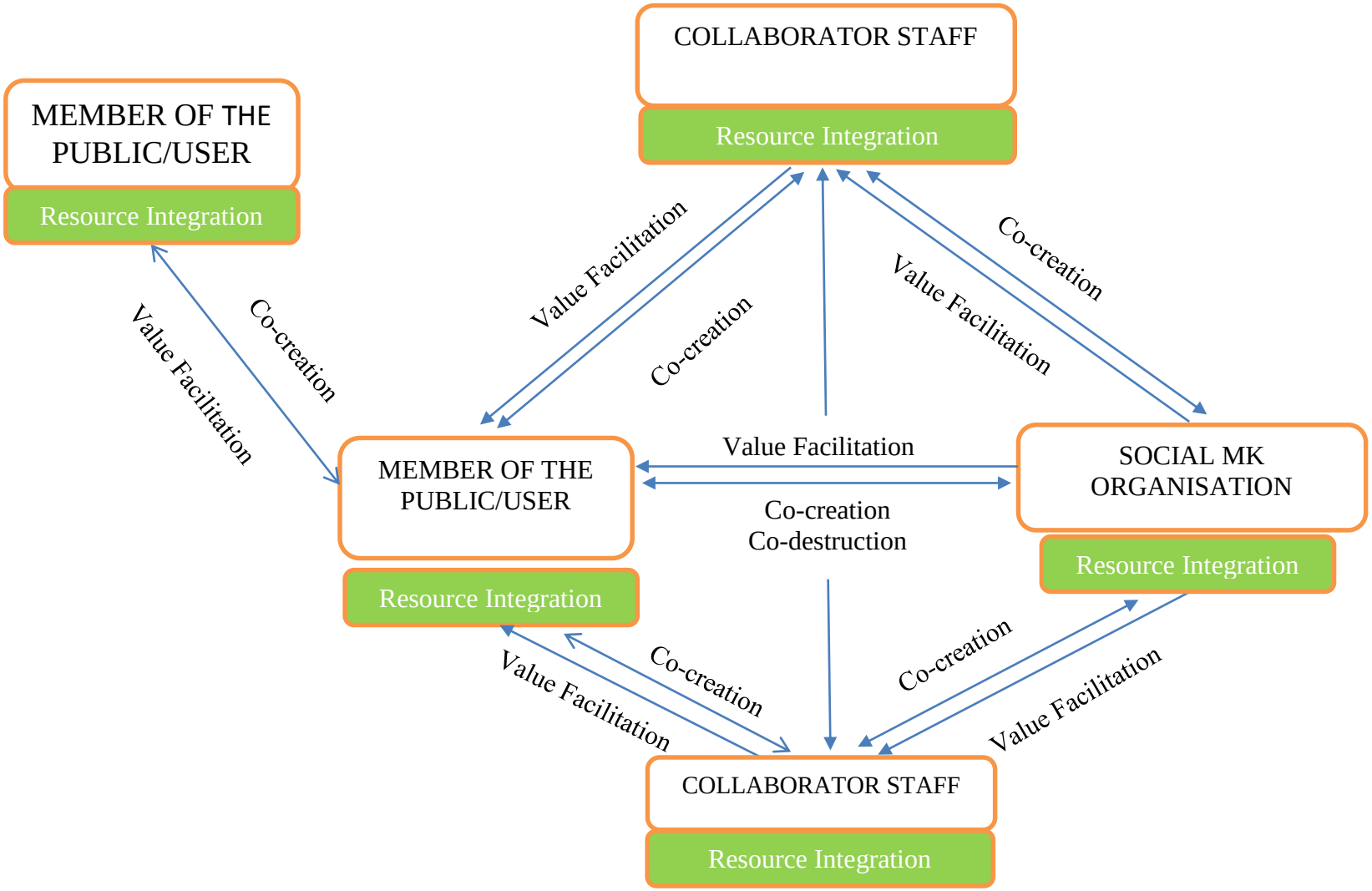


Table 1: Definitions of social marketing

Authors	Key principles	Definition of Social Marketing
Kotler and Zaltman (1971)	Social marketing scope is to influence the acceptability of social ideas	Social marketing is "the design, implementation and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution and marketing research" (p. 5).
Lefebvre and Flora (1988)	Social marketing is linked with health promotion – health marketing; from an agency centred to a consumer centred approach.	"Health marketing refers to health promotion programs that are developed to satisfy consumer needs, strategized to reach as broad an audience as is in need of the program, and thereby enhance the organisation's ability to effect population-wide changes in targeted behaviours" (p. 302).
Andreasen (1995)	A shift from influencing social ideas to behaviour change	"Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of the society of which they are a part" (p. 7).
French and Blair-Stevens, (2007)	Social marketing is both operational and strategic	"Social marketing is the systematic application of marketing alongside other concepts and techniques, to achieve specific behavioural goals, for social good" (p.7).
Dann (2010)	Social marketing is adoption and adaptation of commercial marketing concepts to social contexts.	Social marketing is "the adaptation and adoption of commercial marketing activities, institutions and processes as a means to induce behavioural change in a targeted audience on a temporary or permanent basis to achieve a social goal" (p. 151).
Lee, Rothschild, and Smith (2011)	Emphasis on the strategic dimension and stakeholders	Social marketing is "… a process that uses marketing principles and techniques to influence target audience behaviours that will benefit society, as well as the individual. This strategically oriented discipline relies on creating, communicating, delivering, and exchanging offerings that have positive value for individuals, clients, partners, and society at large" (p.1).
AASM, ESMA and iSMA (2013)	This is the consensus definition of the European, International and Australian social marketing Associations; generated as a result of a collaborative process, the	"Social Marketing seeks to develop and integrate marketing concepts with other approaches to influence behaviours that benefit individuals and communities for the greater social good" (p. 1).

Authors	Key principles	Definition of Social Marketing
	definition suggests the broadening of social marketing scope.	

Table 2: Comparison SDL and traditional social marketing

FP /axioms	SDL foundational principles (FP)	Traditional marketing (goods dominant)	'Goods dominant' social marketing
FP1/axiom 1	Service is the fundamental basis of exchange	Goods (products) are the fundamental of exchange.	Exchange: an intervention involves a voluntary exchange of resources between social marketers and the target audience (Lefebvre and Flora, 1988) Focus on the individual
FP2	Indirect exchange masks the fundamental basis of exchange	Dyadic exchanges firm-customer of goods	
