THE ADOPTION AND INSTITUTIONALISATION OF SOCIAL INNOVATION IN THE MALAWIAN HEALTH SYSTEM: THE INFLUENCE OF SOFTWARE FACTORS

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DECLARATION

I, Lindi van Niekerk, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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ABSTRACT

Background:

Universal Health Coverage (UCH) is embedded as a core goal of the Sustainable Development Goals (SDGs). Achieving these goals in Africa requires innovative and creative solutions that are owned at a country level and are responsive to the contextual and cultural realities. The prevailing paradigm through which health programmes and policies are developed is through expert-driven, top-down approaches in which participation of a broader range of actors from across sectors and governance levels, especially engagement of the communities, while encouraged, remains limited. This approach aligns with a mechanistic and economic-reductionist perspective of health systems and fails to account for the system software (human) dimensions, such as ideas, values, relationships and power dynamics. Social innovation has gained attention as an alternative approach to addressing complex systemic challenges – namely, as a 'complex process of introducing a new program, policy, procedure, process and or design that seeks to address a systemic health challenge and intends to ultimately to shift resource and authority flows, social routines and cultural values of the system that created the problem in the first place. Implementing social innovation can be conceived as an evolving process with the potential to bring about institutional change within systems – provided it is institutionally embedded. Despite the presence of a growing number of social innovations in low and middle-income countries (LMIC), evidence on social innovation in health systems is limited. This thesis examines whether social innovation has a contribution to make to LMIC health systems and how a social innovation initiative can be embedded into the public health system in a low-income country such as Malawi.

Methods

The purpose of this study was to explore the adoption and institutionalisation process of a primary care social innovation in the context of Malawi and to identify the software factors influencing these processes. The research was undertaken as an interdisciplinary qualitative inquiry, situated within the realm of health policy and systems research (HPSR). It was conducted in 2017 - 2020. Two methodologies used were: a semi-systematic narrative scoping review and a case study. The scoping review was comprised of peer-reviewed publications in English over a 10-year time period (2010-2020) and focused on social innovation as applied health or healthcare, from different disciplinary perspectives. The case study was selected, that of 'Chipatala Cha Pa Foni's (*health centre by phone*) adoption and institutionalisation process as part of the public health system of Malawi'. A conceptual social innovation framework, integrating micro-, meso- and macro-level insights from institutional theory, positive organisational scholarship and positive psychology was used to guide the thinking and development of the data collection and analysis. Data were obtained from interviews, observations and document reviews and data collection occurred over 18-months. A total of 54 participants were interviewed from the Ministry of

Health, the implementing NGO, community leadership, and other health implementers. Data was triangulated and thematically analysed, drawing on the conceptual framework, through deductive and inductive approaches.

Results

Existing social innovation studies held several limitations. First, social innovation studies did not report research methods frequently or in detail, hence making it challenging to assess the quality of evidence. Second, the majority of studies explored social innovation in healthcare from a technocratic paradigm, neglected the institutional paradigm. Social innovation shows alignment with the principles of people-centred health systems, through fostering cross-disciplinary and multistakeholder action.

In the case study conducted in Malawi, it was found that a small group of institutional entrepreneurs lead the adoption efforts. This group was extended to include more cross-sectoral and cross-hierarchical actors in support of the institutionalisation process. Five critical software factors emerged as key in supporting adoption and institutionalisation namely: i) cross-boundary relational construction; ii) shared experiences; iii) positive emotions; iv) everyday innovation; and v) contradictory institutional logics influencing national ownership (Malawian collectivist and national identity logics, versus development or Western individualist logics).

Multiple positive practices supported each of these software factors in the context of Malawi such as respectful engagement, mutuality, experiential educating, facilitated shared space, shared leadership, hope, advocacy, symbolic work and creative embedding. A collectivist logic, underpinned by history, culture and national identity, had an important influence as to whether national ownership of this initiative was attained.

Conclusion

Beyond the value of social innovation offers as practical solutions in support of the achievement of Universal Health Coverage, the process of social innovation may hold even greater potential. Social innovation as a process challenges the prevailing instrumental notion of health systems by moving the dial towards more responsive and participatory governance, while simultaneously giving attention to new and dormant resources within the health system. Adopting a logic-attuned implementation approach and utilising positive practices can strengthen national ownership of social innovation and support in achieving its outcomes. Social innovation's potential to support the institutional strengthening of the technical but also human dimensions of health systems merits further inquiry.

ACKNOWLEDGEMENTS

A PhD holds true to the sentiment that it is about the journey, and not the destination. Little did I understand what this journey will bring when I embarked upon it back in 2016. I started this journey based on what can only be explained as hope or faith in that which is yet to be seen, and this provided me with the motivation to continue, even when it felt like traversing a desert at times. Arriving at the end of a journey always calls for reflection and gratitude for all that I was privileged to experience and to those special individuals who walked the road with me.

Acknowledgment has to start with the people in Malawi who placed trust in me and this project - Prof Don Mathanga, Barwani Msiska, and Dr Vincent Jumbe at the University of Malawi; the team from VillageReach in particular, Upile Kachila and Lucky Gondwe who spent hours with me; all the representatives of the Malawi Ministry of Health, who gave generously of their time to be interviewed despite so many competing demands; and Chief Kwaitane, who offered to give me a little piece of land in his village. To all the amazing friends I made during my visits to Malawi – Gay, my Malawi mother provided me with a haven of a home; Austin and his family, who prayed for me and blessed me throughout my time in the country; and Flor and Innocent, who gave me an even deeper insight into the country. Malawi is a country of great generosity, kindness, and acceptance. I am forever changed by all I learned from each Malawian I met.

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My sister played a special part during this journey and sharing it by living with her for a part of it provided me with many delicious home-cooked meals. She is also the designer of all the graphics within this thesis that deserves acknowledgment. My crazy way of living across different places around the globe has not always made sense to my parents but I am very grateful for their support in providing a home for me while I was living in London as well as the amazing example they are of passionate, determined and socially conscious people.

Lastly, what I have gained in personal life experiences and lessons facilitated by doing this PhD, may hopefully set me up for writing a book that will attract a broader audience. I have a lot of stories to share. The final stage of the PhD allowed me to embark on the greatest life experiment yet. I packed two suitcases and came to California, with the same heart-directed guidance, as which the PhD was embarked upon. Thousands of miles across the state led to exploring the beauty of nature I only dreamed about before. Parts of this thesis were written from my little orange tent overlooking the Pacific Ocean on the Big Sur Coast, from a bench next to Whiskeytown lake in Northern California, and from many homes, Californians generously trusted me to look after. I have discovered that there are no better PhD writing companions than the many dogs and cats I looked after during this time, in particular, my best dog friends Rickey and Levi in Los Angeles and Hans, my favourite desk-sitting cat companion in San Diego. A final mention must be Harry, the most life-loving surf coach one could ever want. There is nothing quite as invigorating as finally catching the wave and riding it all the shore – in more ways than one!

PREFACE: Motivation for pursuing a PhD

For the past 10 years, I have been working in social innovation. I did not embark on this career focus by conscious choice, rather I was led down this path by necessity. I started my career as a medical doctor, but soon after starting clinical practice I realised the shortcoming of my prescription. In 2008 – 2010, I turned to social innovation as a means of dealing with the strain of trying to provide care to patients, especially patients with chronic organ failure, in the context of a struggling health system. As a young medical doctor, I applied the principles of social innovation to design the first hospital-based palliative care programme in a public hospital in Cape Town, South Africa. Despite the scepticism of my colleagues at the first presentation of the idea, my rather unrelenting passion succeeded in convincing the hospital leadership to implement and test the idea. The programme had a measurable impact on reducing patient hospital admissions, it led to an increased number of patient deaths in their preferred place of death (home) and it enhanced family and patient satisfaction of the care experience. The most remarkable to me was the programme's effect on the hospital and staff culture. This little 'innovative' programme seemed to fill my colleagues with a sense of renewed hope that our individual efforts as frontline health workers, could indeed affect a positive change in the health system. Now more than 12 years later, this programme has been scaled up to other hospitals in Cape Town and become a core foundation in the provincial policy on palliative care.

From 2011 – 2016, my interest shifted beyond developing my own initiatives, to rather supporting the development of the ecosystem for social innovation in Cape Town. This was done with a goal I had of providing other frontline health workers with a similar opportunity to turn their ideas into a reality. While working at the University of Cape Town Graduate School of Business Bertha Centre for Social Innovation and Entrepreneurship, my team and I did several projects – a national social innovation conference, inclusively uniting diverse cross-sectoral actors across hierarchical levels; the implementation of the first public sector health innovation lab, incubating the ideas of frontline workers; and a body of research to identify existing social innovations in health in South Africa. This work grew to a global level through the support received from TDR, the Special Programme for Research and Training in Tropical Diseases (World Health Organization) and I was one of the co-founders of the Social Innovation in Health Initiative (www.socialinnovationinhealth.org). I designed and led the initiative's multi-partner research to identify and study 25 social innovations in health models across 17 countries in Africa, Asia, and Latin America [2, 3]. Together with TDR, we took further efforts to advocate for social innovation at WHO, global health funders and Ministries of Health.

Throughout my PhD journey (2016 – 2021), I continued working in a consulting capacity to build and support the ecosystem for social innovation at a country level in Malawi, Uganda, the Philippines, and Colombia. I

oversaw the establishment of university-based social innovation research hubs in each country and delivered technical and research capacity building support to each institutional team [4]. This work awarded me the privilege to continue gaining more first-hand experience with social innovations in these countries, while simultaneously engaging with the respective Ministries of Health. Time and again, I was asked by decision-makers in the Ministry of Health, how it could be possible for them to integrate social innovations as part of the existing health system.

It is based on my deep respect for the decision-makers, frontline health workers and social innovators I met over the years; coupled with my deep love for Africa as a continent of possibility, that I embarked on this PhD research. Chipatala Cha Pa Foni, a social innovation that has received support from the Malawi Ministry of Health, made for an ideal opportunity to find some answers that could support advancing our collective understanding of how social innovation could be embedded in health systems. Now more than ever, as health systems around the world are struggling under the pressures of the Covid-19 pandemic, Malawi can an exemplar to other countries, on how socially innovative solutions developed by citizens and non-traditional actors, can support and strengthen the existing system. My hope is that the findings of this thesis can further the knowledge on social innovation in health systems, in support of achieving health and wholeness for people who live in low- and middle-income nations.

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List of Acronyms

ADC – Area Development Committee
CCPF – Chipatala Cha Pa Foni
CHAG – Community Health Action Groups
CHAM – Christian Health Medical Association
CMED – Central Monitoring and Evaluation Division
DHMT – District Health Management Team
EHP – Essential Health Package
HIC – High-income countries
HPSR – Health Policy and Systems Research
HSA – Health Surveillance Assistant
LMICs – Low- and Middle-income countries
MDGs – Millennium Development Goals
MoHP – Malawi Ministry of Health and Population
MoLGD – Ministry of Local Government and Development
MoU – Memorandum of Understanding
NGO – Non-governmental organisation
POS – Positive Organisational Scholarship
SCM – Steering Committee Meeting
SDG – Sustainable Development Goals
SLA – Service Level Agreements
UCH – Universal Health Coverage
VDC – Village Development Committee

1 CHAPTER 1 – INTRODUCTION

1.1 The role of the socio-cultural health systems perspective in UHC achievement

Health plays a central role in the achievement of all Sustainable Development Goals (SDGs) [5]. The attainment of Universal Health Coverage (UHC) (SDG target 3.8) will support the achievement of other health-related goals. However, even before the Covid-19 pandemic, more than half (53%) of Africans didn't have access to the needed medicines or medical treatment, and people in rural areas were twice less likely to have accessible care, as compared to urban residents [6]. In sub-Saharan Africa, one in six people live more than two hours away from a public hospital and one in eight people live one hour away from the nearest health centre [7]. As stated by Olu et al [8]: "attaining UHC requires innovative approaches to achieve the outcomes of all health services, for all people, in all situations, for which the current approaches to health care in Africa is not designed". The Lancet Commission on the future of health in sub-Saharan Africa also emphasised the need for African home-grown innovative solutions embedded with the realities of different country contexts and communities [9].

The shortcomings of adopting innovations developed through reductionist and linear approaches, those purely focused on technical health aspects and those failing to acknowledge the socio-political contexts, have been well described [10]. To achieve the vision of UCH through contextualised African innovative approaches, a nurturing and incubating health systems environment is required, one that is inclusive of all actors, in particular non-state actors and communities, and one sensitive to normative and sociocultural dimensions. In recent times, the theoretical perspective seeking to explain what health systems are and how they work has evolved from a mechanistic and economic-reductionist perspective, represented by routinisation, structuralism compliance, hierarchy, bureaucracy, tracing how inputs translate into outputs and efficiency [11] to one that recognises health systems in terms of its human-dimensions and as socio-cultural institutions [11-15]. This latter perspective recognises the software factors inherent in health systems, and also the influence of software on overall health system performance [13]. Software factors can be intangible and tangible. Tangible software factors include management knowledge, skills and processes [16]. Intangible software factors include norms, beliefs, ideas, and values held by people. These factors also include the power dynamics and trust within social relationships as well as the actor's agency [13, 16-20]. Although significant emphasis has been given to ensure health systems have sufficient material resources in support of resilience, software factors such as health worker motivation, healthy organisational culture and well-balanced power dynamics among system actors can play a critical role in cultivating strong and resilient health systems [19, 21].

The evidence focusing on health systems as social institutions in the context of low- and middle-income countries is limited [15], and, in practice, as described further below, it has not yet translated sufficiently into the day-to-day work of health systems strengthening for UHC.

The SDG Goal 17 calls for cooperation, collaboration and partnership between governments, civil society and business [5]. Unfortunately, inclusive participation and attention to the relationship between government health systems and actors remain suboptimal. Despite significant investments made in strengthening government capacity, it is clear that in many resource-constrained African contexts, the government cannot be the sole responsible for achieving all the envisioned public health goals. Partnerships with non-state actors have therefore been promoted in support of financing and extending primary service delivery [22-24]. Governments have tried to engage with this heterogeneous group of non-state actors, which include non-governmental and faith-based organisations, private for-profit organisations, traditional leaders, informal providers and development funders, in a variety of ways, including, among others, public-private partnerships, social marketing and contracting out [24]. While these partnerships have resulted in benefits for African health systems, they have also challenged these systems due to the complexity, inadequate capacity, and power asymmetry in these engagements. Scholars have highlighted the importance of strong regulatory governance and accountability arrangements to ensure UHC outcomes are achieved [23, 25, 26]. However, a smaller subset of scholars has started referring to a greater need to focus on the software and institutional components that support cultivating partnerships that are mutually beneficial for all parties concerned. These components include the nature of the relationship between government and non-state actors and additional factors such as the presence of high levels of trust, appreciation, respect for local values, effective dialogue, and shared decision making [23, 27, 28].

Similarly, on the heels of the Astana Declaration on Primary Health Care [29], there has been a renewed motivation not only for new partnerships with non-state actors but also to give greater opportunity to communities in support of the achievement of UHC. Allotey et al. [30], make the case for community participation and engagement 'as a key towards making the universality of health care possible', especially for marginalized and excluded groups. However, community engagement and true participation remain limited. A systematic review of 260 health systems research studies found that only 4 studies illustrated community involvement across the full continuum (design, implementation, management, and monitoring of interventions.

The 2016 Integrated People-Centred Health Services Strategy further emphasised the importance of engagement and empowerment of all health service users, citizens and community members [31]. Yet, despite positive concepts used in global policies and international guidelines [29] such as - 'the participation of individuals, citizens and communities in the development and implementation of policies and plans' and 'voice their needs and so influence the way care is funded, planned and provided'; this, in reality, remains mostly a top-down prescription where at best, care is 'co-produced' under the guidance of an external expert but not fully owned and led by communities. True co-production would instead recognise people as assets, build on people's existing strengths, display reciprocal relations with mutual responsibilities, engage with networks inside and outside of services, remove tightly defined role boundaries and shift from delivering services to capacitating them to happen [32]. As emphasised by Odugleh-Kolve et al [33], not only is it a fundamental responsibility for health systems to strengthen their dynamic interrelationship with patients, communities and stakeholders but also that community engagement will be more effective if it gives recognition to the emotional, mental and social interconnection of people. Community and citizen engagement is thus very much inherent in strengthening the human aspect of health systems to achieve UHC [33].

A different approach to health systems strengthening is required to achieve quality, broadened participation in healthcare and ultimately UCH. It requires a shift from following a top-down, selective, and expert-driven approach to one that allows for more a co-creative, collaborative, and participatory approach, inclusive of both non-state and community actors. This has been emphasised in the context of policy literature [34] but is also applicable to systems strengthening approaches. Elmore [35] mentions the influencing behaviours of actors who are the closest to the problem as well as the importance of organisational factors such as developing competence and trust within organisations to strengthen implementation. Hjern [36] explores the importance of implementation structures that cross organisational and hierarchical borders to form collaborative networks to support implementation at an operational level, especially across public and private actors. Lastly, DeLeon [37] advocates for a more democratised approach, one that goes beyond the passive representative citizen numbers to one where citizens are actively engaged in recommending actions. Health systems strengthening thus requires more collaborative and participatory action by a range of non-state actors, including citizens.

To realise the achievement of UHC in Africa, an opportunity space needs to be created for more mutually enhancing relationships across all hierarchies of health systems to support the creation of new contextually embedded innovative solutions. In addition, greater attention and appreciation of health system software factors will support that these innovative initiatives to achieve sustained collaboration and action. In so doing, it will

enable the democratised development and implementation of policies that achieve health outcomes for all people.

1.2 Social innovation in support of institutional and systems change

Social innovation has been presented with promise, in both academic and policy discourse, as an alternate and complementary approach to achieve systems transformation, especially in systems plagued with complex challenges, convoluted overlaps in authority and multiple players operating at different scales [38]. This section serves as a summary of social innovation as presented in greater detail in Chapters 3, 4 and 6.