FP3	Goods are a distribution mechanism for service provision	Goods are operand resources and end products.	Behaviour change is conceptualised in terms of 'the product' (Kotler and Lee, 2008) Design of social marketing based on the marketing mix: product, price, place and promotion (Andreasen, 2002; Kotler and Lee, 2008)
FP4	Operant resources are the fundamental source of competitive advantage	The surplus of tangible resources and goods (operand resources) is the source of wealth. The competitive advantage consists of owning, controlling, and producing operand resources.	A managerial mindset: social marketers to design programmes/campaigns/interventions they would then target at segmented audiences (Brenkert, 2002; Newton et al., 2013). Focus on planning and control of the programme to reach behaviour change objectives clearly identified prior to the programme (Andreasen, 1994; Peattie and Peattie, 2003)
FP5	All economies are service economies	Economies are centred on exchanging goods	A neoclassical economics perspective: Focus on cost/benefits analysis and value-in-exchange (Domegan et al., 2013) Social marketing 'consumers' perceived as rational agents (Crawshaw, 2012; Glenane-Antoniadis et al., 2003)
FP6/axiom	The customer is always a cocreator	The customer is the recipient of	The customer is involved in initial customer research to

FP /axioms	SDL foundational principles (FP)	Traditional marketing (goods dominant)	'Goods dominant' social marketing
2	of value	goods. Marketers 'do things to customers' segmentation, targeting, distribution and promotion are activities that envisage the customer as a passive actor. The customer is an operand resource.	understand their 'needs and wants' and in pre-testing the message (Kotler and Lee, 2008) Carefully designed messages to persuade and influence the target audience (Brenkert, 2002) Reliance on the 4Ps marketing mix (Gordon, 2013; Lefebvre, 2012; Wood, 2008)
FP7	The enterprise cannot deliver value, but only offer value propositions	The 'firm' creates value that is then 'delivered' to the customer through exchange.	A managerial view (Domegan et al., 2013) The focus is on social marketers' role to design programmes aimed to affect behaviour and social change (Andreasen, 2002; Brenkert, 2002) Social marketers need to provide the target audience with information, tangible products and services, or other incentives that can be considered benefits in exchange (French and Blair-Stevens, 2007).
FP8	A service-centered view is inherently customer oriented and relational	A goods-centred view is manager/firm focused.	
FP9/axiom 3	All social and economic actors are resource integrators	The firm is considered to have the main role in creating value.	
FP10/axiom 4	Value is always uniquely and phenomenologically determined by the beneficiary	Value is determined by the producer. It is embedded in the goods (operand resources). Value is defined in terms of 'exchange-value.'	Value is defined by social marketers as the benefits of the behaviour change for the individual and the society overall (Peattie and Peattie, 2003). Less focus on the 'emotional' aspect of value (Zainuddin et al., 2011) and the experience associated with change.