The literature presents social innovation as a multi-dimensional concept that has been studied from different theoretical streams and viewed through different paradigmatic lenses. Social innovation, like health systems, can be approached through a technocratic or an institutional paradigm (see Chapter 3). The technocratic paradigm is more concerned with the development of creative solutions to support the achievement of greater effectiveness and efficiency; while the latter is focused on socio-political transformations [39] that would catalyse disruption of institutional structures in support of systems transformation [1, 40]. It is particularly this institutional paradigm of social innovation drawing on institutional theory, from sociology and organizational studies, that could hold potential in addressing complex systemic challenges hindering the achieving of Universal Health Coverage. Institutional theory aids in explaining how locally-embedded innovations and patterns of interaction (within communities and organisations) can cascade upwards, leading to structural and institutional transformations [41] (see Chapter 4). Nilsson describes five institutional dimensions in which social innovation causes transformation (see Chapter 6): (1) roles (who does what); (2) social identities (who belongs to what); (3) resource flows (who gets what); (4) authority processes (who decides what); and (5) meanings (who signifies what) [42].

Social innovation could be summed up as an "agentic, relational, situated, and multi-level process to develop, promote, and implement novel solutions to social problems in ways that are directed toward producing a profound change in institutional contexts" [43]. Social innovation occurs through connections between the micro-, meso-, and macro-levels and changes in individual-level institutionalised frames, in turn, lead to larger-scale changes in the predominant institutional frames at the organisation and systems-level [44].

To explain this process further: at the micro-level, the social innovation process is operationalised by placing actors irrespective of background, discipline, or hierarchical level right at the centre of the creation and implementation process. Battilana [45] describes the 'paradox of institutional agency' in which actors who are

traditionally constrained by the institutional context in which they operate, have the agency and ability to bring about systems and institutional change. These actors operate as boundary spanners, brokers, or network orchestrators to foster new collaborations and partnerships across organisational and sectoral silos in support of new ideas [46-48].

At a meso or organisational level, these actors engage in what is known as 'institutional work': 'the purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions' [49]. Thus, social innovation's ability to harness agency and shift power dynamics opens the space of enhanced relationships, participation, and agency of a range of non-traditional or unlikely system actors. These actors then subsequently unlock new or dormant material or immaterial resources (such as human capital and positive emotions). By challenging and changing the cultural-cognitive institutional frames, macro-level normative changes are achieved that result in greater equity, fairness, and justness. (See Figure 1-1 below for a schematic representation [50]). This paradigm of social innovation also aligns with the socio-cultural perspective of health systems recognising the role of actors, relationships, values, and cultural-cognitive factors.

Scholars have also drawn on the adaptive cycle framework by Hollings [51] to explain how social innovation generates resilience within the macro-level of systems. The social innovation process that embraces collective learning and collective power results in benefits beyond that of the individual social innovation initiative. The process itself has the potential to strengthen the system's capacity for ongoing creativity and reflexivity, and in so doing also enhances resilience [1, 52-55].

However, for social innovation initiatives to achieve sustained systems-strengthening benefits and large scale transformative change, evidence suggests that the initiatives must be institutionally embedded (instantiated and reproduced) or institutionalised at different scales (levels) across the system: at a micro level, the idea is accepted by individuals or groups; at a meso-level, the innovation is incorporated into organizational structures; and at a macro-level, systems-level change become accepted as part of the taken for granted structures [43, 56].

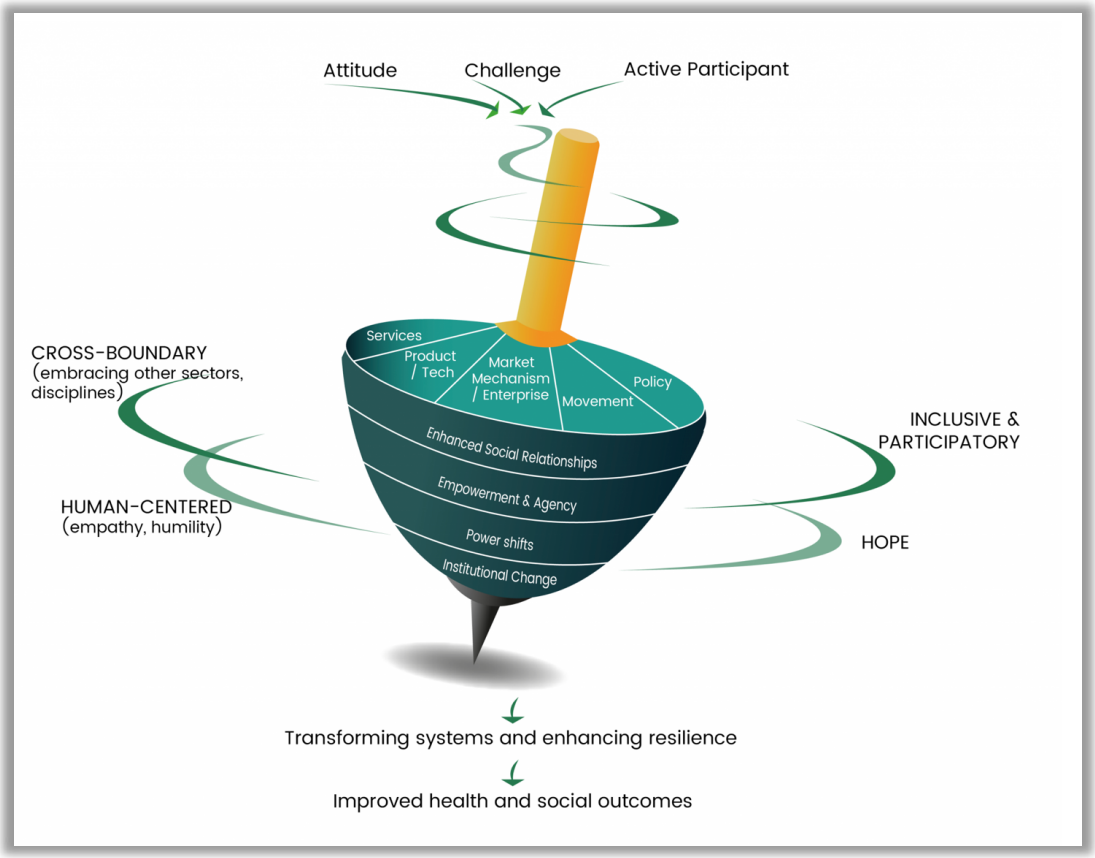


Figure 1-1: *Social innovation conceptual representation* [50]

1.3 Gap and opportunity for research on social innovation in health systems

There has been a burgeoning of research in social innovation in the past 15 years due to scholarly and policy interest [57]. A systematic review by van der Have et al. [58], to determine and describe the current evidence base (1986 - 2013), found 172 unique publications about the distinct concept of 'social innovation'; drawing on four scholarly communities: (1) creativity research, (2) social and societal challenges, (3) local development, and (4) community psychology. A second systematic review by Do Adro et al [59] found a total of 331 publications between 1970 – 2018 with a sharp increase in the number of publications between 2013 – 2018.

A prior review by Rana et al [60] on social innovation research studies found 185 articles related to social innovation (undefined time period) from disciplines such as business economics, ecology, psychology, public administration and sociology. The largest proportion of social innovation research was conceptual in nature but some of the most frequently used empiric methodologies included case study research, surveys, and secondary data analysis. Experimental designs were only used in two studies. The vast majority of social innovation

research was undertaken by high-income countries (most commonly, the United States, England and Canada), with only 4 publications found from South Africa, Zimbabwe and Tanzania) [60].

Neither the review by van der Have nor the review by Rana reported any studies pertaining to social innovation in health, and there is a clear gap in the evidence arising from and authored by low-and middle-income countries (LMICs). (Chapter 3 will present a more thorough review of available literature on social innovation in health from across all disciplines, globally and in so doing emphasises the gap and opportunity for more research).

Further research is thus required that would fill the academic and pragmatic gap in understanding social innovation from an LMICs perspective and to inform how this concept could be relevant to the global goals, such as UCH in healthcare. A research study was designed and conducted with the following academic questions in mind: how can social innovation be understood conceptually and applied within healthcare? From an LMIC perspective, what is the role of health system actors and the influence of the country context on social innovation? How can social innovation be institutionalised within health systems and what software factors influence this process? The study also had the pragmatic intention of providing practical guidance to health implementers (social innovators) and government actors on how social innovations, developed externally, could be institutionally embedded as part of the government health system, and what practices can be used in support of this.

This study was informed by reviewing relevant literature in a systematic way as well as by primary data collection from a single country case study, considering the adoption and institutionalisation of Chipatala Cha Pa Foni (Health centre by phone) as part of the national government health system of Malawi. For this study the following social innovation definition was adopted:

> *cultural values of the system that created the problem in the first place. [1]*

1.4 Research Question, Aim and Objectives

1.4.1 Question

Can public health systems in low-income countries, such as Malawi, adopt and institutionalise social innovation and if so, what are the software factors influencing the achievement of this objective?

1.4.2 Research Aim

The purpose of this study was to explore the software factors influencing the adoption and institutionalisation process of a social innovation addressing primary health care services within the Malawian public health system, and from this experience, develop potential recommendations for health systems wanting to engage with social innovation in LMIC African settings.

1.4.3 Research Objectives

Five key objectives were defined for this study:

Objective 1: Critically review the literature on social innovation as applied to healthcare and identify current limitations in its application.

Objective 2: Describe the role of actors in the adoption and institutionalisation of social innovation and identify factors that enable actors' agency and action (the micro-level).

Objective 3: Identify institutional work practices that facilitate the adoption and institutionalisation of social innovation as part of the public health system (the meso or organisational level).

Objective 4: Analyse the influencing role of institutional logics on the adoption and institutionalisation of social innovation as part of the public health system (the macro-level institutional context).

Objective 5: Generate potential recommendations, based on the Malawi experience, for supporting the adoption and institutionalisation of social innovations in health as part of the national health systems in other LMICs settings.

1.5 Thesis structure

Chapter 2 provides an overview of the methodological approach taken in conducting this study. To achieve the overarching aim and to address each of the various research objectives, a qualitative inquiry was undertaken. This consisted of a scoping narrative review and a longitudinal case study design of a single social innovation initiative within a specific geographic context (Malawi). Data were collected using methods such as document reviews, semi-structured interviews and observations and it was collected in three cycles (a total of 12 weeks of fieldwork) over an engagement period of 1-year (June 2018 – July 2019). A thematic analysis, using deductive and inductive approaches was conducted.

Chapter 3 provides the reader with a deeper understanding of social innovation and its application in healthcare. In addition to the results from the scoping review, it provides an overview of the history of social innovation and the components inherent in social innovation definitions. This chapter assisted in identifying the opportunity to study social innovation from an institutional paradigm as a way of contributing to health systems strengthening, as well as to fill the evidence gap in studies on this topic from a low- and middle-income country context. The scoping review was published on 8 March 2021 in the Journal of Infectious Diseases of Poverty titled "The application of social innovation in healthcare: a scoping review"[61].

Chapter 4 provides the reader with a deeper understanding of the theoretical underpinning of this study. It provides a justification for choosing neo-institutional theory and informing this with theory from positive organizational scholarship and psychology. This chapter presents the study conceptual framework in the light of the relevant theoretical basis for this study.

Chapter 5 described the nuances and influencing factors in the contextual setting of Malawi, the location of the case study. It provides an overview of key country and health system indicators, a discussion of the political history and political culture, the role of traditional leadership, the structure of the healthcare health system and the various influences on the government management culture. This chapter informs Chapter 9.

Chapter 6 is the first results chapter, providing a rich description of the case study under investigation – the adoption and institutionalisation of Chipatala Cha Pa Foni (CCPF) as part of the government health system of Malawi. It examines the development and evolution of the social innovation initiative over time, and an overview of the actions and organisations involved, to serve as a background to the findings presented in Chapters 6, 7 and 9. It also provides the rationale as to why CCPF can indeed be considered a social innovation, viewed through the lens of institutional work.

Chapter 7 is the second results chapter. It explores the software factors affecting adoption and institutionalisation at the micro-level. The analysis focuses on identifying and describing actors who operated as institutional entrepreneurs. It further presents the findings of the analysis in terms of the types of institutional work the actors engaged in to embed the initiative as part of the government health system.

Chapter 8 is the third results chapter. It explores the software factors affecting adoption and institutionalisation at the meso or organisational level. It presents the various positive institutional work practices utilised at group-level, as identified in the analysis. The chapter further provides insight as to the role of selected positive emotions and how these could have value in supporting the institutionalisation process.

Chapter 9 is the last results chapter. It explores the macro-level contextual influences. It shares the findings of the contextual factors influencing innovation institutionalisation in general in Malawi and discusses the role of relevant institutional logics and contradictions in logics on the process of adoption and institutionalisation.

Chapter 10 concludes a presentation of the main findings by objective. It also presents a proposed explanation of how various software factors contribute at different stages of the adoption and institutionalisation process. The chapter also highlights the limitations of this study and identify areas for further research.

2 CHAPTER 2 – METHODS

2.1 Introduction

This chapter presents how this study was undertaken to achieve the set aim and objectives outlined in Chapter 1.

First, this chapter provides an overview of the approach, methodologies and research paradigm adopted. Second, it discusses the methods selected for each objective, the rationale for doing so and how each method was executed. Third, it gives detail about the data analyses approach and lastly, it discusses relevant considerations pertaining to trustworthiness and the ethical considerations in this study.

2.2 Research Design

2.2.1 Overview of the study

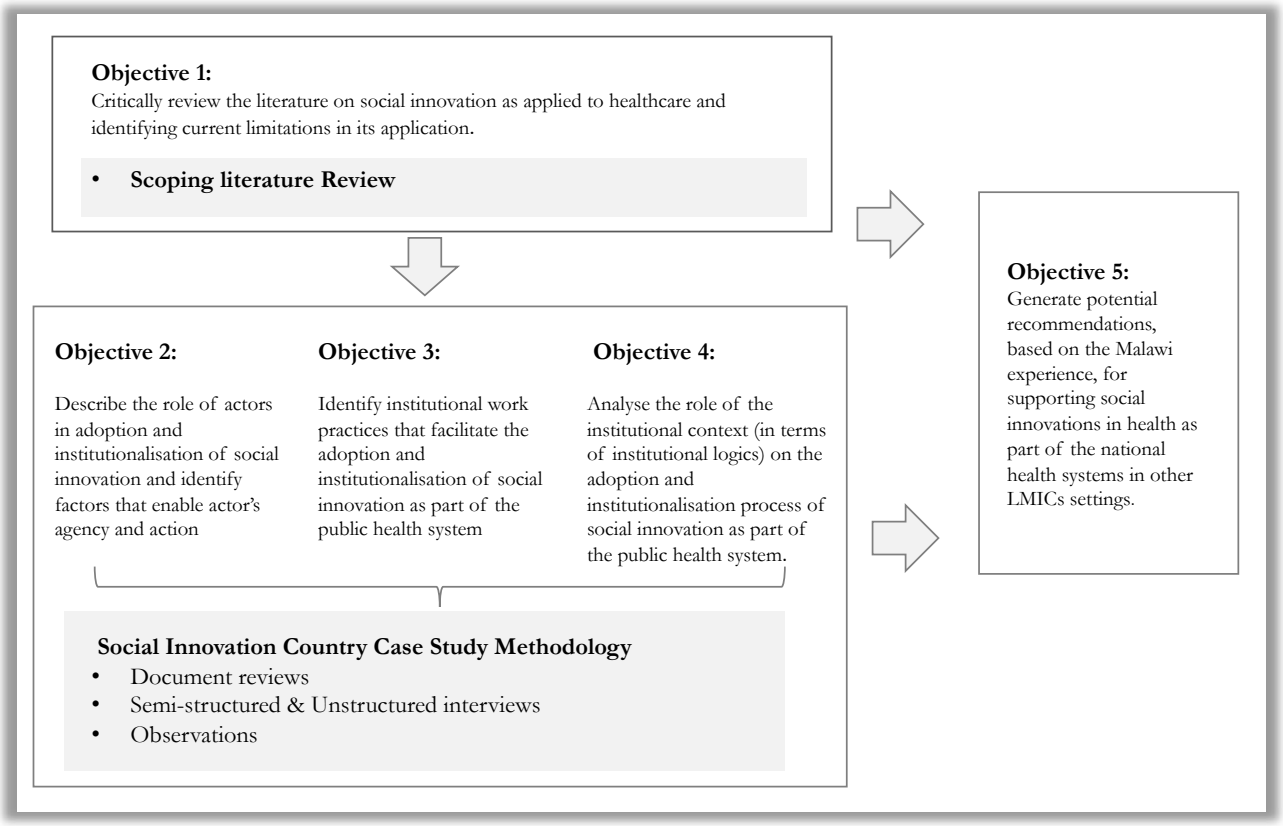


Figure 2-1: *Study research design*

2.2.2 Research Paradigm

This study was positioned with the field of health policy and systems research (HPSR), as it considered how the health system responds to adopt and institutionalise a social innovation in health by assessing the role of actors, their efforts and the context [62]. This study, rather than focusing on the hardware or instrumental dimensions of the health system, focused on the non-instrumental or software dimensions such as the ideas and interests, norms, values and the relationships between the actors [13](Chapter 1 & Chapter 4). Like health systems, social innovation is a complex phenomenon that required this research to account for its dynamic nature and the multiple contextual influences. This phenomenon was studied within the real-world context of Malawi, a low-income country setting.

Secondly, this study was an interdisciplinary study – going beyond the boundaries of a single disciplinary field to rather drawing upon several. Social innovations often emerge at the intersection of sectors and disciplinary boundaries, to solve social challenges that have a high degree of complexity. This is illustrated by the fact that existing social innovation research lacks a single disciplinary origin. Systematic reviews on social innovation have described disciplinary underpinnings from fields such as business, economics and management, environmental sciences and ecology, psychology, public administration, urban and regional studies, and sociology [58, 60]. In researching this phenomenon, it was thus required to approach it as an interdisciplinary study. Interdisciplinary studies go beyond merely consulting different disciplines to compare their perspectives as in multi-disciplinary studies, but instead, they seek to derive insights into a common problem or question by integrating different perspectives and constructing a more comprehensive understanding [63]. Moulaert and van Dyck [64], ascribed transdisciplinary research as appropriate for social innovation analysis. Transdisciplinary knowledge production goes one step further to integrate insights generated outside of scholarly communities, such as where participants in the research communities are involved in defining research questions and methods as well as being empowered in the process. Due to the time constraints of this study, it was not possible to include participants or lay people in its design and implementation. It remained an interdisciplinary study, drawing on different social science disciplinary areas such as public health, sociology (institutional and organisational studies) and psychology to inform the study framework such that it can aid in the gaining of a more comprehensive understanding of the question under investigation.

Thirdly, this study ascribed to a critical realism perspective. Critical realism (CR) is a relatively new paradigmatic position put forth by Roy Bhaskar [65-67]. It represents an alternative to the pure positivist and post-positivist positions but instead presents an integrated position [68]. A positivist position regards the inquirer and the object of inquiry as independent and distinct; it seeks to achieve causality and provide explanations that are free from contextual influences. By contrast, a constructivist paradigm holds a view that there is no independent reality

outside of constructions of the mind. A critical realist perspective holds a position that human knowledge only captures a small part of a deeper reality and thus the nature of reality (ontology) is not limited to our knowledge of reality (epistemology) [69, 70]. CR thus acknowledges the complexity that is inherent in social phenomena and social reality and provides an approach to examine this complexity. It subscribes to ontological realism and epistemological relativism in which it is accepted that there is a reality that exists independent of our thoughts and observations, yet the nature of reality is subject to the actor's interpretations. As such, events (actual level) are the result of mechanisms (real level) that are often invisible to the researcher at first, without deeper questioning [70, 71]. These mechanisms 'could be physical, social or psychological and may not be directly observable except in terms of their effects [72, 73]. The critical realist perspective is usually represented through the image of an iceberg (Figure 2-2 below) in which neither level is more or less real than the other, rather each level reveals a greater understanding of the same entity.

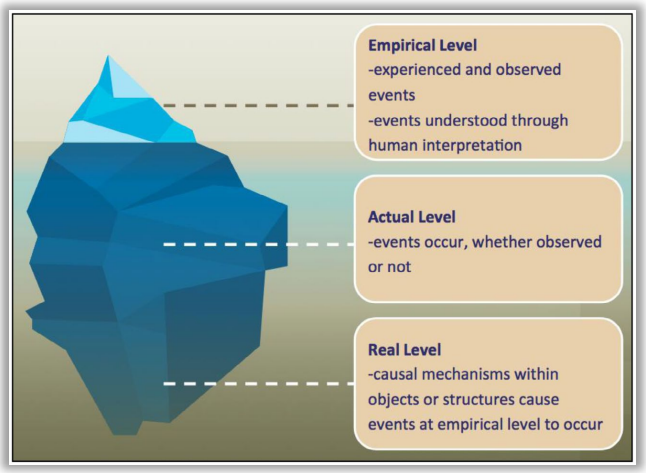


Figure 2-2: *An iceberg metaphor of CR ontology [69]*

Moulaert et al [64] commented how 'from the social innovation perspective, 'truth' is concerned with the (socially accepted) relevance of the scientific answers for the satisfaction on (non-revealed) needs, the transformation of social relations and the empowerment of communities.' Social innovation research ascribes to a critical realist perspective as it is about looking into the conditions, including the events and structures that make transformation of social systems possible [64]. From this perspective, structures can be viewed as institutionally mediated and reproduced through collective and individual action and interaction between agency and structures. HPSR also makes allowance for a critical realist paradigm in understanding the nature of reality and knowledge [74].

This study did not envision assessing causality via experimentation. It regarded all working hypotheses to be context- and time-bound, shaped by multiple interacting factors, events, and processes. Its aim was not to

achieve generalisability but instead, enable understanding of the patterns and mechanisms within the context that can support a degree of transferability [75]. This study does not intend to provide a set of generalisable recommendations on social innovation that will apply to all African low-income countries. However, the findings from this study could potentially provide working hypotheses on the topic relevant to other low-income country contexts, guiding further investigation.

2.2.3 Methods

2.2.3.1 Objective A: Scoping literature review

A scoping literature review was conducted to gain an understanding of existing academic research of social innovation in healthcare. Three questions were answered through this review:

- How is social innovation as a concept (a binary term) applied to health, healthcare or health services?
- What are the barriers or enabling factors supporting the design and implementation of social innovations in healthcare?
- What are the limitations of current literature relevant to social innovation in examining how it can contribute to health systems strengthening?

A narrative scoping review of peer-review literature, conducted in a semi-systematic manner, was selected as an appropriate method [76, 77]. This review format was chosen for several reasons. Firstly, social innovation has been studied in multiple academic fields, with each discipline using its own set of research methods. Secondly, the lack of theoretical conceptual clarity or consensus of the definition of social innovation as well as the breadth that the concept encompasses (either as an object, a process, or an outcome) has led to social innovation research being approached through different lenses or paradigms. Thus, only articles dealing with the distinct concept or binary term of 'social innovation' was included in this review to avoid having to make any independent judgements as to whether it was truly social innovation as per the chosen definition adopted in the primary research component of this study. The focus of this review was not to assess what social innovation is but rather how social innovation has been applied regarding healthcare.

Thirdly, although published articles in social innovation have been growing rapidly in the past decade there remains a marked lack of evidence generated through empirical research. The majority of publications are found in social science journals, with each holding varying standards for reporting on the research methodology of these studies. Within the health sciences, rigorous reproducible evidence is held in high esteem especially if seeking to influence policy and decision-making. Narrative reviews acknowledge the need for transparent and

complete reporting of academic knowledge as per the PRISMA Statement (Preferred Reporting Items for Systematic Reviews and Meta-Analyses') [78] and this review thus followed some of the components for preferred reporting by only including articles with a clear methodological description and published in peer-review journals. Due to the small number of articles that would meet these criteria, it was not feasible to further assess the quality of evidence.

Search strategy

Online databases were searched between April – June 2020, including Academic Source Complete, CINAHL, Business Source Complete, Psych INFO, Pub Med and Global Health. Databases were selected for their disciplinary breadth. Search terms used are listed below:

((social innovation [subject heading]; OR "social innovate*" [abstract]; OR "social innovate*" [title]; OR social N1 innovat* [abstract] OR social N1 innovat* [title])

AND)

Health OR healthcare OR health care OR health system OR health services (abstract)

Eligibility Criteria

The inclusion of articles was according to the criteria in Table 2-1 below.

TABLE 2-1: SCOPING REVIEW CRITERIA

Inclusion Criteria	Rationale
Articles directly using the term 'social innovation' as a concept and that defined their understanding of the concept	Multiple definitions exist on social innovation and from different paradigm standpoints. To assess how it has been defined/ understood regarding health and which paradigm of social innovation is being applied to this field.
Articles to do with health (from any academic field)	Social innovation has been applied to several social development areas, but the interest of this study is on health. Thus, to focus on an aspect of health or healthcare to be addressed in the article, to which social innovation has been applied. Due to a limited number of articles the review is not limited to health literature only.
Articles that report primary or secondary research conducted with a clear methodology	This review only included empiric research studies which report a clear methodology to gain an understanding of the type of evidence generated, the methods used, and from where this research has originated.
10-year scope [2010 – 2020]	This review relates to the most recent applications of social innovation given the rapid development in the field.
English Full-text articles	The researcher can only read English. Limitation: more articles may exist published in Spanish and French. Some articles may not be available for access due to university library restrictions.

Analytical approach

Following the identification, review and selection of articles, a data charting table was developed to capture a descriptive summary of each included article [79]. Following that, an analytical framework was used, derived from the framework that Edwards-Schachter and Wallace [80] used to conceptualise core meanings in their systematic review of social innovation definitions.

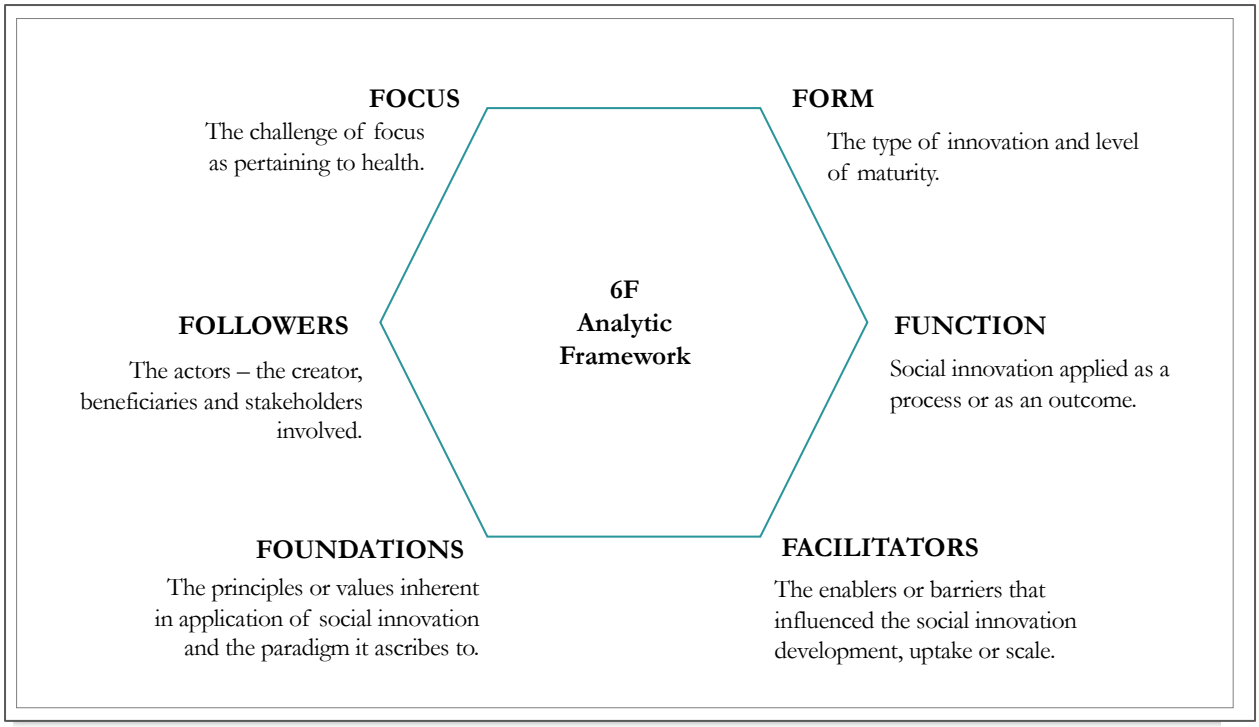


Figure 2-3: The *6F Analytical Framework*

This was one of the only prior reviews which described their analytic process. This framework focused on three areas, answering several questions about social innovation:

- Area 1 - Aims & purposes of the social innovation (why & what?)
- Area 2 – Actors involved in the social innovation (who?), the locus of the social innovation (where?), Sources from which it originated (which?), Organisations and governance (how?) involved in implementation.
- Area 3: Outcomes of the social innovation (what are the results?)

Building upon this framework and modifying it based on additional literature reviewed, the final analytical framework was derived (as per Figure 2-3 above).

The framework was used to deductively analyse the different aspects of each paper included in the review using NVivo 12. This process found the six areas of the framework to be useful in gaining a broad understanding of the literature.

The findings of this review were submitted to the Special Issue on Social Innovation of the Journal of Infectious Diseases of Poverty and published on 8 March 2021[61].

2.2.3.2 Objective B – E: Primary Research Methodology

Study Design

As mentioned before, this study draws on a body of work within Health Policy and Systems Research (HPSR) and it adopted a critical realism perspective to produce explanations or theories to explain the reasons behind the observed processes to/of why things happen [81]. Neither HPSR nor critical realism have a prescribed set of methodological approaches or methods but takes a pragmatic stance to fit the study design [62, 71].

For this study, a qualitative case study methodology was selected due to its exploratory and explanatory potential. 'Case studies are, methodologically, an example of researching 'open systems' where the phenomena can less be controlled, variables are not linear and they interact in changing ways over time' [82, 83]. Within the field of HPSR, case study research is a well-recognised and useful methodology [62]. Social innovation is an evolving process and highly context-bound and this makes case study methodology appropriate for this line of inquiry [64]. Case study methodology allowed for the use of different qualitative methods to provide rich descriptions [84], test theory [85, 86] or generate theory [87, 88]. In this study, the case phenomenon under investigation was the adoption and institutionalisation process of social innovation as part of the Malawi public health system.

Case Selection

To select the case for investigation, a range of selection criteria were developed (see Table 2-2 below). This was then applied to the database of social innovations held by the Special Programme for Research and Training in Tropical Disease, hosted at the World Health Organisation (TDR, WHO) to identify potential cases. Each of the +/- 30 cases from the TDR, WHO social innovation case cohort was reviewed against the case selection criterion. In the final selection stage, two cases met each of the six criteria listed below: *Chipatala Cha Pa Foni* (CCPF) in Malawi and *One Family Health* (OFH) in Rwanda. Both these social innovations were initiated in response to the challenges posed by extended geographic distances limiting access to primary healthcare services. Following the approach of theoretical sampling, the final case was selected based on the ability 'to collect data from places, people, and events that will maximise opportunities to develop concepts in terms of their properties, and dimensions, uncover variations and identify relationships between concepts [89].

Initially, the study was proposed to be conducted in both Malawi and Rwanda. In October and November 2017, a scoping visit was conducted to both countries to conduct a preliminary discussion with each of the identified social innovation initiatives and explore whether they would be willing to engage in this research. Unfortunately, due to PhD time restrictions and the long time required to gain ethical approval in two countries, the decision was made to pursue only the study in Malawi.

Malawi presented a favourable research context due to strong existing linkages with the researchers at the University of Malawi College of Medicine's Social Innovation in Health Initiative, willingness from the case study organisation to engage, a favourable response by the Ministry of Health, and an existing project with ethics approval within which this study could be located as a sub-study.

TABLE 2-2: CASE SELECTION CRITERIA

	Criteria	Rationale
1.	A social innovation model that has been adopted or is in the process of being adopted by the National Ministry of Health	To allow for the examination of the institutional structures and actors' pathways to adoption and institutionalisation.
2.	Low-income African country with a drive to reform primary healthcare policy.	A context that has institutional weaknesses/ voids hindering the adequate delivery of primary health care but simultaneously regarding it as a national priority.
3.	A social innovation model focused on an aspect of primary healthcare.	Bound to a specific focus of health care delivery.
4.	A social innovation model developed by an actor outside of the formal health system.	Clearly distinguish from public sector innovation, as the focus is to study how initiatives from outside the health system become adopted as part of the public health system.
5.	A social innovation model implemented for at least 3-years and is in at least 3 districts.	Adequate implementation and adoption journey such that the process can be studied over time.
6.	A social innovation initiative and the Ministry of Health that is willing to engage in and support this research.	A key practical consideration is required for the successful execution of this study.

In summary, the selected social innovation case was that of a primary care health information initiative (*Chipatala Cha Pa Foni*) accessed by rural populations via mobile phones and run by qualified nurses. The idea was put forward by a Malawian citizen as part of an innovation contest in 2010, run by Concern Worldwide. It was subsequently piloted (2011-2013) by an international non-profit non-governmental organisation (NGO) operating in Malawi. Subsequently, the NGO commenced efforts to scale the initiative to a national level (2014 – 2019) in partnership with the Malawi Ministry of Health and Population (MoHP). In 2017, the initiative was

formally adopted by the MoHP, and this started a two-year process to institutionalise the initiative as part of the government health system. The date set for the completion of the institutionalisation process was July 2019.

Table 2-3 provides an overview of the selected case study and Figure 2-4 presents an overview of the timeline of evolution. (Chapter 6 presents a more detailed description and timeline of the CCPF initiative).