SDL FP explanations adapted from Vargo and Lusch (2004; 2008a; 2014)

Table 3: Social marketing and tobacco control

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
Alwan et al., 2010	Mixed methods (pre and post) Quantitative: survey Qualitative: focus groups	Smokefree homes	Parents in Beeston, Leeds, UK	Multi-level and collaborative: events and activities in schools, training of community workers; Empowering young people to negotiate smokefree	Exchange is emphasised as the key element of social marketing; It highlighted learning, feedback and praising commitment to smokefree as key elements. A pledge model (it offered a gold

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
				environments.	certificate as a reward)'
Ary et al 1990	Quantitative: randomised controlled trial	Smoking prevention	6th-7th grade pupils in Oregon, US	School based; Social influences approach.	Focused on developing youth's ability to resist to tobacco; The marketing mix included teaching training (to deliver the intervention) and peer support.
Biglan et al., 2000	Quantitative: experimental and control conditions; cross sectional survey	Smoking prevention	7th-9th grade pupils in Oregon, US	School based and community based programme; Media advocacy.	Community and policy strategies to reduce access to tobacco; Parent communications; community Mobilisation; retailer education and anti-smoking activism.
Botvin, 1997	Quantitative: randomised controlled trial	Smoking (and other drugs) prevention	7th grade students in New York, US	School-based; Social influences approach and cognitive behavioural theory; Interactive lessons.	It emphasises personal competence skills; Curriculum developed to teach pupils resistance to tobacco advertising; Lessons were tailored for minority youth.
Carleton et al., 1995	Quantitative: Quasi-experiment, Cross sectional baseline surveys and follow-up surveys	Smoking cessation (as part of a programme to reduce risk for cardiovascular disease)	Adults on low income in a Rhode Island City, US	Seven-year multi-component community intervention; Social Learning Theory; community behavioural psychology and community participation.	Counselling and groups; Grass-roots community and worksite activities; Quit contests and a quit line.
Carro-Ripalda et al., 2013	Qualitative; Ethnography (interviews and observation)	Upstream: tobacco control, anti-counterfeit tobacco	Public health professionals, law enforcement and tax collecting	Collaborative involving a wide range of stakeholders from public health practitioners to enforcement and tax collecting agencies; Media campaign	Marketing associated with promotion and persuasive messages; Concerns about the role of marketing in categorising and stigmatising people; Targeting only easy to reach audiences.

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
			officers, smokers in North of England		
The COMMIT Research Group, 1995	Quantitative: randomised controlled trial (cross sectional baseline and follow-up survey and biochemical testing)	Smoking cessation	Adult (heavy) smokers; community based organisations in 11 North American communities	Community organisation and participation principles (task forces); Mass media and media advocacy	Cessation groups, quit contests and resource assessments; Policy advocacy; It emphasised positive smokefree norms.
Cuijpers et al., 2002	Quantitative: baseline and follow-up survey	Smoking and drug abuse prevention	12 year olds in the Netherlands	School and home based; Social influences approach	Needs-assessment and pre-testing; It addressed direct and indirect pressures to smoke; It aimed to provide 'fun' and 'attractive' activities.
De Gruchy and Coppel, 2008	Quantitative: post-test design	Smoking cessation	Smokers in deprived communities in Nottingham, UK.	Stages of Change (evaluation and segmentation); Promotion focused campaign (media and outdoor promotion).	Small budget, short campaign; Limited human resources capacity; Marketing focused on promotion.
De Vries et al., 1994	Quantitative: randomised controlled trial (baseline and follow-up survey)	Smoking prevention	8th grade students in the Netherlands	School and home based; Social influences approach.	Needs-assessment and pre-testing It addressed direct and indirect pressures to smoke.
Egger et al., 1983	Quantitative: quasi-experiment; surveys and bio-chemical testing	Smoking cessation	Adults in two communities in New South Wales, Australia	Mass media; Communication theory.	Self-help materials; quit line, cessation groups (testimonials from quitters). Health professional intervention.
Flay, 1995	Quantitative:	Smoking prevention	7th grade	School-based and mass media;	Parent involvement;

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
	Randomised controlled trial	and cessation	pupils in schools in Los Angeles and San Diego, USA	Social influences approach.	Strong emphasis on resistance skills; positive role models; Class sessions, TV programming Coping strategies and relapse prevention.
Flynn et al., 1994	Quantitative: quasi-experiment	Smoking prevention	4th-10th grade students in two Vermont communities, USA	Mass media; Social influences approach.	Segmentation: personality based (conformists and rebels); Positive non-smoking role models; It addressed pro-smoking social norms and built resistance skills.
Forster et al., 1998	Quantitative: controlled trial	Reduce youth access to tobacco	Retailers, local officials, media and other stakeholders; 8th -10th grade students in Minnesota	Community development approach; Community awareness building; Test purchasing; Media advocacy; Stakeholder consultation and lobbying.	Demarketing and stakeholder engagement; Policy and legislation; Segmentation of stakeholders based on their power level.
Fortmann et al., 1993	Quantitative: quasi-experiment; baseline and follow-up surveys	Reduce smoking	Adults aged 25-74 in five California communities	Community and mass media; Social cognitive theory; Community organisation; Worksite smoking cessation.	TV based smoking cessation programme; leaflets Cessation groups and quit contests; Strategies to avoid weight gain; Testimonials from successful quitters.
Hoek et al., 2011	Quantitative: survey	Smoking prevention	12 to 24-year-old in New Zeeland	Social norms approach; Social identity and stereotype priming theory[17] Media based	The campaign emphasised smokefree individual and collective identities; It used role modelling and peer involvement in the development of the messages.

[17] Stereotype priming theory suggests messages should increase the salience of positive stereotypes about people who follow the advocated behaviour pattern and heighten negative stereotypes about people who fail to do so (Pechman et al., 203, p. 193).

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
Kong et al., 2014	Review	Smoking cessation	International	Text message based smoking cessation interventions; Motivational messages grounded in behavioural and social cognitive theories.	Most interventions provided strategies to quit; Individually tailored messages that included personal goals were shown as effective; Some of the interventions provided access to peer support, nicotine replacement therapy, self-help booklets and quitting hotlines.
Lavack et al., 2007	Review	Smoking cessation	International	Quit and Win contest model (participants pledge to stay smokefree for four weeks).	Use of a wide range of promotional efforts (media, public relations, merchandising etc.). A support system: hotline. The importance of social support in smoking cessation.
MacAskill et al., 2002	Mixed methods: survey and focus groups	Smoking cessation	Glasgow communities	Engagement of the communities in the process of research to understand the context of behaviour.	Formative research stage to understand the customer, motivation and readiness to change, and the social and individual circumstances. It emphasised the importance of the context (socio-economic-cultural factors). Important factors to consider: the power of community norms and the existence of strong social networks.
McAlister et al., 1992	Quantitative: quasi-experiment (baseline and follow-up surveys)	Smoking cessation	Adults in low income, high chronic disease communities on US-Mexican border	Mass-media and community components.	A promotion approach: TV stories, self-help and booklet distribution in communities. Use of positive role-models. Tailored to Hispanic populations Support through one-to one counselling to address barriers to change (e.g. unemployment)