TABLE 2-3: SOCIAL INNOVATION CASE OVERVIEW - Chipatala Cha Pa Foni (Health centre by phone), MALAWI	
Characteristics	**Description**
Challenge that the social innovation intends to solve	Address issues associated with access to care e.g., geographical distances & lack of appropriate, quality, and timely health information (initially, for maternal and childcare)
Creators	Soyapi Mumba & Clement Mwazambuba (Malawian) – 'Save a life, share an idea' innovation contest
Implementing organisation	VillageReach Malawi
Start date	2011
Solution components	Nurse-run, toll-free mobile phone hotline providing health and referral advice Interactive voice messages providing health education
Main beneficiaries	Initially, pregnant women, later extended to low-income rural men, women, and children
Scope	9-districts in Malawi initially focused on maternal and neonatal health issues but later extended to all primary care health issues.
Engagement with MoHP	National scale-up by 2019 with full transition to MoHP for all operations
Community engagement	Implemented in partnership with communities Community uptake – traditional authorities' by-laws; invest in mobile phones; health messages transcribed on houses
Funding	Grant funding (USAID, GIZ, Johnson & Johnson, Concern Worldwide, Seattle International & Vitol Foundation
Partnerships	A public-private partnership between MoHP and Airtel (national mobile phone operator)

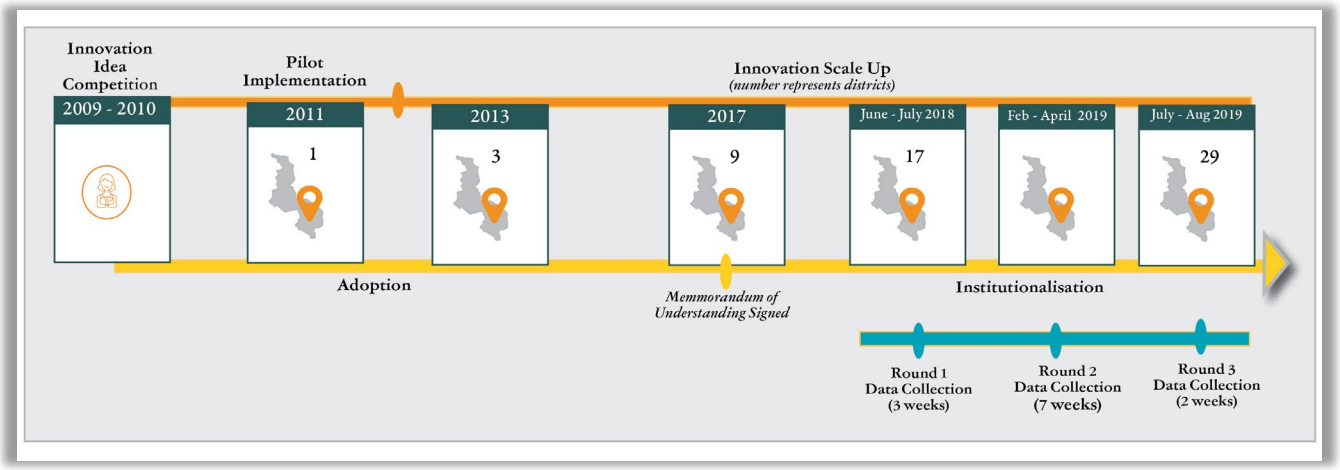


Figure 2-4: *Innovation key milestones and data collection process.*

Conceptual Framework

The study conceptual framework was developed iteratively. Initially, conceptual thinking (Appendix 12.3) was informed by the resilience cycle framework [52, 90], useful in describing the stages of social innovation and its resultant systems effects, merged with Kingdon's Multiple Streams Policy Analysis framework [91]. The intended use of these frameworks was to adequately account for the evolving process (of both the social innovation and the health system's response to it) over time as well as various policy-related factors that might influence each stage of the process. These frameworks were identified in the literature, during the study design phase (2016), to have the best fit with the study. The initial conceptual thinking informed the data collection by enabling exploration of the evolution of the problem and the solution, the role of actors, windows of opportunity and political as well as other contextual influences. Although it guided the data collection in the initial rounds, it gradually became clear that it did not fully support the understanding of the institutional practices and non-instrumental factors involved in the unfolding process at different levels of the system (micro; macro and meso level). To capture such, inductive analysis was applied alongside deductive analysis, revealing richer explanations, and resulting in a modified framework being developed and adopted before the third and final round of data collection. This new framework was first published in August 2018 [43] and I used it to develop a modified version of the framework after 2019.

Chapter 4 presents a detailed description of the adopted study framework by van Wijk et al [43] underpinning the findings (see Figure 2-5). Institutional theory was a more suited underpinning for studying a social innovation in health in the context of a health system, for multiple reasons. This multi-level framework can sufficiently accommodate a systems and critical realist perspective by examining the unfolding process as it occurs at the

micro, meso, and macro-level. The framework, originally grounded in institutional theory, was further adapted drawing on literature from positive organisational scholarship, sociology, and positive psychology.

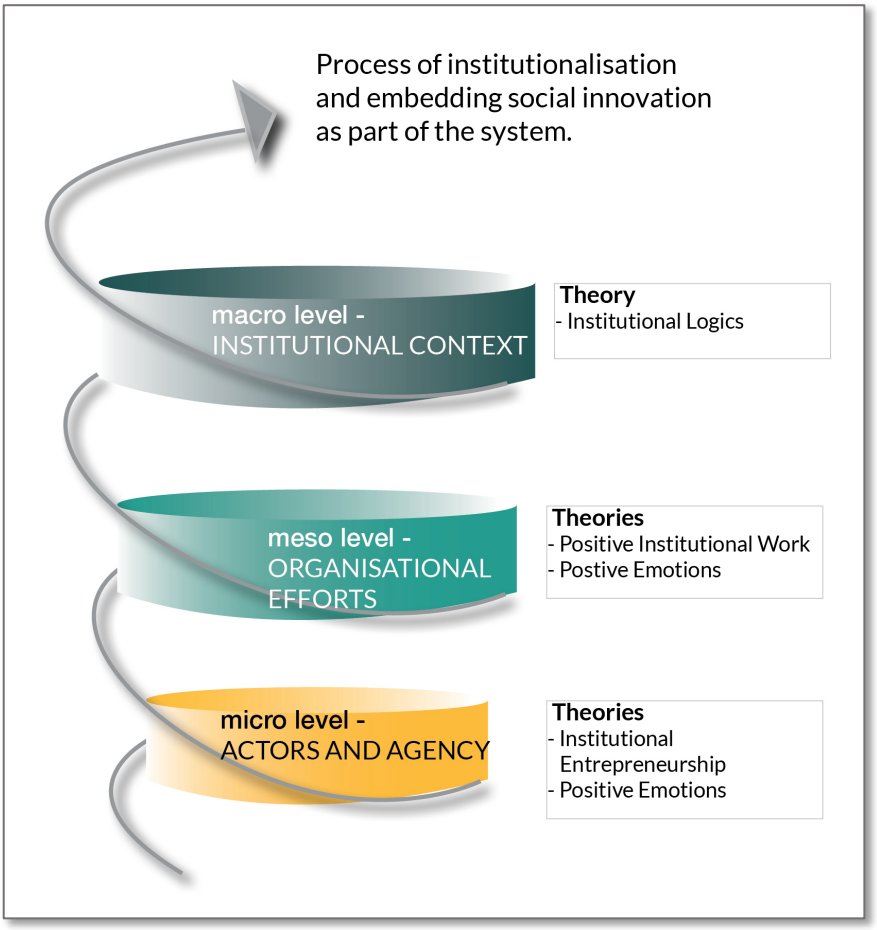


Figure 2-5: *Modified study framework*

Case Study Methods

Qualitative methods were used to conduct the case study [92-94]. Different methods were triangulated such that a holistic understanding of the phenomenon under investigation could emerge. The following methods were employed:

i. Document reviews

A range of documents was reviewed to gain a greater understanding of the actual events: the historical evolution and operation of the social innovation as well as of the Malawi Ministry of Health. Document reviews provided a

foundational understanding and informed the development of interview schedules. The documents that were reviewed included several types:

- Documents related to the functioning of the social initiative – Steering committee meeting minutes, transition plan documents
- Formal reports of the social innovation - Monthly progress reports, evaluation studies conducted, published articles
- Health System documents – Malawi Ministry of Health Sector Strategic Plan II, Community Health Strategy

ii. Observations

Observations open up areas of inquiry and allow for wider ranges of data to be collected, in turn allowing for a richer understanding to be gained of the cases [82]. In this study, observations were treated as supplementary to the primary method of data collection. Observations paid attention to group processes, day-to-day management processes, actor participation, reactions, and contributions.

During my fieldwork sessions in Malawi, I was able to observe how the operations of the health information hotline that is part of this social innovation (+/- 20 hours) were run. I attended and participated in selected meetings with the NGO, stakeholders, and government and, in addition, to team meetings conducted with the NGO (+/- 40 meeting hours). These meetings were key in assessing the interactions between various stakeholders. I also spent extensive time at the Ministry of Health and Population offices and the NGO's office (average of 4 hours per day during each country data collection period). This time assisted me in gaining a broader perspective of the day-to-day activities and interactions among actors.

Although I did not conduct observations at community level, I was able to draw on my prior experience of working at the community level in Malawi (2015 – 2018) which greatly assisted in informing my understanding of the context and how the culture informed how people expressed themselves [95].

I kept a field note diary, going beyond merely noting down what was observed as I also used this process of documentation to support my reflexive process. This procedure/diary further assisted me in informing the interview schedule development and iteration of the interview schedule in subsequent rounds of data collection.

iii. Interviews – Participant Selection

The primary data for this study is constituted of semi-structured in-depth one-to-one interviews. Before data collection, a stakeholder mapping exercise was undertaken to list all the key roles or actor types who are involved at each of the different stages: the creation, implementation, scale, and transition of a social innovation initiative.

To gain a holistic, comprehensive understanding and to account for complexity, participant selection was defined by three overlapping categorical classifications: participant type (implementers, community actors, Malawi Ministry of Health and Population (MoHP) actors at national or district level, project partners and other actors); participant operating level (top-level / decision making vs mid-level / frontline / community level) and participant level of involvement (directly or indirectly involved vs independent or uninvolved) (see Table 2-4 below).

TABLE 2-4: PARTICIPANT MAPPING / SELECTION

Category		Type	Level	Involvement	Reason for inclusion
1. Implementers	Creator	• Innovator / Founder / Initiator. • Country Director & deputy country director.	Top/ Mid-level	Direct - Low	To gain insight into the evolution of social innovation, to understand any processes that informed its development & to determine any unintended consequences.
	Implementer	• Key staff members implementing the project. • Frontline providers/field staff *(two sites across at least 2 districts).*	Bottom / Frontline	Direct - High	
	Informers	Community leaders/members who were engaged in the development of the social innovation *(two sites across at least 2 districts).*	Bottom / Frontline	Direct - Low	
2. Government	MOH Actors – National or District [positive supporting & negative opposing]	Ministry of Health officials who were directly engaged with the social innovation during its various stages of development *(across different departments).*	Top/ Mid-level	Direct – High or Low	To understand the institutional context of the public health system and the changes that were required to facilitate the social innovation adoption.
		Ministry of Health officials who are aware of the initiative but not actively engaged with it *(across different departments).*	Top/ Mid-level	Indirect - Independent	
3. Contributors	Project Partners [positive supporting & negative opposing]	Relevant representatives of project partners– funding agencies, private sector, university researchers.	Top/ Mid-level	Direct - Low	To understand the broader view of the innovation landscape within the context and factors that influence the social innovation adoption.

4. Other country actors	Actors engaged in developing/ implementing innovation	Founders of other innovations that may have been adopted/engaged within the public health system.	Top / Mid-level	Indirect - Independent	To determine any unintended consequences & whether the process of adoption was similar/different.

As a first step, a complete list of all stakeholders was developed with input from the social innovation implementing organisation, partnering researchers at the University of Malawi's College of Medicine, and considering already-existing contacts I had with those who were engaging in social innovation in Malawi. Participants from this list were subsequently invited for an interview (see Table 2-6 below). The final list of participants (by Round 3 of data collection) did all fit within the categories as mapped out in Table 2-4. However, participants who were not included in the list compiled based on the pre-study mapping were participants who emerged over time, and whose involvement in the initiative only started during the data collection period. These were mainly government actors.

For government actors, contributors and other country actors, attention was given to seeking out voices of conflict or disagreement. Throughout data collection, and as the institutionalisation process progressed, more contradictory voices emerged. These actors were added to the interviewee list and invited to participate in the study. Other country actors, who were not directly linked to the social innovation initiative provided be a valuable resource as they were able to reflect more critically on the initiative and the current processes that were occurring, especially how these processes were undertaken in the context of the health system and broader Malawian context and culture.

With Malawi having a decentralised health system with national government driving policy but district government departments responsible for implementation, it was important to not only gain perspectives at a national level but also a district level. Within the districts, officers working for the district health department were interviewed, as well as community stakeholders in some districts. Table 2-5 highlights the rationale for purposely selecting five out of 28 districts in Malawi. Districts such as Dedza, which was one of the first expansion districts, was selected with the rationale that it would be interesting to investigate whether project partners engaged the district health staff and also whether this engagement was sustained over time. Districts that were part of the more recent national scale-up, such as Phalombe, Zomba and Lilongwe, were selected, similarly, to assess whether district health staff were knowledgeable about the initiative and to gauge whether they were receptive to the initiative. This purposeful selection was done to assess the influence of the imitative upon the district health system, in the context of decentralisation. It was expected that conflicting and

contradictory views on the institutionalisation process may emerge from district level actors, as compared to central level government actors.

TABLE 2-5: DISTRICT SELECTION			
Region	**District**	**Rationale**	**Data Collection**
Southern Region	Balaka	The district where the innovation was piloted and implemented since 2011.	Round 1
	Zomba	A district the innovation was expanded to by the implementing NGO with a specific focus tailored to adolescents; different from the more generalised target group of beneficiaries.	Round 1
	Phalombe	A district part of the national scale-up, as part of the adoption by the government. A 'new' district only engaged with the innovation in October 2018.	Round 3
Central Region	Dedza	One of the first expansion districts with implementation led by a project partner (2013) and not the NGO.	Round 1
	Lilongwe	The district is considered for managing the ongoing running of the innovation following government transition and is the only district part of the Steering Committee.	Round 3

iv. Interviews – Data Collection

Data collection occurred over a total of 18-months of engagement, with 1-year of more intensive engagement (July 2018 – July 2019) and 12-weeks in the country. This was done to track the ongoing evolution of the social innovation and the process by which the innovation was being adopted and institutionalised by the Malawi Ministry of Health. Figure 2-4 presents an overview of the innovation's key milestones as well as the data collection periods.

During the 3-years before this study, I frequently travelled to the country for other work projects, so I had a baseline familiarisation with the country context and the health system. I was involved in research on other social innovations in Malawi, conducted interviews with various actors to map the social innovation landscape and developed an initial film on the Chipatala Cha Pa Foni project. Figure 2-6 presents the objectives of each round of data collection.

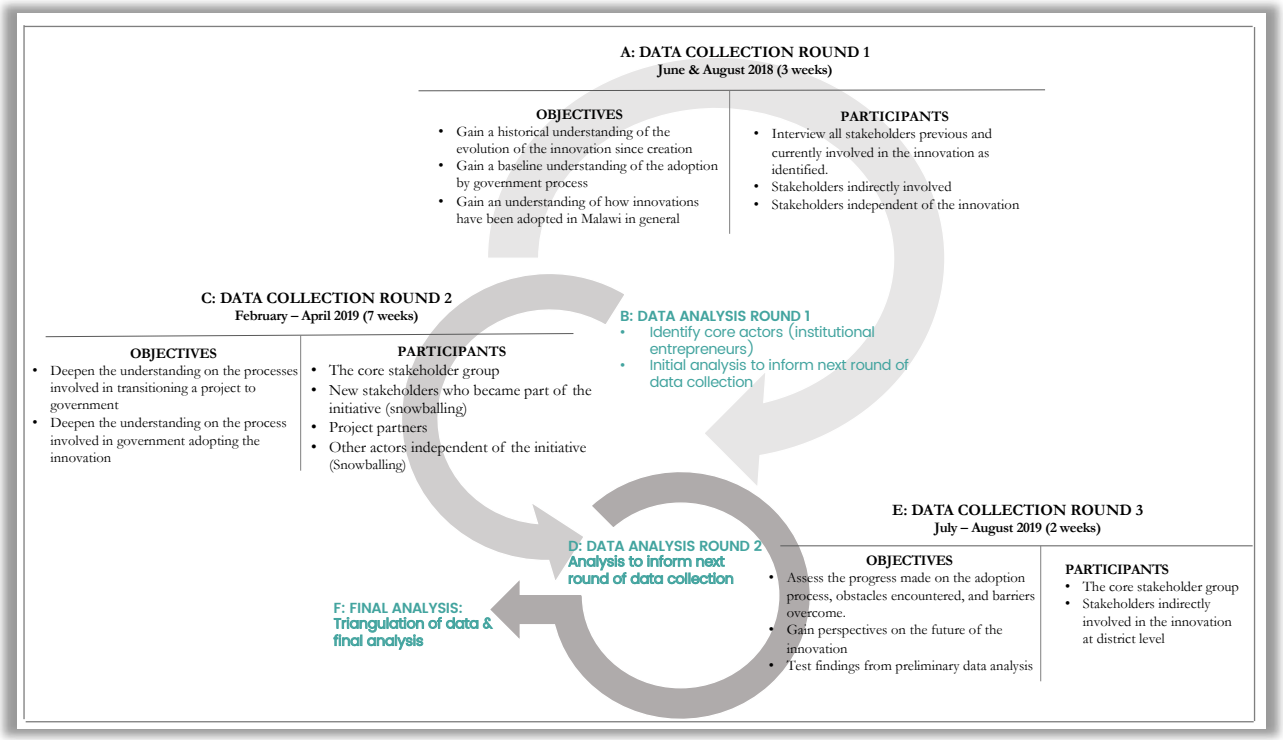


Figure 2-6: *Data collection process overview*

Data collection instruments were developed for each participant category group (see Table 2-4 below) and adapted for each subsequent round of interviews. Semi-structured interview schedules allowed for a few, broad, open-ended questions to be asked but also provided flexibility and the opportunity to add more questions depending on the information that the interviewee was sharing [96]. The development of the initial interview schedules (Round 1 and 2) was guided by the study objectives and the initial conceptual thinking. The guides for Round 3 were developed iteratively by including questions stemming from themes that emerged from preliminary analysis of Round 1 and 2 data as well as according to the modified conceptual framework innovation by van Wijk et al (Figure 2-5). Interview schedules from Round 1 data collection can be found in Appendix 12.4.

The majority of interviews were conducted in-country (Malawi) and in-person, however on a few occasions the participant was not available during the country visit and then a telephone/Skype interview was conducted following the visit (4 interviews). The majority of participants were comfortable conducting their interviews in English. At the community level, a small number of interviews (2 interviews) were conducted in Chichewa with the aid of a translator. The interviews lasted 30 – 60 minutes, depending on the available time of the participant and were conducted in locations preferred by the participants. All participants, except for one participant, provided permission for their interviews to be audio recorded for later transcription.

A total of 54 participants were interviewed across the three rounds of data collection and a total of 68 interviews were conducted over the period of 1-year (See Table 2-6 for a full list of participants). In addition, between visits, informal interviews were conducted with the officer appointed to manage the transition and adoption process, such that evolving changes could be captured. Each round had a specific set of objectives to be achieved and each subsequent round built upon the understanding achieved in the prior round while tracking the process of adoption and transition over time (Figure 2-6). In both rounds 2 and 3, allowance was made for snowballing – the addition of participants based on referrals or specific areas. This particularly assisted in gathering perspectives from either those involved in community implementation or participants who were independent of the innovation.