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
McPhee et al., 1995	Quantitative: quasi-experiment (baseline and follow-up survey)	Smoking cessation	Vietnamese men in California, USA	Mass media; Information and education approach.	Segmentation: tailored to Vietnamese men; Distribution of quit kits; Development of refusal skills and provision of counselling support for quitting.
McCausland et al., 2009	Quantitative: three cross sectional phone surveys	Smoking cessation	Four cities, USA	Mass media campaign	Behaviour change theory: Stages of Change (segmentation); Health Belief Model; Social marketing centred on promotion, branding.
Schmidt, Kiss, and Lokanc-Diluzio, 2009	Mixed methods: pre and post campaign web surveys; focus group testing; interviews with the stakeholders	Smoking prevention	Youth of age 12-18 in Calgary, Canada	Media, social norms campaign.	Marketing centred on promotion; Engagement of students in the promotion of the campaign; It illustrates the acknowledgement of the need for peer support.
Schorling et al., 1997	Quantitative: quasi-experiment (Baseline and follow-up survey)	Smoking cessation	African-American adults in a rural community in Virginia, USA	Church based Stages of Change	Community needs assessment and resource inventory; One-to-one counselling, self-help materials; Cessation contests; Empowerment model.
Sussman, 1993	Quantitative: randomised controlled trial (baseline and follow-up survey)	Smoking prevention	7th grade students in high schools, California	School-based; Normative social influence, and information on physical consequences	It highlighted the importance of consumer research and segmentation; It aimed to address the direct and indirect influences of tobacco.
Vartiainen et al., 1998	Quantitative: Baseline survey of 903, 7th grade students in six	Smoking prevention and reduction of cardiovascular risks	12-13 year olds in six schools in North Karelia,	School and community-based, part of a community-wide cardiovascular disease prevention programme.	It emphasised the importance of individual motivation, and aimed to foster community action. Emphasis on social support and

Study	Methodology	Programme focus	Target and Setting	Approach	Lessons for social marketing
	schools, followed-up for 15 years		Finland	Classroom sessions; Social influences approach.	environment change to support adoption of new behaviours in the community.
Walsh et al., 2010	Quantitative; cluster analysis	Anti-smoking	25 EU states	Media advertising campaigns.	It highlights the importance of segmentation and customisation in social marketing.
Wildey et al., 1995	Quantitative: controlled study: illegal sales data gather before and post intervention.	Reduce youth access to tobacco; Promote compliance with laws on youth access to tobacco.	Retailers in six low income ethnically diverse communities in San Diego county, CA, USA	Retailer educational campaign; Mass media, educational materials; employee training videos, community events.	Focus on encouraging law compliance; Pretesting the materials with the retailers and community stakeholders; Segmentation: materials tailored for managers and sales assistants; Feedback: engagement was rewarded through letters of approval and newspaper coverage; The offering included materials aimed to develop staff skills to refuse underage buyers.
Windsor et al., 1988	Quantitative: randomised pre and post-test (baseline and follow-up survey)	Smoking cessation	University of Alabama employees, USA	Workplace based	Offering included: brief advice and self-help manuals; Counselling, skills training and buddy support; Monetary awards for cessation.

Table 4: Participants interviewed for this research

Participant name (pseudonym)	Job role/position in the network	Children's Centre number
Victoria	Manager	Centre 1 & 2
Bella	administrator/receptionist	Centre 1
Sella	family support officer	Centre 2
Sophie	Children's Centre teacher	Centre 2
Laura	manager	Centre 3

Participant name (pseudonym)	**Job role/position in the network**	**Children's Centre number**
Kady	family support officer	Centre 3
Callie	manager	Centre 4
Christy	administrator/receptionist	Centre 4
Clarrise	childcare learning officer	Centre 4
Ellie	family support officer	Centre 4
Kelly	senior family support officer	Centre 4
Jessie	manager	Centre 5 & 8
Dana	play leader	Centre 5
Mira	manager	Centre 6
Penny	administrator/receptionist	Centre 6
Sylvia	manager	Centre 7
Karrie	administrator/ receptionist	Centre 7
Sandy	administrator/receptionist	Centre 8
Mona	manager	Centre 9
Jill	Childcare learning officer	Centre 9
Kathleen	manager Smokefree homes	
Lydia	manager STOP	
Maris	clinical team leader for health visiting and school nursing	centres 10 & 11
Lucy	health visitor team manager	centres 4, 6 & 8
Sandra	health visitor	centre 8
Patty	health visitor	centre 8
Marcia	health visitor	centre 10
Alba	health visitor	centre 12
Shonda	health visitor	centre 11
Karla	community health development	centres 4 & 8

Participant name (pseudonym)	Job role/position in the network	Children's Centre number
	coordinator	
Minnie	community health development coordinator	centre 6
Sara	nurse	Children's Hospital
Lara	training lead	Children's Hospital
Paula	community midwife	area 13
Celina	maternity support worker	area 13
Claire	manager midwives team	area 13
Corrine	member of the public	centre 14
Gilbert	member of the public	area 8
Jessica	member of the public	centre 7
Sal	member of the public (Nadira's spouse)	centre 5
Nadira	member of the public (Sal's spouse)	centre 5
Selena	member of the public	area 15
Denisa	member of the public	area 5
Kalista	member of the public	centre 5
Jenna	member of the public	centre 5
Jarina	member of the public	centre 5
Carrie	member of the public	centre 5

Table 5: Data analysis framework

A framework for data analysis		Examples
Patterns/Common themes	What patterns and common themes emerge? How do these patterns (or lack	Patterns and themes connected with: Factors underlying value creation and engagement:

A framework for data analysis		Examples
	thereof) help to answer the broader research questions?	Emerging themes: Networks, relationships and roles
Deviations	Are there any deviations from these patterns? Are there any factors that might explain them?	Emerging themes: Relationships: reliance on public services staff; individual responsibility? Children's Hospital staff engagement Variance of health visitors' engagement Lack of feedback to some of the staff Soft approach – can it be perceived as 'it's OK to smoke'?
Interesting stories	What interesting stories emerge from the responses? How can these stories help to answer to the research questions?	Anticipated theme: Multi-dimensional value Emerging themes: social, functional, altruistic, epistemic value Choice versus care Staff – users - a power dimension Changes of the networks affecting engagement
Additional data	Do any of these patterns or findings suggest that additional data may need to be collected? Do any of the research questions need to be revised?	Included midwives as participants Conducted additional health visitor interviews
Similar findings	Do the patterns that emerge corroborate the findings of any corresponding qualitative analyses that have been conducted? If not, what might explain these discrepancies?	Linking the findings with the literature; corroborating other smokefree related studies (Ritchie et al., 2008; 2009) Novel findings regarding the dynamics of the value creation processes in social marketing

Adapted from Miles and Huberman (1994)

Table 6: Illustration of coding

Empirical codes (first level)	**Pattern codes (Second level)**	**Emergent Themes**	**Theoretical concepts**	**Research question element**
Isolation 'vulnerable to listening'	Lack of socio-emotional support Reliance on staff	Blurred ties between staff and users Ties that hinder engagement and change	Networks: weak and strong ties; The network effect	Factors influencing engagement
Assessment 'Sharing data' Setting priorities	Management support	Management support is key for facilitating engagement	Value networks	Factors influencing engagement
Non-paternalistic, non-judgemental, friendly non-confrontational manner	Building trust Informal approach	Strong ties with staff	Roles and competences Practices	
Provide information Signpost 'pinpoint the small bits'	Choice and support	An empowerment based approach	Empowerment	Factors influencing engagement Value creation processes; Challenges and barriers to co-creation
Individual's responsibility to make choices Client-focused solutions Each person is unique	Individual realities Co-design of solutions	Customised cues of action 'Customers' /final users are envisaged as active actors Involving individuals in the decision making	Interaction; Co-creation Co-production	

Empirical codes (first level)	**Pattern codes (Second level)**	**Emergent Themes**	**Theoretical concepts**	**Research question element**
Lack of ambition Financial constraints Smoking not a priority Language Illiteracy, Learning disabilities Misunderstanding	Complex life situations Smoking/health not a priority	Choice versus care Member of the public ability to translate information and advice into their life Resource deficits and vulnerable consumers	Resources and capabilities Customer as empowered, engaged and networked?	
'Message drip feeding'	Long-term approach	Tensions between social marketing and community driven models Action to overcome resistance	Collaborative governance; multi-actor reflexivity	Challenges of the service approach
Volunteers participation 'people that you never reach'	Community consultation 'localise the project' Reaching	Community consultation saturation Community consultation saturation	'participation fatigue', tokenism, Top-down versus bottom up approaches Segmentation and targeting Sustainability of programmes	Challenges of the service approach
Nurturing Observing Providing support Child protection	Safeguarding	Asymmetrical information and power laden relationships staff-members of the public	Asymmetry of information	Factors influencing engagement; value creation processes Challenges and barriers to co-creation
Conversation Provide data Adaptation Training Knowledge Adding Participating 'taking the lead'	Dialogue Feedback Learning	Interaction and dialogue facilitate resource integration and capability building.	Value facilitation; Co-creation; Reciprocal value propositions	Value creation processes