Interviews and further data collection ceased in Round 3 when theoretical saturation was reached. At this stage, 'gathering fresh data no longer sparked new theoretical insights or new properties of core theoretical categories' [97] and additional ' data tended to be redundant of data already collected' in terms of participants understanding of the phenomena of interest.

Multiple country visits and rounds of data collection greatly assisted in gaining access to key individuals, building relational capital with them, and fostering deeper trust. Selected key individuals were interviewed at each round, and with each interaction greater levels of depth were achieved as participants felt more comfortable to share their insights honestly and openly. Repeated interviews led to more unfiltered, conflicting and contradictory views emerging by Round 3 as opposed to in Round 1.

(Table 2-6: *removed for confidentiality*)

Data Analysis

The process of data analysis commenced while in the field, as part of the weekly synthesis of the data collected up until that point. More formalised data analysis was done at three intervals – between each data collection period (between Round 1 and 2, and between Round 2 and 3) so to assist in informing future data collection rounds, and a final data analysis of all forms of data collection was conducted at the end of Round 3 (See Fig 2-6).

Reflexivity was an ongoing process I practised before, during and after fieldwork [98]. Reflexivity is a key practice that aligns with qualitative inquiry and case study research methodology. According to Ruby (1980) "Being reflexive in doing research is part of being honest and ethically mature in research practice" [99]. Reflexivity encouraged me, as the researcher, to be aware and self-critical from the start of the data analysis process, acknowledging that my prior knowledge, personal and cultural views, assumptions, and biases may play an influencing role in my conversations and observations [97, 100, 101].

During fieldwork, at the end of each day's interviews, the perspectives and views shared by participants were reflected upon. Every few days, I reflected in my journal on data shared by participants up to that stage and synthesised some emerging themes. This process of reflection and synthesis was helpful and important to inform further data collection and ongoing analysis. Frequently, interview schedules had to be adapted ahead of the next day's scheduled interviews to allow for deeper inquiry and to improve my understanding of the phenomena under study. At intervals I was also able to reflect with my co-investigators at the University of Malawi about the emerging findings, especially considering the changing political context (national elections, public anti-government demonstrations) during my time in Malawi. In addition, I read the daily newspaper to broaden my understanding of the country context. Reflecting on both the emerging findings and the country as well as health system context helped me to give guiding direction to the study as it unfolded.

Throughout the research, I also had to be aware of personal qualities such as my background, professional status etc. that could influence the findings. These factors had the potential to shape the power dynamics between myself and the research participants as "despite the best intentions, the interview situation may be experienced as, and may be, a form of abuse" [99]. Initially, I introduced myself to participants as being South African but on one occasion the translator who assisted me at the community level suggested I refrain from saying that I am South African, as at the grassroots level Malawians have developed a distrust of South Africans due to xenophobic violence against other African citizens that occurred in South Africa in recent years. Being aware of my position throughout this research was important. Depending on the level of the participant I would disclose my background as a medical doctor. For similarly qualified participants, it fostered trust but with frontline

participants, I refrained from doing so in the hope that they would feel more comfortable sharing their reality versus 'what the doctor wants to hear'. I mainly introduced myself as a researcher working with the College of Medicine and LSHTM. Malawians have greater trust in their national institutions than in foreign institutions, and one participant did express his discontent with foreign researchers 'taking from us and we never see anything thereafter'. Repeated country visits and interviews with the same core group greatly assisted in people sharing beyond surface-level facts or the politically correct view, to rather them sharing their personal opinions. As my relational capital with participants developed, especially in Round 3, participants shared more openly, with less reserve and with greater candour.

The interviews (67), with exception of one participant who declined, were audio-recorded and transcribed for analysis. Detailed handwritten notes were made from the unrecorded interview and later typed up. The audio-recorded interviews were transcribed by me and two transcribers from the University of Malawi. Three interviews required the assistance of a translator in the field and subsequently were first transcribed and then translated from Chichewa to English. Back translation was not done. All interviews – audio recordings and transcripts – were de-identified and unique study identification numbers were provided. Observational notes were taken in my journals during each interview and these journals were scanned and stored online. The original journals and consent forms are kept securely. All data products are stored on my password-protected computer and a password-protected, encrypted external hard drive.

A thematic content analysis was conducted using deductive and inductive approaches – allowing for the recognition of patterns, whereby themes (or codes) that emerge from the data subsequently become the categories for analysis [102]. This process supports studying parts of the data but understanding such within the 'context' of the whole, which also accommodates the research question, the research context and the theoretical framework [102, 103]. Following the first round of data collection, a pen and paper analysis was done by reviewing the transcripts. I re-read and familiarised myself with the data and identified some initial themes. A reflective discussion was held with my supervisors following this rough preliminary analysis.

Following the second round, interview data gathered up to that stage was organised and imported into NVivo 12. An initial deductive code manual was developed informed by the initial study conceptual thinking (see Appendix 12.3) and with codes arising from the first round of analysis. This provisional code manual consisted of 16 code categories and 43-sub codes. High-level codes from the initial conceptual thinking included, among others: evolution, key turning points, processes, relationships, innovation components, contextual factors, actors (including values, actions, and emotions). Most sub-codes emerged inductively. The second round of analysis served as a helpful opportunity to test the predefined codes list while also allowing for other codes to emerge

from the data. Throughout this iterative coding process, my initial list of codes expanded into 192 and they were then grouped and reduced ahead of the final coding cycle. It was also through reviewing my inductive codes - and the broad themes that emerged from these, that it became clear I needed to go back to the theoretical literature and to rethink the study conceptual framework as explained above. The new framework as per Figure 2-5 was used henceforth.

In the third and final round of analysis, all available data collected from every three rounds of analysis – documents, interview transcriptions, observational notes – were combined and organised using NVivo 12. The revised conceptual framework allowed broad deductive coding but to inform each level of the framework, I continued to apply inductive analysis to identify more specific non-instrumental factors at each level (e.g., specific institutional work practices relevant to the micro and meso level).

Trustworthiness in case study research

Trustworthiness is a key consideration in qualitative research [82, 104, 105]. As proposed by Lincoln and Guba (1985), four criteria for trustworthiness exist transferability, confirmability, dependability and credibility [101]. I considered each of these four criteria during different stages of my research and the practical strategies adopted in support of trustworthiness [82, 106, 107].

Transferability refers to the degree to which my findings can be applied to other contexts or groups. Reading extensively and discussing the historical context of the country with colleagues helped me to become more aware of country-specific aspects of this research. The repeat interviews with selected participants further helped to generate rich data from which it was possible to distinguish which of the findings may be relevant across different government settings irrespective of the context. Having travelled and conducted research in other African countries also helped me to determine transferability, especially my interactions with Ministries of Health in these countries.

Confirmability refers to the extent to which the findings are because of the participants and not of other influences or biases. As mentioned above, a field journal in which I wrote regular reflections supported the identification of any influences or personal biases. I was also able to ask questions, especially about the broader cultural context or possible emerging themes, with my co-investigators (experienced Malawian researchers) at regular intervals.

Dependability refers to whether my findings would be consistent if the study is to be replicated. To address both these elements of trustworthiness, I have documented the steps taken from the start of the project until the

reporting of the findings, especially documenting any changes in the research protocol or design based on the practical realities of working in a real-life setting. Changes occurred both in switching from an initially envisioned multi-country design as well as in changing the theoretical underpinning. Copies of all the interview schedules, which were amended based on the progress in the data collection and emerging themes are also provided (Round 1 interview schedules in Appendix 12.4 – round 2 and 3 schedules can be provided)

To enhance the credibility of my findings, I relied on triangulation. Triangulation is a strategy by which credibility and validity in qualitative research can be enhanced [108, 109]. I draw on three types of triangulation by which to enhance the understanding and validity of the findings: method triangulation, data source triangulation and theory triangulation [108, 110]. Data was obtained from documents, observations and interviews conducted at three different intervals. During interviews, data from documents and observations were cross-checked with respondents for greater clarity and respondent data was cross-checked against project monthly reports. For interviews conducted, data was obtained from participants at different levels of the health system (frontline, mid-level, and senior-level) and participants at the national and district level. I also interviewed participants with no direct link to the case study or who were sceptical. Without breaking confidentiality, I was able to check my emerging ideas and findings with actors at different levels as well as with actors supportive and sceptical of the innovation. Data analysis was an iterative process in which each proceeding round built upon the prior round. In the final analysis, datasets from all three rounds were triangulated around the codes emerging. Social innovation theory, institutional theory and to a lesser extent, theory from positive psychology were used to interpret the findings emerging from the data.

Ethical Considerations

i. Ethical approval

Research ethics approval for this study was obtained from the London School of Hygiene and Tropical Medicine's Research Ethics Committee – Reference 15476, Date: 29 June 2018. In-country research ethics approval was obtained from the Malawi National Commission for Science and Technology – Reference NCST/RTT/2/6, Date: 25 May 2018. This study was conducted in partnership with researchers from the University of Malawi's College of Medicine Social Innovation in Health Initiative, under the Malaria Alert Centre. (See Appendix 12.1)

ii. Consent

Formal written consent was obtained from all participants who were requested for an interview. Consent forms were made available in English and Chichewa (see Appendix 12.2 for consent forms) and ahead of each

interview, the consent form was verbally explained and thereafter an opportunity was given for participants to read through the consent form ahead of signing it. Participation in the interviews/ observation was voluntary and there was no recourse to the individual if he/she declined participation. It was clearly explained that they could withdraw at any time and that the data collected would not be fed back to the organisation's leadership/ management team, nor shared with local country authorities. Participants were given a copy of the signed consent form for their keeping.

Interviews were conducted in English and Chichewa, based on the participant's preference and the availability of a translator. All participants, except for one, gave second permission for their interviews to be recorded for transcription. For the participant who declined recording, detailed handwritten notes were taken during the interview.

iii. Participant Confidentiality

Throughout the research, I took measures to safeguard the participants' confidentiality, however, it is worth noting that the names of all the organisations involved in this case study as well as the leading or key actor names are available in the public domain. It was made known to participants that the name of the social innovation would be disclosed and by their involvement in the innovation, it was not possible to fully protect their anonymity even if their names would not be made public. Most participants did not show concern, except for 1 participant who was concerned about their identity being kept confidential, especially as they expressed a critical opinion. Consideration was paid to this when writing the thesis. When interviewing employees of an organisation (the NGO, the Ministry of Health or partner organisations), especially participants of a lower organisational level, privacy was best ensured by not referring to respondent's answers or their participation when interacting with them in other settings or when interacting with participants who may be their direct managers.

As mentioned above, all data sources were de-identified, and given unique identification numbers but based on the small team of actors most closely involved in the project, full anonymity cannot be assured. Transcriptions were done by me and qualified research support staff from the University of Malawi College of Medicine. All data sources were stored on password-protected devices. Paper copies are being securely held in a home office. On completion of the thesis, all study materials will be stored electronically on the LSHTM archive server for safekeeping for 10-years.

The data is only available for access by the immediate research team. The raw data will not be made available for open access as per certain journal requirements neither on request by any other research institutions or agencies and the data will only be used for the reasons for which the participants gave consent.

iv. Benefits and Risks

This research was done to contribute to the broader knowledge base on social innovation and health and to support the achievement of this PhD qualification. The research carried minimal direct risk for the participants (noting that some information is already in the public domain), and no financial incentives were offered. Transport reimbursements were only provided to community participants who had to travel from their villages to attend an interview. Interview questions were centred around the participants' role or engagement with the social innovation and no personal or private questions were asked. All work was done to highlight the case in a fair and unbiased manner, acknowledging all the relevant individuals but also protecting the confidentiality of selected participants who may not want to be known e.g., employees (especially within the Ministry of Health). I took the utmost care to be respectful of the local country's political situation also as most of the data come from government employees. While every precaution has been taken to de-identify the data, there does remain an indirect risk that acquired data could affect an employee-supervisor relationship although no information has been shared or relayed to the head of the organisation or local government authorities.

3 CHAPTER 3 – SCOPING REVIEW: LITERATURE AND THEORY ON SOCIAL INNOVATION IN HEALTH

3.1 Introduction

Humanity is not unfamiliar with innovation. Over the centuries, people from all walks of life have been able to apply their imagination to creating possibilities previously unrecognized. In the 21st century, now even maybe more than ever before, as stated by John W. Gardner [111]: 'we are all faced with a series of great opportunities - brilliantly disguised as insoluble problems.' An arising global social consciousness has resulted in a renewed and enthusiastic interest in the concept of social innovation. As a caveat, McGowan [112] states that the use of the term 'social innovation' has not been employed in a common or mutually intelligible way, and to this date, it remains a contested concept lacking conceptual clarity [80, 113-115].

The purpose of this chapter is thus two-fold: firstly, to provide a historical background of social innovation as well as a conceptual understanding of its dimensions. Secondly, this chapter is intended to address Objective 1 of this study – to critically review the literature on social innovation as applied to healthcare and identify current limitations in its application. It shares the findings from the narrative scoping review conducted on peer-review published literature applying social innovation to healthcare and identifies the gaps and opportunities as implications for future research.

This chapter was published as a paper in the Journal of Infectious Diseases of Poverty on 8 March 2021, titled "The application of social innovation in healthcare: A scoping review" [61].

3.2 Background: Social Innovation

3.2.1 Historical evolution

Scholars have tried to trace the evolution of social innovation, trying to identify when the need for such an alternate form of innovation first arose and when the term came into use. Figure 3-1 below highlights the use of the bigram 'social innovation' since 1800 [116]. The common thread among examples throughout history is that each were once regarded as an inconceivable and even radical idea and implemented either through means of diverse social processes or leading to social outcomes such as the enhancement of social relationships, new ways

of social organization or the transformation of social institutions [113, 117]. There is consensus among several authors that 'social innovation is a new label for historical instances of social change and reform [118].

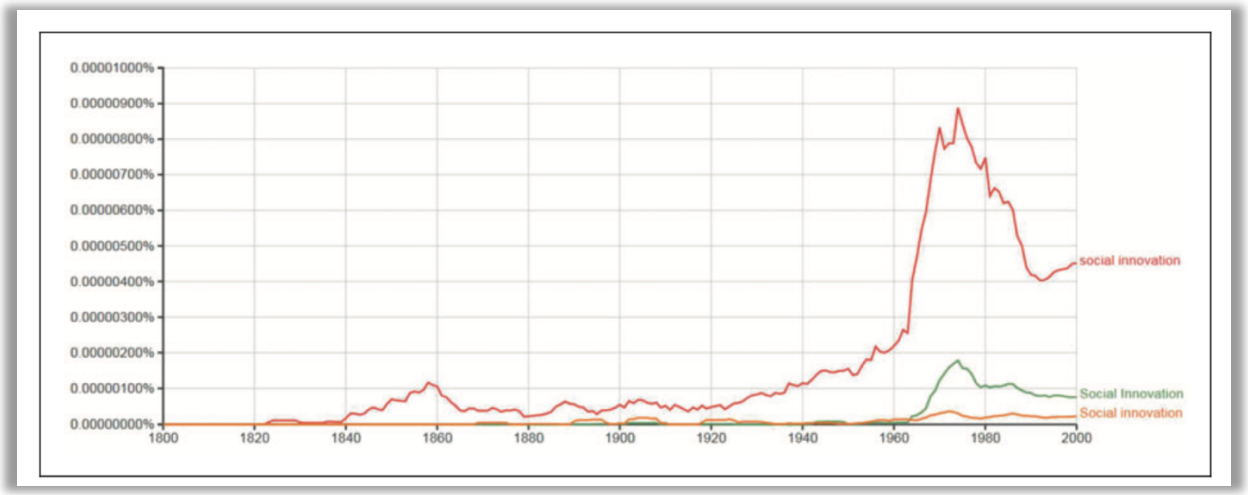


Figure 3-1: *Use of 'social innovation' over time*

In his historical review, Godin [119] states that the concept of social innovation owes its origin to socialism in the 19th century, with the first use of the term dating back to 1803. Scott-Cato et al [120], referencing Chambon et al [121] state that the term 'social innovation' first emerged from the intellectual French-speaking community in France, followed by England and the US. The origin of the word 'social innovation' made an appearance in 1803 and 'social innovator' in 1805. At that time social innovators, or rather known as social reformers or radicals, were those accused of overthrowing the established social order, privileges and institutions, particularly in regards to property and capitalism [119]. Around the 1830's social innovation was 'regularly equated to revolution, leaving no system unchallenged' [119]. Mulgan [122], a British scholar, dates the appearance of social innovation back to the wave of industrialization and urbanization in the early 19th and 20th century. At the time, the new human geography overwhelmed traditional civil society and religious institutions that provided basic services, and thus giving rise to the need for social innovations, such as mutual self-help groups, cooperatives, trade unions, new models of childcare, social care, and new models of community development. Mumford [123], an American scholar, conducted a case-based historic approach that led to the identification of Benjamin Franklin, politician and philanthropist, as an early social innovation pioneer in Philadelphia USA from 1726 - 1757 for his creation of more than ten social innovation initiatives contributing to the social environment such as subscription libraries, the police force and paper currency. The post-World War II era, saw a rise of not only individuals but also governments taking the lead in social innovation and examples of such include the creation of the welfare state model and the national health service in the United Kingdom [122].