Empirical codes (first level)	**Pattern codes (Second level)**	**Emergent Themes**	**Theoretical concepts**	**Research question element**
Health policy Work in partnership Part of the job Access to people's homes	Job roles Practices Institutional context	Organisational resources facilitate actor engagement with Smokefree	Operant resources: organisational	Resource integration: how actors integrate resources to create value
Building relationships with users Long relationships Insight Information Experience	Job roles Practices	Smokefree to facilitate users' access to resources they could then link to their life goals and concerns	Operant resources: skills, knowledge, relationships Resource integration: the expanding effect; emergence; creative effect of resources	
Leaflets 'Freebies' Children's Centres facilities Financial costs Promotional items	Tangible resources Tangible resources	Tangible promotional items are important; The lack of certain operand resources limit actor engagement with the social marketing offering (i.e. Smokefree)	Operand resources: physical spaces, tangible goods; The interplay between operant and operand resources	Resource integration Resource integration: how actors integrate resources to create value
'To do more in fewer hours' Time pressure Budget cuts	Policy change Roles and profession change	Roles, practices and institutional context as a resource and a structural barrier	Resource deficits: The inhibiting effect of resource deficits on other resources	
Stop smoking Persuade others Protect others	Actors' personal goals and objectives	Actors who are not the direct target audience use the Smokefree offering to pursue their own personal goals	Fluid value networks where actors play the role of facilitators, co-creators and resource integrators	Value creation processes; Facilitation, co-creation; resource integration
'it sinks in' 'more understanding' 'comes across better'	Making the message 'real' Making sense of the message	Interaction and conversation enable a better understanding of the message and its relevance to individuals' lives	Value-in-context; Co-creation as spontaneous	
'my experience'	Sharing		Customisation	

Empirical codes (first level)	**Pattern codes (Second level)**	**Emergent Themes**	**Theoretical concepts**	**Research question element**
'a change of message'	'a soft approach'	A soft approach to tackling smoking	'readiness of change'; social norms Segmentation and targeting	Value facilitation
Peace of mind Doing something good 'it felt good' Feeling passionate	Reassurance	Engagement with Smokefree as a positive experience	Value dimensions Emotional value	Value is subjective and includes various benefits
Well equipped	Confidence			
'as a smoker'; 'as a mother' Children's health	Identity Role model To protect others	Engagement with Smokefree to reinforce identity (member of the public) Engagement with Smokefree for other's benefit	Social value Altruistic value	Value dimensions and motivation
A step towards change 'A tool' An incentive to stop	Self-oriented goals	Engagement with Smokefree for one's own benefit	Functional value	Value dimensions and motivation
Novel approach 'soft approach'	Learning and curiosity	Engagement with Smokefree to learn something new	Epistemic value	
Keeping the momentum Rewards Incentives 'part of the job'	Extrinsic factors	Job role compliance Compliance with others requests	Extrinsic motivation	Motivation of actors
'feeling confident'	Intrinsic factors Competence	Personal beliefs	Intrinsic motivation	
Children's health	Intrinsic factors			

Empirical codes (first level)	Pattern codes (Second level)	Emergent Themes	Theoretical concepts	Research question element
'feeling strongly'				

Table 7: Smokefree sign-ups

Agency	Sign ups	Referrals to Stop
Community Health Development workers/coordinators – Centre 4	23	5
Community Health Development workers/coordinators – Centre 5	93	3
Community Health Development workers/coordinators – Centre 8	673	140
Children's Hospital (children's outpatients department) – (Stop Advisor on Stand) Children's Out patients - No smoking day Advisor stand Hospital (without stop Advisor present) Neonatal team at Children's Hospital	27 35 2 3	7 9 1 2
Children's Centres (city wide)	2,247	551
Fire Service visit to primary schools	160	38
Health visitors (all but 2 sign-ups are from 2013, in 2012 most HV sign ups were included in the Children's centre count and also HVs had not had separate team training at that time)	142	56
City Council Housing	5	3

Agency	Sign ups	Referrals to Stop
Housing event (Stop Advisor on Stand)	15	4
Midwives (a few other midwife sign-ups are included in children Centre sign ups)	1	1
Stop advisors (who usually sign up clients they are supporting to stop smoking as part of the treatment programme)	266	32 (separate sign-ups from event stands etc.)
University student volunteers trained in Smokefree	2	1
Hostel	19	4
Family nurse Partnership	4	2
Health and Social Care Team (older people)	1	1
Blanks - No particular agency listed on the sign-up form (may have been picked up from City council information stand or other sources given un coded leaflets)	77	31