Social innovation saw a re-emergence in the 21st century due to limitations in technological innovation. A systematic review by Edwards-Schachter et al [80] traces and classifies the most salient voices of social innovation into three categories: those arising from a managerial or organizational change perspective; those arising as a critique to social policy and social services and those reclaiming the need for the third sector. In 1957, the American management scholar, Drucker [124] drew attention to the need for social innovation, as non-technological practices that can produce social change. In 1987, he cautioned against the overemphasis of science and technology as change agents and stated that 'social innovations – may have had even profounder impacts on society and economy'. He ascribed social innovation in the 20th century as the task of the manager [125]. In 1999, another management scholar, Kanter [126] followed suit by making an argument for companies to move beyond corporate social responsibility to rather actively pursuing social sector problems. She described this 'new paradigm for innovation' as being partnerships between private enterprises and public interests that will result in profitable interest and sustainable change for both sides. From 1967 onwards, other voices from the United States and Canada presented social innovation as a way to alleviate social problems arising from government social policies, bureaucratic structures and poor services that limit people's quality of life [127, 128]. Since 2000, this rationale for social innovation has become re-evoked through the awareness of global 'grand challenges' and introduced as a rationale of policies and part of the Europe 2020 strategy [129, 130]. Contrary to the earlier history of social innovation where government was regarded as the social innovator in the context of the welfare state, more recent motivations for social innovation is as a way to overcome the failures of the welfare states particularly in Europe and the United Kingdom by promoting a neoliberal austerity political agenda [131, 132]. As governments have been unable to financially sustain all citizens, it has led to a renewed emphasis of social innovation as a means to address the unmet social needs, create new relationships and enhance society's capacity to act [133, 134]. A particular focus has been given to the role of the third sector collaborations, especially social enterprises, to support government and to foster active citizen participation.

As a final remark on the historical origins of social innovation as pertaining to health, two examples are cited in literature, each from the Christian tradition. Mulgan [135] emphasizes the role of religion in generating, sustaining and scaling social innovations and mentions Florence Nightingale, supported by the Irish Sisters of Mercy, as one of the pioneers reforming nursing care. Jiang [136] describes the case of Cicely Saunders, as motivated by her faith, that led to the creation of what was to become a global hospice movement for palliative care.

3.2.2 Nature and attributes of social innovation

To gain further understanding with the aim of overcoming this apparent confusion and bringing together these disparate definitions, conceptual framing of characteristic aspects of social innovation is provided (see Table 3-1). In Figure 3-2, I draw on the work of Ayob et al. [113], and supplement their proposed framing with factors pertaining to the understanding of social innovation – its components, theoretical underpinnings and paradigms. In the following text, each aspect is briefly discussed.

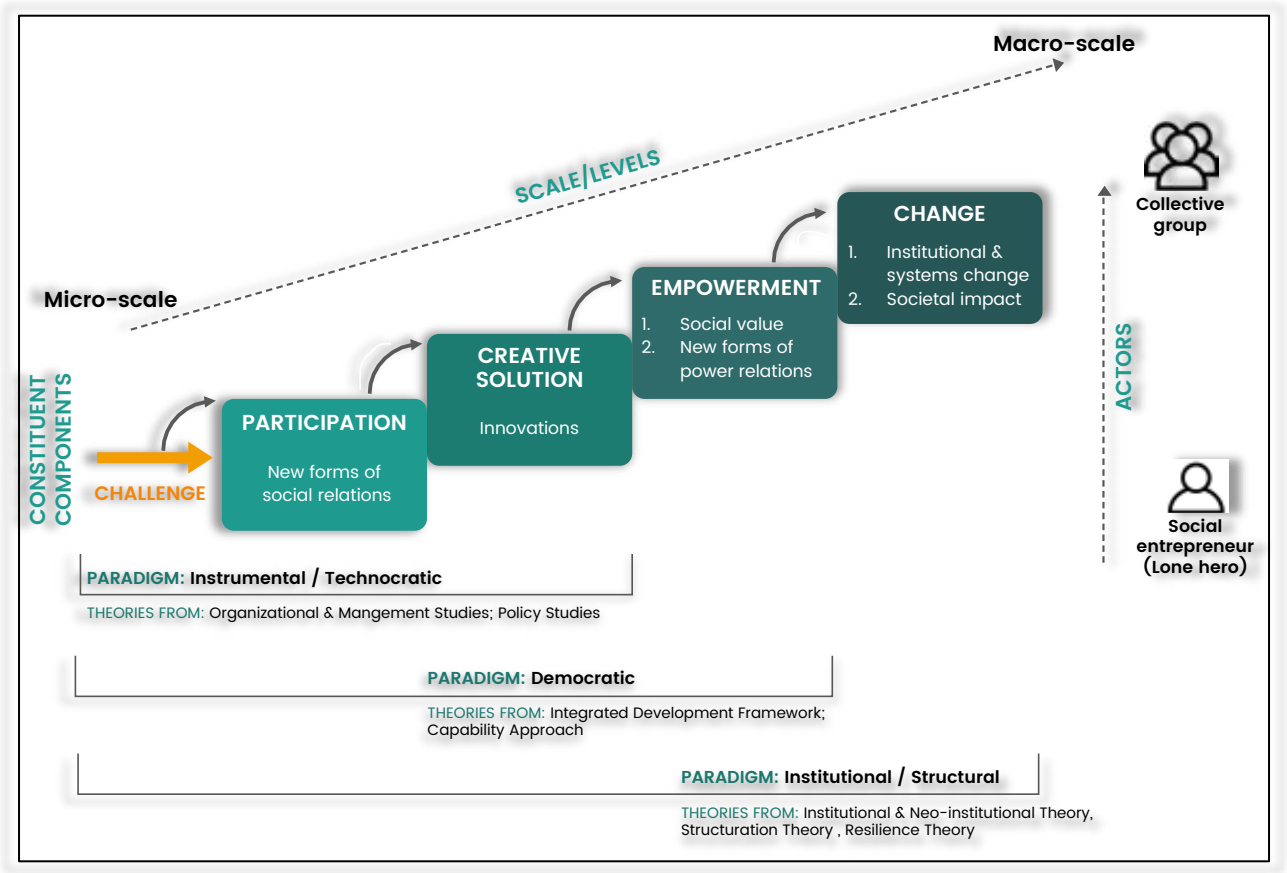


Figure 3-2: *Components, Paradigms, Theories, Scales and Actors of Social Innovation*

TABLE 3-1: KEY SOCIAL INNOVATION DEFINITIONS			
Theme	**Author**	**Definition**	**Published**
Addressing social needs, through new initiatives to improve society	Mumford, M (2002) [117]	The term social innovation, as used here, refers to the generation and implementation of **new ideas** about how people should organize interpersonal activities, or social interactions, to meet one or more common goals	Creativity Research Journal
	Mulgan, G (2006) [137]	Social innovation refers to innovative activities and services that are **motivated by the goal of meeting a social need** and that are predominately diffused through organizations whose primary purposes are social.	Innovations
	Phillls, J et al. (2008) [138]	A novel solution to a social problem that is more effective, efficient, sustainable, or just than existing solutions and for which the value created accrues primarily to society rather than private individuals (2008: 36).	Stanford Social Innovation Review
	Pol, E & Ville,S (2010) [115]	A *desirable* social innovation is one that in fact ('in fact' meaning 'there is convincing evidence') improves the macro-quality of life or extends life expectancy.	Journal of Socioeconomics
	European Commission (2011) [130]	Social Innovation relates to the development of new forms of organisation and interactions to respond to social issues (the process dimension). It aims at addressing (the outcome dimension): a. social demands that are traditionally not addressed by the market or existing institutions and are directed towards vulnerable groups in society. b. Societal challenges in which the boundary between 'social' and 'economic' blurs, and which are directed towards society as a whole. The need to reform society in the direction of a more participative arena where empowerment and learning are sources and outcomes of well-being	Report: Empowering people and driving change
Forms of participation, relationships & practices	Howaldt, J *et al.* (2010) [139]	New forms of **social relations** lead to innovation, which in turn leads to societal impact.	
	Neumeier, S (2012) [140]	Social innovations as changes of attitudes, behaviour, or perceptions of a group of people joined in a network of aligned interests that in relation to the group's horizon of experiences lead to new and **improved ways of collaborative action** both within the group and beyond.	European Journal of Rural Sociology
	Cajaiba-Santana, G (2014) [114]	Social innovations are **new social practices** created from **collective**, intentional, and goal-oriented actions aimed at prompting social change through the **reconfiguration of how social goals** are accomplished.	Technological Forecasting & Social Change
Empowering for action	Murray, R *et al.* (2010) [133]	Social innovations as new ideas (products, services, and models) that simultaneously **meet social needs** and create **new social relationships or collaborations**. In other words, they are innovations that are both good for society and **enhance society's capacity to act**.	Open Book of Social Innovation
	(Moulaert et al, 2005 & 2013)	Social innovation as a practice (collective satisfaction of human needs) and a process (changes in social relations, **empowering governance dynamics**) in local development Social innovation references to changes and agendas, agency and institutions that lead to better inclusion of excluded groups and individuals into various fields of societies at various spatial scales. It is very strongly a matter of process innovation of changes and the dynamics of social relations including power relations'	Urban Studies International Handbook on Social Innovation
Institutional & systems change	Westley, F et al (2006, 2010) [1, 52]	Social innovations are products as well as deliberative processes and policies that are **transformative i**n their outcome with respect to building greater **social resilience** (Westley, Zimmerman and Patton, 2006). Social innovation is an initiative, product or process or program that profoundly changes the basic routines, resource and authority flows or beliefs of any **social system**	Getting to Maybe (book) The Public Sector Innovation Journal
	Van Wijk, J et al. (2019) [43]	Social innovation for us describes the agentic, relational, situated, and multi-level process to develop, promote, and implement novel solutions to social problems in ways that are directed toward **producing profound change in institutional contexts** (see also Cajaiba-Santana, 2014; Lawrence, Dover, & Gallagher, 2014). We understand this process as embedded and self-reflective, and that it may be coordinated and collaborative, or that it may be the emergent product of accumulation, collective bricolage and muddling through daily work (Garud & Karnøe, 2003; Smets, Morris, & Greenwood, 2012).	Business & Society

3.2.2.1 Challenges

The stimulus to social innovation, as for many other types of innovation, is a challenge or problem that requires a new solution. By the 1970s scholars had developed an awareness of the limitations of technological innovation and business approaches to effectively meet explicit social needs. Thus, the focus on achieving social aims and providing value for society has been described as the first factor characterising social innovation. This contrasts with other forms of innovation motivated by market-based objectives such as profit maximisation [114, 141]. Increasingly in the last decade, social innovation has emerged as an alternative to address complex and intransigent challenges such as climate change, poverty, the effects of globalisation and inequality, and to produce lasting social change. These challenges transcend geographic, administrative, and political boundaries. For this reason, Van Wijk and colleagues [43] summarise that the challenges best addressed by social innovation have been labelled as: 'wicked problems' [142], 'metaproblems' [143], 'grand challenges' [144], or complex challenges with interdependencies across multiple systems and actors [43]. Mulgan [135] highlights the systemic nature of these challenges by noting that existing systems and structures often fail the very people they intend to serve. Others point to the existence of 'institutional voids' – absent or weak institutional arrangements – in the context of markets and governments that may hinder the participation of communities. The result is that social and economic inequalities emerge or are reinforced [145, 146]. However, Mair argues that these same institutional voids alternatively represent an opportunity for social innovation, allowing new forms of participation by a range of actors with complementary objectives [147].

3.2.2.2 Participation

A second distinguishing feature of social innovation, as compared to technological innovation, is its participatory process. Social innovation actively promotes social inclusion – reforming existing and promoting inclusive social relationships among individuals, especially those previously neglected from political, cultural, or economic engagement [56, 116, 139, 140]. This is often referred to as 'innovation in social relations' [40, 117]. As Marques and colleagues note [25], social innovation and participatory governance are not equivalent. It extends beyond the notion of participatory governance, as despite the ability of participatory governance to achieve greater social accountability, it can still do so by focusing only on special interest groups or by limited inclusion [116]. Participatory governance initiatives can be classified as social innovations, however, if they address an unmet human need and result in more inclusive public processes [116]. Thus, co-creation, co-production and co-design have become popular mechanisms used especially by governments to engage citizens in social innovation [148]. Co-creation seeks to overcome the passivity inherent in models and practices of community participation, and so encourages active involvement [149, 150]. Parra [151] connects social innovation with sustainable development,

by highlighting how alternative forms of expertise, such as indigenous and citizen knowledge, can result in greater collective learning and knowledge building beyond the technical rationality of scientific protocols.

Four actor groups participating in social innovation are commonly identified: individuals (citizens); social movements; organisations including state and non-state entities (governments, non-governmental organisations, charities, community-based organisations); and new hybrid organisations such as social enterprise [152-154]. Social innovation is unique in terms of cross-boundary or cross-sectoral partnerships at the intersections of business and non-profit sectors. Relationships and trust play an important role in fostering these partnerships [155].

3.2.2.3 Creative Solutions

Most definitions reference social innovations as creating new ideas or solutions but remain agnostic of the form that this could take – social innovation might involve new products, programs, services, processes, activities, practices, or social movements [1, 114, 117, 122, 133, 135]. Yet, social innovations are rarely based on something entirely novel; instead they combine or involve a 'bricolage' of two or more existing ideas, theories or products [54]. Diverse theoretical approaches, disciplinary perspectives and even geographic contexts result in different paradigmatic views. One example is the instrumental or technocratic paradigm, originating out of organisational and management studies and public policy from a European context. This paradigm is described first as focusing on products and services to address market failures more effectively [40]. This is in line with the qualifying characteristics of social innovation as 'more effective, efficient, sustainable or just than existing solutions' [138]. Scholars from these fields are mainly concerned with social innovations such as social enterprises (hybrid organisational models), social finance, corporate social responsibility and public private partnerships [138]. Others have been critical of this paradigm due to its politicised nature. Marques [116] sees social innovation as the 'rebranding of political agendas, community development and corporate social responsibility' by policy makers or academics, without fundamentally altering the goals or outputs. Montgomery [132] highlights how social innovation has become a way for European policy makers to construct a discourse that aligns with a neoliberal political agenda for welfare states, which includes encouraging the development of social enterprises in favour of reducing public spending. He warns that this approach could reinforce rather than disrupt top-down vertical power distributions within social relations.

3.2.2.4 Empowerment & Agency

A second view of social innovation, the democratic paradigm, emerges once the components of empowerment and agency are included [132]. Based upon work by Moulaert [156], a spatial planning scholar, and as presented in the Integrated Development Framework, social innovation is seen as a means to meet human needs by increasing participation levels and empowerment, enabling greater access to resources, and increasing social and political capacities. The quality of participation conceptualised in this view contrasts with that of the technocratic paradigm. While the technocratic paradigm can result in the 'creative destruction' of social relations, the democratic paradigm results in the 'creative transformation of social relations' [132]. In a case study on the Great Bear Rainforest, Moore and colleagues [157] highlight the role and the distribution of power between citizens and government in social innovation, that led to governance transformations. Development scholars like Tiwari [158] and Ibrahim [159] have drawn on Sen's capability approach for human development [160-162] as a way of explaining a bidirectional relationship between agency and social innovation. They argue that through generating agency, social innovations can help achieve new collective capabilities, which can be used by communities to achieve what they value most in life. This work presents a broader view on empowerment, not only as a transfer of power but as the expansion of people's agency.

3.2.2.5 Institutional and Systems Change

In the last set of definitions, social innovation is presented as institutional change or transformation in complex adaptive systems. In the literature, authors name this paradigm variously as institutional [40], structural or structuration [114, 116] or systemic [52]. Theoretically it is underpinned in institutional theory, focusing on socially constructed rules, norms and beliefs. Micro-level patterns of interaction are linked to the development of macro-level social structures. Social innovation occurs through micro-macro links, with individual cognitive frames and beliefs revealed in organisational and structural forms [44]. However, institutional theory does not adequately explain the role of actors in reforming or creating new social systems and structures [114]. Scholars have drawn on neo-institutional and structuration theory to further explore the role of actors as institutional entrepreneurs and their ability to transform the very institutional structures that constrain action (so called, the paradox of embedded agency) [45, 163, 164]. Van Wijk et al [43] further suggest that the positive emotions experienced by actors as they interact and collaborate enable them to accommodate different viewpoints, stimulate reflexivity, question taken-for-granted perspectives, and so enable innovative ways of thinking and acting. These scholars regard agency as a core catalyst in institutional change which in turn will stimulate transformative change in the social system. In the domain of ecology, scholars have drawn on adaptive cycle heuristics to explain how social innovation generates constant change within social systems by challenging the

basic routines, resources, authority flows and beliefs of the social system and so, doing social innovation enhances resilience in the system [1, 52-54]. This approach helps to explain the multi-scalar nature of social innovation – how micro-level local innovations (within communities and organisations) can cascade up, leading to transformations at larger scales [41].

In summary, social innovation is a multi-dimensional concept that has been studied from different theoretical streams and viewed through different paradigmatic lenses. Beyond regarding social innovations as tangible outputs or solutions, created to address unmet societal needs, social innovation at its core challenges the underlying culture and values of the dominant system. As described above, social innovation also includes innovation in social relations and in power dynamics, leading to governance transformation and changes in internalised (mindsets) as well as externalised (structural) institutions. Social innovation thus holds potential to alter the root issues responsible for systems not delivering their intended objectives to society as a whole.

3.3 Scoping Review Results

As described in Chapter 2, a scoping review was conducted of empirical studies published in the past 10 years, to identify how social innovation in healthcare has been applied, the enablers and barriers affecting its operation, and gaps in the current literature. A number of disciplinary databases were searched, with studies identified and analysed using a predetermined criterion.

3.3.1 Overview of studies included

A total of 27 studies met the eligibility criteria and were included in the scoping review (Figure 3-3). The majority of articles (75%) were published between 2015 and 2020. Half (14/27) were published in health-specific journals and the remaining half in a range of other disciplines including management and business studies and programme, policy and planning studies, innovation and informatics, and agriculture. The most common methods were case studies (14/27) and scoping, systematic and general literature reviews (4/27). The literature was dominated by research originating from high-income country contexts, particularly in Europe. Nine published studies were conducted in low-income, low-middle income or upper-middle countries (two in Africa; four in Asia; three in Latin America). Low-income country researchers (first author) and institutions were under-represented in the sample, limited to only three representing institutions in Colombia, Uganda and India.

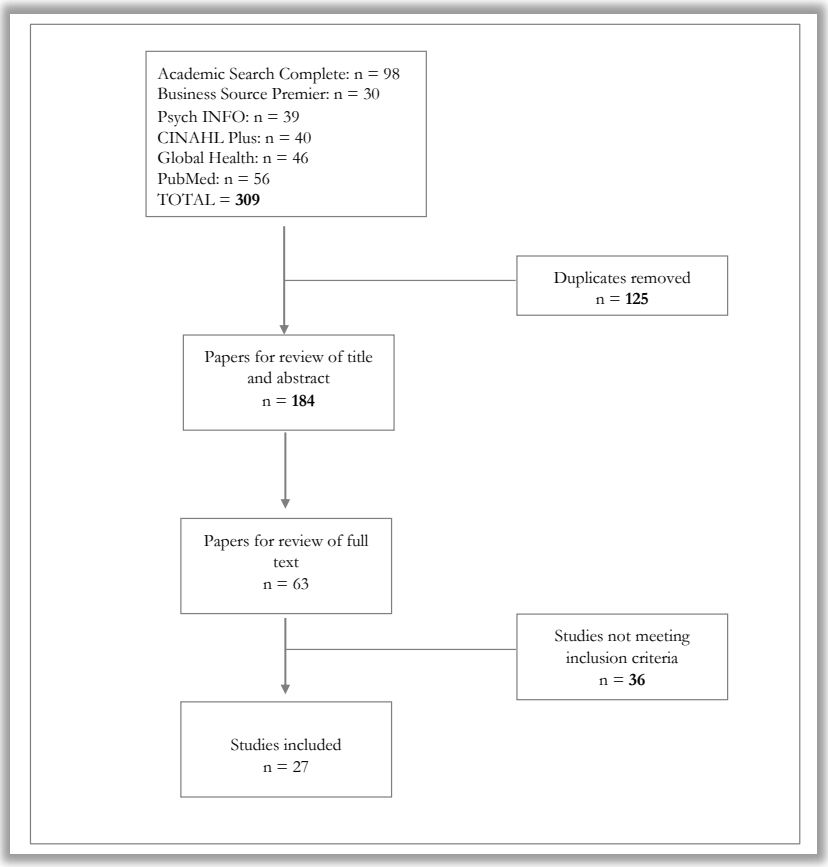


Figure 3-2: *Literature search and review process*

3.3.2 Focus

Social innovation has been applied to a variety of disease focus areas and to meet public health policy objectives (see Table 3-2 below). Social innovations in LMICs focused on infectious diseases, targeting prevention and access to services for malaria, HIV and Chagas disease [165-168]. A second focus of social innovations in LMICs was to achieve equity in access to care and this included women's health issues and social determinants of health such as poverty, rurality, and infrastructure (basic sanitation) [165, 168, 169]. The literature from high-income countries describes a different application of social innovation in terms of disease focus and public health objectives. Many European countries have adopted social innovation to address welfare state failures, particularly related to the inability of governments to sustain rising health expenditures for ageing populations [170-176]. Social innovations have also been developed in response to policy objectives concerning public participation in health, often as a secondary strategy to move the burden of care from the state to individuals and other actors through social enterprise [175, 177-179]. As this indicates, social innovation is typically applied to address health system failures. Kreitzer et al [180], for example, explored the Buurtzorg (Neighbourhood Care) Model in the

Netherlands, designed to overcome vertical service delivery, low health worker satisfaction, and burdensome bureaucratic processes of care. De Freitas et al. [177] presents a participatory process involving families of patients affected by congenital disorders in the design interventions in areas where health systems responsiveness is poor, and Windrum et al. [181] presents the case of creating a standardised diabetes prevention and management programme based on patient-centred principles. This programme led to the reform of care provision across multiple countries.

Table 3-2: Social Innovation Focus

		PUBLIC HEALTH OBJECTIVE			
		Health Equity (including access & affordability)	**Health Promotion & Prevention**	**Health system & care-coordination**	**Expense Reduction**
DISEASE FOCUS	**Infectious Disease**	Srinivas et al. (2020)	Castro-Arroyave et al (2020a) Castro-Arroyave et al (2020b) Srinivas et al. (2020)		
	Non-Communicable Disease	Mason et al. (2015)	McCarthy et al. (2013) Rugge et al (2013) Grindell et al (2017) Windrum et al (2018)	McCarthy et al. (2013) Henry et al. (2017) Valentine et al (2017) Windrum et al (2018)	Dube et al (2014)
	Maternal, women & child health	Mason et al. (2015) Cheema et al. (2019) Awor et al. (2020)	Castro-Arroyave et al (2020a)	McCarthy et al. (2013) Dufour et al (2014) Farmer et al (2018)	
	Ageing population		Gigha et al (2020)	McCarthy et al. (2013) Kim et al (2019)	Currie et al (2014). De Rosa et al (2017(Merckle et al (2018)
	Mental health / disability	Mason et al. (2015)	McCarthy et al. (2013)	De Freitas et al (2017)	
	Social determinants of health (poverty, gender, water & sanitation)	Castro-Arroyave et al (2020a)	Pless et al (2012)		
	No disease focus			Kreitzer et al (2015) Ballard et al (2017) Vijay et al (2018) Mariavittoria et al (2019)	Wass et al (2015) Mariavittoria et al (2019)

Table 3-2*: Social Innovation Challenge Focus*

3.3.3 Form and Function

The classification of social innovations was problematic because of their divergent operational definitions. Two articles provided a proposed typology for social innovations in health. Mason et al. [170] proposed four types of social innovations in health equity: as social movements; services; social enterprises; and digital products. Farmer et al. [178] proposed a typology developed by frontline providers to promote child dental health as: extending

existing practices; developing cheaper versions of existing products; adapting existing practices in different contexts or practice spaces; and translating ideas directly from evidence. From these cases studies of specific social innovations, however, the proposed typologies proved too narrow or restrictive as classification structures. The case studies fell into two functional categories, with social innovation treated either as a process or an outcome.

Four studies focused on social innovation as a process. These studies employed participatory mechanisms to give patients, family members, beneficiaries and frontline professionals opportunities to contribute to the development of new solutions to local challenges. The goal in all cases was to enhance patient or public participation in health care and enhance social relationships. Collaborative workshops occurred in the form of design sprints, co-design processes and think tank methodologies [177, 178, 182]. All these workshops were led by professional facilitators who were described as being 'bricoleurs', providing inspiration to participants, protecting the innovations, and linking them to resources. Srinivas [167], for example, presented a case that used crowdsourcing contests to give men who have sex with men (MSM) the opportunity to design health promotional material to encourage other men to test for HIV.

Where social innovations were described as an outcome, models included different components (services, products, processes, social movements) and delivery in different settings. Neither single component of the model was particularly unique, but the combination or 'bricolage' of these components resulted in innovation. Three types of models were identified: care models; social network/connection models; and entrepreneurial models (see Table 3-3). These models may or may not have a digital component or a financial component. Innovation in care models involved the re-organisation of care processes, including how services were delivered, often moving facility-based services directly into the community, with the role and scope of providers modified to give more autonomy or allow for task-shifting to non-health professionals [167, 174, 180, 181, 183, 184]. These care models reported positive outcomes on extending access to health services, enhancing affordability and improving effectiveness on disease or wellbeing indicators. The innovative aspect of social network models were the connections and relationships fostered between different actors and sectors [185-187]. Digital products such as mobile apps or online websites were leveraged to facilitate connections between actors. The outcomes of these models included positive behavioural change, building community social capital, and enhancing women's participation and roles. The innovation within the entrepreneurial models were mechanisms to reduce costs of services [176, 188], while also improving access to services and creating new employment opportunities.

(Table 3-3: *Social Innovation as an Outcome* (see at the end of the chapter)

3.3.4 Followers

In the literature, creators of social innovation can operate either as individuals or as collectives, the latter including citizen movements, cross-disciplinary collaborative actor teams and institutions. The characteristics of individual social innovators in health are not well described, but three case studies offer insight into the role of personal experience, hardship or challenge, or of a community playing a significant contribution in the innovator's work. Among the indigenous Maori population of New Zealand, innovations can often be constrained by culture and place, especially when diverted from acceptable mainstream western approaches [183]. However, social innovators in health used cultural, social and place-based capital to create solutions to serve their own communities [169, 183, 184]. In each case, community trust in the innovation was critical to its success.

The collective creation of social innovations in health, either in cross-disciplinary actor teams or networks, has received greater attention. Firstly, the social innovation development process is used to overcome the siloed nature of health and to foster greater interdisciplinarity and intersectionality [165, 166, 170, 171, 173, 182, 185, 188]. This is particularly well illustrated in relation to Chagas disease in Guatemala, where innovation in interventions involved collaboration from epidemiology, biology, anthropology, sociology, engineering and architecture, and various funding agencies, international non-governmental organisations, government and universities [165]. The benefit of teams and collective networks is their capacity to move beyond boundaries and draw on collective cognition, capital, and the pooling and complementarity of capabilities [171].

Within these teams, opportunity was created for the participation of non-expert actors. As described in these articles [165, 178, 182], the value of social innovation from a public health policy perspective is the opportunity it affords less powerful actors (patients, families, beneficiaries, community members) to contribute to new health solutions, drawing on experiential knowledge and personal knowledge that can meaningfully contribute to and complement expert or academic knowledge. Applying social innovation as a process in itself leads to new forms of power relations and empowerment. The participation of actors in solution creation in some cases has translated into community action, but little beyond anecdotal evidence is presented in the health literature of sustained intervention success or actor empowerment [165, 177, 178]. Case studies from the management and development literature provide more depth and longitudinal evidence to substantiate the extent to which communities can be empowered, ensuring that self-governance and community autonomy of initiatives are achieved. The Kerala Palliative Care model, for example, has scaled far beyond its initial locus of implementation. From 1995–2012, 230 community organisations and 26,000 social activists became involved in the delivery of home-based services to 70,000 patients at the end of life [184]. The Graham Vikas social innovation in India also illustrated that the core to its approach is one hundred percent inclusion of members of

the community, particularly women's involvement in all decision-making processes. As a starting point, the program established a representative committee in each village, and a sustainability fund into which community members contributed, according to their means, to co-fund the work. Throughout project implementation, training was delivered on leadership, accounting and other operational procedures to ensure the community can fully manage the initiative independently [169]. Another example, the Business-in-a-Box initiative in Pakistan, illustrated how adopting a micro-entrepreneurship approach to extending access to contraception can empower women to become self-employed income generators while meeting their health needs [188].

In addition to embedding social innovations directly into communities, institutionalised actor networks can work to ensure sustainability. One model which has successfully embedded an initiative across multiple institutional levels is the Therapeutic Patient Education Model for Diabetes [181] in Austria. This case demonstrated the importance of social innovations engaging in institutional and political work with existing professional bodies at local and international levels, while creating new professional bodies to support its translation from research, its diffusion, and its sustainability.

In summary, no category of actor is excluded from social innovation, irrespective of his/her background, organisational affiliation or hierarchical level. Across the literature, social innovation is seen as a democratising catalyst for health, enabling broad-based sectoral action, inclusion of marginalised individuals (including women) and providing communities with opportunities for action.

3.3.5 Values

To examine the principles and values upon which social innovations are based, articles were sub-classified according to the social innovation paradigm to which they ascribed. As illustrated above (Figure 2), three main paradigms exist: the instrumental or technocratic paradigm that accounts for social inclusion in the creation of new solutions; the democratic paradigm that accounts for the empowerment of actors through social innovation; and the institutional or structural paradigm that accounts for changes within existing institutions and systems. The majority of articles (16/27) upheld the instrumental or technocratic paradigm in which context social innovation was regarded as a solution to address challenges and occurred through participatory processes that promoted the social inclusion of different actors. Although encouraging engagement in social innovation, this paradigm does not differ vastly from other approaches to public or patient participation and participatory governance in public health and development. These solutions offer improved ways to ensure greater effectiveness or efficiency, but there is no evidence of transformed relations or structures. These articles originated mainly from Europe, where the approach to social innovation has been influenced by the European Commission's inclusion of the principle into policy with neoliberal agendas [132].

A second but smaller number of articles (8/27) engaged with empowerment. These go beyond giving actors a voice or opportunity to provide input through consultation and provide them with the opportunity to take control. By building the capacity of marginalised or under-represented actors, they developed an enhanced level of agency and action which suggests a change in power relations taking effect. Many larger-scale social innovation care models had people-centredness as a core organising principle [180, 183, 188]. Models were designed to involve not only the patient or the beneficiary at the health centre, but also health workers. The Buurtzog Neighbourhood Care model, for example, illustrated how, by enhancing patient and provider (nurse) autonomy, better outcomes in care provision were achieved and provider motivation and satisfaction were enhanced [180]. The iMOKO (New Zealand) and Business-in-a-Box (Pakistan) cases both illustrated empowerment of the local community by placing access to healthcare in the hands of trusted community members such as teachers, and by giving women in the community opportunities for income generation [183, 188]. The Time Bank model ascribed dignity and worth to the life of each person, and this highlighted the value of community members as active participants in healthcare: "The first core value of the Time Bank operations is asset, something of value to share with someone else … no one is worthless in the world … everyone is a contributor to society in his or her own way" [187]. Social innovations showed how trusted community members such as teachers can play a vital role in promoting health and access to services; how women can play a role in the delivery of health products while being lifted from poverty through income generating opportunities; and how elderly people can be both consumers and providers of services [165, 166, 180, 183, 185, 187, 188].

The third and smallest number of articles (4/27) ascribed and recognised the systemic or structural paradigm of social innovation, and in the research, assessed the changes and dynamics that occurred at an institutional level. The research conducted by Vijay and Monin [184] in India adopted an institutional perspective to examine how certain contexts are more 'poised' – receptive and ready – for social innovations. They also examined how actors, operating as institutional entrepreneurs, exercised agency to play an important role to increase the readiness of specific contexts to innovation and to overcoming the perceived resistance of existing institutions and structures. The Kerala Palliative Care model demonstrated large scale institutional change as it reframed palliative care provision from a medical framework to a social justice framework, with a professional hospice or hospital model replaced by the bottom-up organisation of services delivered primarily by community volunteers. The Therapeutic Patient Education Model for Diabetes revealed that, at the core of this initiative, systems level change was achieved by the institutional work of actors from national professional associations. They worked to embed the model into existing institutions (e.g., health insurance funds), while they created new institutions (new professional bodies) to ensure that new norms, values and practices were embedded at a systems level. Windrum et al. [181] recognised the potential of a model of patient centred care as having the potential of democratising medicine.

Lastly, research conducted by Pless and Appel [169] illustrated how social innovations transformed the norms, values, perceptions and roles within social institutions at community level through several approaches: the complete inclusion of all community members; the establishment of self-governing community structures; the provision of skills building and service delivery. The project placed community members in the role of clients, so that project staff only acted upon community requests. The long-term commitment (> 20 years) of this social innovation ensured that the outcome of an equitable and social society was achievable. This innovation recognised health as an outcome of sustainable development.

3.3.6 Facilitators

As a final part of the framework analysis, the facilitators of social innovations were considered in terms of enabling and limiting factors that are relevant at different stages of the social innovation life cycle. There were several commonalities across the literature in terms of enablers for idea development and implementation including: creating a safe, protective and facilitated environment; the democratic sharing of knowledge; the importance of timing and context and implementing self-governance structures to support ongoing implementation and sustainability. Moving beyond the innovation locus to engage more broadly with partners and the existing system influenced innovation transfer, diffusion and scale. Only two studies – Therapeutic Patient Education Model and the Kerala Community Palliative Care model – described the process of institutionalising a social innovation [181, 184]. In both cases, a clear strategic approach was adopted by the innovators and implementers to replace prior institutional logics with new logics. This entailed deep contextual awareness and engagement in different forms of institutional work: advocacy to support movement building; locating the challenge in a moral or social justice framework engaging existing institutions and creating new ones and investing in the education of those involved in the innovation, both to attain legitimacy and ensure that standards can be maintained. Both of these social innovations have proven sustainable, and as models, they have been scaled to different settings and countries (Austria and India).

TABLE 3-4: Enablers and Barriers	
ENABLERS	**BARRIERS**
Stage 1: Idea Development & Implementation	
A facilitator overseeing the process - guidance, bricolage, linkages with the system [177]	External support - A social innovation process facilitated by professionals would be costly at scale. [177]
A protective niche / environment - a safe setting for ideas to be developed and granting participants permission	
Open information sharing between participants and stakeholders across different sectors and disciplines, including involving community or frontline voices [165, 175, 177]	
Timing / Leveraging windows of opportunity – when resources and support are available. [174]	
Context – history of innovation and enterprise in a specific people group, alignment with cultural values, existing organizations, active civic participation [183, 184]	Political context – a changing policy landscape and mandates [189].
Characteristics of the innovator – an insider (from local community, embedded and lived experience), access to different forms of capital (cultural, intellectual, political, social, financial) [169, 183]	Characteristics of implementers – lacking motivation and drive [189].
Community ownership – self-governance structures to place the community (beneficiaries) in charge of the innovation [168, 169].	
Stage 2: Transfer / Diffusion / Scale	
Alignment with existing regime and structures [178, 181]	Political culture - A lack of willingness of the existing system or government to make allowance for the integration of the innovation or for new actors to play a role [173, 174]
Partnerships with stakeholders & especially policy makers [169, 178]	Resource constraints – limitations in funding [169]
Digital formats e.g., applications, mobile phones, online networks [168, 170, 186]	Limited evidence on social innovation effectiveness and unintended consequences [190, 191].
Stage 3: Institutionalisation	
Political context – encouraging civic engagement and participatory democracy through discussion and deliberation between civil society and state; history of community organizing and social movements; political capacity of government to bring about changes in healthcare [184].	
Communication and advocacy – movement building by engaging a range of organizations to engage in the discussion / spread the message [181, 184].	
Leveraging available infrastructure and competencies (in contrast to creating new ones) – health facilities, health providers including traditional providers [181, 184, 188]	
Political work – engaging existing institutions e.g. professional associations and forming new ones [181]	
Educating work – developing training for new actors to become involved (medical professionals or volunteers) [181, 184]	
Policing work – through certification of certain actors, quality is enforced and monitored [181].	