Adapted from the report (1 January 2012 - 6 November 2013) provided by the Smokefree manager

Table 8: Social marketing benchmarks, debates, revisions and new propositions

Social marketing benchmark	Criticism	Revision to date	SDL principle	Benchmark revised
Behaviour change	"Blaming the victim" - focus on individual responsibility (Crawshaw, 2013; Wymer, 2011) Underestimation of environment/context influence on behaviour (Hoek & Jones, 2011)	Moving upstream (Brennan and Binney, 2008; Hastings 2007; Wymer 2011) and midstream (Russell-Bennett et al., 2013) to influence the environment/context	A systems approach, value-in-context (Chandler and Vargo, 2011); resource integration (Lusch and Vargo, 2006a; Baron and Harris, 2008)	Behaviour and structural change

Social marketing benchmark	Criticism	Revision to date	SDL principle	Benchmark revised
		System of interaction: downstream, midstream and upstream Cherrier and Gurrieri (2014)		
Customer orientation	The problem of beneficiary in social marketing (Glenane-Antoniadis et al., 2003); Lack of real involvement of citizens (Brenkert, 2002)	Community based social marketing (Bryant et al., 2014; McKenzie-Mohr, 2000); relationship marketing (Hastings, 2003); Reflexivity (Gordon and Gurrieri, 2014)	Active, engaged, networked and empowered customers (Prahalad & Ramaswamy, 2004); co-producers, co-creators of value (Vargo and Lusch, 2008a);	Customer orientation and engagement
Exchange	No real transactions (Luck, 1969; Ryan, 2001) and intangibility of social marketing offering (NSMC, 2009); Dyadic exchanges inappropriate for complex exchanges (inter and intra-organisational) (Wood, 2008) The economics rational approach inappropriate for the health field (Buchanan, Reddy and Hossain, 1994; Crawshaw, 2012)	Interaction – instead of exchange (Peattie and Peattie, 2003) Relationship (Hastings, 2003) and service marketing (Russell-Bennett, Wood and Previte, 2013) Co-creation (Desai, 2009; Domegan et al., 2013) Value creation (Russell-Bennett et al., 2009) Zainuddin et al., 2011; 2013)	Value creation (Vargo and Lusch, 2004; 2008a; Grönroos, 2012; Sheth and Parvatiyar, 2002)	Value creation
Competition	The principle of competition and profitability inappropriate in health promotion (Buchanan et al., 1994) The focus on the internal barriers to change (Gordon, Carrigan and Hastings, 2011)	Critical social marketing (Gordon, 2012)	Networks and collaboration (Gummesson, 2008); actor-to-actor mode (Lusch, Vargo and Tanniru 2010)	Competition, networks and collaboration
Segmentation	Focus on ‘easy to reach’, limited	Russell-Bennett et al., 2009)	Relationship and dialogue focus	Segmentation,

Social marketing benchmark	Criticism	Revision to date	SDL principle	Benchmark revised
and targeting	participation of vulnerable populations (Brenkert, 2002; Crawshaw, 2012) Risk of increasing inequality (Newton et al., 2013; Stead, Hastings and McDermott, 2007) Targeting individuals with pre-packed messages (Brenkert, 2002)	– segmentation based on value types	(Ballantyne and Varey 2006 Grönroos, 2007; Gummesson 2008), customisation (Prahalad and Ramaswamy, 2004); customers as operant resources (Vargo and Lush, 2004)	relationships and customisation
Marketing mix	Managerial orientation (Constantinides, 2006); Focus on short term and transactions, neglect of long term relational thinking (Gummesson, 2008). Difficult to apply in a social change context (NSMC, 2009) Emphasis on promotion –manipulation (Brenkert, 2002; Stead et al. 2007)	Change of vocabulary (Peattie and Peattie, 2003) Relationship marketing: Partnerships (Hastings, 2003) Policy (Stead et al 2007) A framework acknowledging the context (Gordon, 2013) Tapp and Spotswood (2013) build on Michie et al (2011) to propose the COM-SM framework (capability, opportunity, motivation)	Service and co-creation approach (Vargo & Lush, 2008a)	Service centred approach