3.4 Discussion

Social innovation is a multi-dimensional concept used in relation to innovations in social relations, governance transformation, and social and complex adaptive systems. Actors, as individuals or collectives, play a key role in the social innovation process, especially moving initiatives from a localised level to a macro-level. In this article

we sought to critically review the application of social innovation in health care and present the results of a scoping review of peer review research published from 2010 to 2020. In doing this, several research gaps and opportunities for social innovation in health and related research emerged.

The 27 research articles revealed that social innovation draws on diverse disciplines and fields, with half of the articles arising from fields other than health. Case study research was the main method applied in studying social innovation. As a result, the evidence remains exploratory and descriptive, with weak proof of impact. Most case studies are snapshots of social innovations at specific points in time, without strong theoretical underpinning. No case studies adopted a health policy and systems research (HPSR)perspective. The lack of longitudinal or historic evidence underpinned by theory are barriers to the deeper understanding of the evolutionary process by which social innovation develops, how it is sustained over time through community embeddedness, and how systems change as a result of the adoption and institutionalisation of social innovation. Although research on social innovation in health has increased in recent years, there is still very little research originating from low- and middle-income countries. There is consequently ample opportunity and a need to build stronger evidence on social innovation in health, to deepen the investigation, engage more social scientists, draw on theory from management, organisational and institutional studies, adopt a health systems perspective, and build capacity for this concept and its processes and outcomes in LMICS.

When comparing research conducted and published in health journals with those published in other disciplines, health researchers often adopted a reductionistic view of social innovation, limited to the instrumental and technocratic paradigm of social innovation as a means to an end. Most definitions used to conceptualise social innovation in this literature only addressed the first three dimensions of social innovations: addressing a challenge; adopting a participatory process; and creating solutions. The focus of many of the health solutions presented in this literature was to enhance the effectiveness and efficiency of current health systems. The literature from Europe focused on cost reduction and cost savings to reduce the burden of the state, in line with the neo-liberal political agenda. In this literature, social innovations were described as a variety of disconnected solutions without evidence of how these might act in a coherent and complementary way to achieve systems transformation. This approach appears to re-emphasise the prevailing belief of health systems as mechanistic and compartmentalised, led by technical experts. Social innovation has not been studied through a health systems lens that views systems as social and human institutions [192].

In several studies, the inclusive and participatory process of social innovation has been applied without evidence that led to the empowerment of beneficiaries, patients and frontline workers; social innovation appeared simply

as a new buzz word [193]. In line with this, the health literature emphasises the need for facilitators. But cultivating an enabling environment for social innovation does not necessarily require an external, and often costly, facilitator. This current emphasis raises the question whether social innovation is yet another top-down process in health, instead of one that encourages and supports those actors who already demonstrate embedded agency despite constraining institutional structures or settings [45]. For these barriers to be overcome and for social innovation to deliver value, it is imperative to move towards a more democratic and systems paradigm of social innovation. Health researchers would benefit by adopting an interdisciplinary research approach, reviewing, and engaging with theories used by other disciplinary scholars, while reflecting on their own expert-driven notions of health.

Social innovation provides practical insights into how implementation in health systems and practice can be enhanced. It also provides a framework towards understanding systems innovation – the change and transformation of existing systems, beyond mere incremental improvement, or the creation of new systems organised around people's needs, realities, and desires instead of only based on structures solely designed to achieve functional efficiency.

Social innovation supports the development of people-centred systems by suggesting ways to extend the range of actors beyond those traditionally involved in public health programmes. It enhances equity by giving a voice, and thus power, to ideas and solutions, especially those emerging at grassroots level. By recognising the value inherent in individuals and the knowledge gained from their lived experience, it achieves deeper insight into the structures of power that dictate and limit the roles, capacities, and functions of actors and by shifting the power dynamics, new avenues for involvement and participation in health services are created. In addition, social innovation does not seek to provide symptomatic solutions but often addresses the root causes that produce marginalisation, such as addressing community and societal perceptions around the role and participation of women. By design, social innovation initiatives place 'the last, first' – those with the least experience or least perceived value by society become the creators, drivers, and implementers. It invites beneficiaries, frontline providers, and community members to be part of the full continuum of implementation, extending to them power and agency to become the leaders and ultimately the owners of health interventions and programmes. In this way it also addresses the limits of community engagement noted in public health and extends it beyond mere tokenistic consultation [194].

Social innovation's system's transforming capacity is further derived from it being inherently interdisciplinary and intersectoral, with boundary-spanning incorporating approaches and practices from different fields and

applied in health care, such as from environmental studies. It thus can be a useful tool for policy makers seeking to enhance holistic socio-developmental policies as espoused in the Sustainable Development Goals, and to solve complex systemic challenges outside sectoral silos.

3.5 Conclusion

Key in its implementation, social innovation emphasises context. No two contexts are approached in the same way and the nuances and uniqueness are accounted for, so limiting 'one-size fits all' models. Case studies illustrate how this has occurred through contextual embedding, adaptation and participation of communities and beneficiaries. Caution should be given however to avoid social innovation becoming a new label for tokenistic participation without a shift in power dynamics across the full spectrum of implementation. Finally, social innovation illustrates the importance of addressing prevailing institutional voids, while holding steadfast the vision of what renewed institutional logics could achieve and providing an inclusive opportunity for all actors to move forward. In this way change occurs slowly, requiring multiple micro-shifts in individuals, communities, and health care institutions to ensure sustainability and embedding. To explore the full potential contribution that social innovation offers healthcare, further research is required that adopts an institutional theoretical underpinning and systemic paradigmatic lens.

TABLE 3-3: Social Innovation as an Outcome								
	Author	**Model**	**Country**	**Innovator**	**Location of delivery**	**Scope & Beneficiaries**	**Components**	**Reported outcomes**
Care Models	Kreitzer, MJ et al. (2015) [180]	Buurtzog (Neighbour-hood Care Model)	Netherlands	A Dutch nurse (Jos de Blok)	Community	630 nursing teams (7188 nurses), 55 000 clients (2013)	Overcoming costly, fragmented home care through: − Self-directed, empowered and autonomous nursing teams providing a range of comprehensive services in a relationally oriented way that would achieve patient independence. − One-cost fee for service with limited managerial staff to keep administrative overhead to a minimum. − A digital intranet to connect all nurses and perform scheduling, billing, documentation and outcome monitoring.	↑ health worker motivation. ↑ patient outcomes & satisfaction. ↓ fee for service.
	Henry, E et al. (2017) [183]	iMOKO Innovation	New Zealand	A Maori medical doctor (Lance O' Sullivan)	Community	3800 school-aged children from Maori indigenous group	Overcoming lack of access to care to do place, cultural incongruency and cost of services through: - A digital application to support diagnosis and treatment of school-aged children by linking community professionals (e.g., teachers) to network of primary care doctors. - Teachers act as main custodian of school children health.	↑ community ownership over health in line with collectivist cultural values. ↓ in indirect costs of accessing care via in person doctor consultation. ↑ affordability of care. ↑ appropriateness of in-person consultations.
	Merkel et al. (2018) [174]	Gesundes Kinzigtal (Healthy Kinzigtal)	Germany		Facility		Overcoming fragmented and uncoordinated care through the HK integrated care programme - A joint venture between a network of physicians and healthcare management company to extend health services. - Model supported by two sickness funds and a network 150 partners including allied health services, sports clubs, and self-support groups. - Outcome-oriented financial approach: profit only made if cost margins of population goes down i.e., outcomes improve. - Provider training in supporting patient self-management and shared decision making. Patient accountability through a patient advisory board, satisfaction surveys and patient ombudsman.	↑ patient outcomes. ↓ in health expenditure.
	Vijay et al (2018) [184]	Kerala Community Palliative Care	India	Indian medical doctors & volunteers	Community	230 community organisations (85 doctors, 270 nurses 15,000 volunteers, 26,000 social health activist providing care to 70,000 people across 143 villages (2012)	Overcoming access to end-of-life services and the restrictions of a hospice-based approach: - A hub-and spoke model linking community organisations to clinics. - Non-medical professionals, community volunteers, deliver palliative services. - Services delivered directly in people's home.	↑ access to of care. ↑ affordability of care. ↑ awareness of palliative care.
	Windrum et al. (2018) [181]	Therapeutic Patient Education	Austria		Facility		Restructuring chronic disease diabetes care according to a patient-centred approach comprised of: - Training diabetes educators (different health professionals) and specialist physicians' postgraduate course - Engaging professional associations to set standardised processes for diabetes care and ensuring compliances Including the services as core to the Social Health Insurance fund	↑ patient knowledge & self-management. ↑ healthy lifestyle behaviour in diabetics.

	Srinivas, ML et al. (2020) [167]	Learner Treatment Kit Self-collection for HPV Screening	Malawi Peru	Save the Children & Malawi Ministry of Health University research team	Community	School age children in 58 schools 643 low-income women	Addressing underdiagnosis of malaria in school children due to cost & access to care: - Providing a product supply box of malaria diagnostics, treatment and other first aid supplies to schools. - Training of teachers to administer diagnosis and treatment. Addressing cervical HPV screening availability limitations in low-income areas through: - Leveraging CHWs to provide self-screening kits to women and take kits for diagnostic procedures at health centre. - Self-testing HPV done by women.	↑ access to of care. ↓ school absenteeism.
Social network models	Ruge, D et al. (2012) [195]	LOMA	Denmark	University research team	Community - Schools		To address obesity among adolescents a multi-strategy approach: - Linking schools to local organic food suppliers for local production and procurement. - Food education for children through linking them to local farmers and combined teacher-pupil cooking classes. - Shared engagement in meals by teachers and pupils (eating together).	↑ knowledge of children on food production and nutrition. ↑ social capital between school and local community. ↑ sense of wellbeing through social relationships.
	Grindell, C et al. (2017) [186]	iStep Prototype	United Kingdom	University research team	Community	School-aged children & teachers	To address obesity and limited physical activity in school children through: - Pairing up intergenerational teams of school children with teachers or older adults through shared walking challenges. - A digital pedometer linking to an online platform to measure progress.	↑ physical activity. ↑ social connections.
	Kim, H (2019) [187]	Time Banks	South Korea	American innovator (Edgar S Cahn) – replicated in Korea	Community	950 senior citizens	Addressing the ageing society, high incidence of mental health and suicide in elderly and limited co-ordination between health and social services through: - Model that connects people with a need for a service to those who want to serve (creating mutual support network and providing the elderly an opportunity to receive and give services (reciprocity). - Time credits are exchanged for services such as shopping, dog walking, childcare etc.	↑ community solidarity & agency. ↑ individual physical & mental wellbeing. ↑ access to necessary social services. ↓ in health-associated costs.
	Cheema, A et al. (2019) [188]	Business-in-a-box	Pakistan	Rural Support Programmes Network (RSPN) in partnership with Population Services International (PSI)	Community	450 women	Addressing low contraception prevalence rate and high unmet need for reproductive health provision through a micro-entrepreneurship approach: - Training local women as community resource persons. - Providing a product kit – a bag with contraceptive, household and hygiene products. - Establishing a micro-franchise chain to ensure regular product provision.	↑ increase access to contraceptives. ↑ female financial independence & empowerment.

Entrepreneurial models	Cicellin, M et al. (2019) [176]	Low-cost clinic models	Italy	Centro Medico Santagostino; Nuova Citta; Medici in Famiglia	Facility		Overcoming service gaps in the national healthcare system for which quality is low or waiting lists are long through different business models that include a social cooperative, a network of low-cost clinics. These social business models, made possible through: - Recruit and engage medical staff at reduced renumeration but with long term financial incentives. - Different pricing models and a select number of high-value services - Operating at economies of scale. - Cross-subsidization between wealthy and low-income groups or between services generating different profit margins.	↑ affordability of care. ↑ access to of care

4 CHAPTER 4 – THEORETICAL OVERVIEW: UNDERSTANDING SOCIAL INNOVATION THROUGH AN INSTITUTIONAL LENS AND THE INFLUENCE OF SOFTWARE FACTORS IN ITS ADOPTION AND INSTITUTIONALISATION

4.1 Introduction

In this research study, I will study social innovation through an institutional lens for two reasons: first, as identified in the scoping review (Chapter 3), studies pertaining to social innovation in the domain of health or healthcare have a limited theoretical underpinning and have been along the lines of the technocratic paradigm, focused on achieving outcomes such as efficiency, effectiveness, and enhanced participation. However, the technocratic paradigm of social innovation provides an insufficient explanation of how systems and institutional change come about as a result of social innovation. Second, although frequently used theories, for example Roger's diffusion of innovation theory, have been used in understanding the adoption of innovation in public sector contexts; these do not sufficiently account for the software or 'non-instrumental factors' influencing this process. Software captures the tangible and intangible process and affective factors which play a role in health systems as well as in the institutionalisation of social innovation [13, 16, 196] (see Chapter 1).

In this study, I draw upon neo-institutional theory, from the field of sociology and organisational studies, in seeking to explain micro- and macro-level influences of social innovation. This will be complemented with theory from positive organisational scholarship and psychology, to explain the micro-level and meso-level influences.

The purpose of this following chapter is three-fold:

- Highlighting social innovation as a concept focused on institutional and systems change.
- Introducing neo-institutionalism (institutional work theory and institutional logics) as a lens in studying social innovation and describing its relevance for studying the software factors which has an influential role in the process of adoption and institutionalisation.
- Introducing the analytic framework of this study and reviewing the theoretical literature associated with each three levels of the social innovation model, including the respective components in each.

4.2 Social Innovation in Health: Institutionally Embedded to achieve Systems Change

As described in Chapter 3, the majority of research studies on social innovation applied to healthcare, approached social innovation through an improvement-based, technocratic lens, similar to that of market-based innovation. These studied focused on assessing social innovation's potential to bring about incremental change in terms of care enhanced effectiveness, efficiency and participation. Only a small number of studies (3/27) adopted the institutional paradigm in studying social innovation and were able to provide insight as to how a change in practice at a micro-level, could lead to macro-level system transformations [169, 181, 184].

To understand 'the adoption and institutionalisation process of a Chipatala Cha Pa Foni as part of the Malawian health system', I adopt the institutional paradigm on social innovation. This perspective is reflected in Westley & Antadze's (2010) definition of social innovation chosen for this study:

> "*social innovation is a complex process of introducing a new program, policy, procedure, process and/ or design (that seeks to address a systemic health challenge) that profoundly change basic routines, resource and authority flows, beliefs (cultural values) of the system (that created the problem in the first place) in which the innovation occurs*"[1].

A prerequisite for social innovation to achieve transformative change is it being institutionally embedded or institutionalised at different scales or levels across the system [197]. In its most simplest explanation – institutionalisation is the process in which ideas are transformed, entangled and automated in formal structures and accepted as an effective way to achieve objectives [198]. This process can be seen to occur at three levels: at micro level, the idea is initiated and accepted by individuals or groups; at meso-level the innovation is incorporated into the organisational structure; and at macro-scale, it becomes part of the overarching system. Boundary-spanning actors, brokers, or network orchestrators play an important role in this cross-scalar institutional embedding process [46-48]. To develop an understanding of the case under investigation, it is necessary to explore the process of social innovation at a micro-, meso- and macro-level and account for the role and actions of actors at each level.

Nilsson [42] provides a more comprehensive heuristic or framework to understand a social innovation based on the institutional paradigm. The heuristic demonstrates the institutional shifts or changes that are required as social innovations become institutionally embedded in the five performative areas as per Westley's definition above: operating: roles, resource flows, authority flows, social identities and meanings. Table 4-1 below provides more detail of how social innovation influence each dimension. In Chapter 6, I describe how Chipatala Cha Pa Foni – the initiative which is the focus of this study - operated in each of these dimensions.

TABLE 4-1: HEURISTIC FOR SOCIAL INNOVATION [42]	
Performative institutional field dimensions	**Social Innovation's influence**
Roles – *who does what*	Role creation – creating new roles for actors by valuing previously disregarded types of knowledge as credible (cultural or experiential). Role deconstruction – breaking down the role to function combinations (especially those of overt disciplinary professional) and letting new traditionally regarded 'non-legitimate' actors pursue some of the sub functions.
Resource flows – *who gets what*	Leveraging hidden and discounted resources of value or potential value and decentralizing resource distribution channels or infrastructure through new actor types or information platforms.
Authority flows – *who decides what*	Increasing local autonomy by valorising local knowledge or convening relational (dialogic & value-based) decision-making making processes.
Social Identities – *who belongs to what*	Making social identity (emotional solidarity associated with roles) boundaries permeable, allowing for participation of previously oppressed or marginalized actors and convening cross-identity interaction.
Meanings – *who signifies what*	Challenges the institutional logics through interrogating the participatory dynamics (towards more inclusive and collaborative) and encouraging more holistic (whole-person or whole system) purposes

4.3 Limitations in applicability of the current models and theories of scale and adoption of innovation

Ahead of presenting the main theoretical framing of this study, that of neo-institutional theory, I briefly review two more commonly applied theoretical perspectives to innovation in public sector contexts. In this chapter, I will briefly describe the limitations of these perspectives and why they were not suitable for this study.

The first of these reflects the approach of Westley and other scholars [199, 200] who distinguish between two strategies for increasing social innovation's impact – 'scaling out' and 'scaling up'. 'Scaling out' refers to an organisation's attempt to become bigger and cover a larger geographic area [201]. This is done through strategies such as replication, dissemination and organisational growth [201]. The notion of 'scaling up' tries to provide a more encompassing perspective; extending the social innovation to all who may have a need for it. 'Scaling up' is supported through strategies that will result in institutional change at the level of policy,

rules, and laws [199, 200]. Yet, scaling up deserves cautionary note against the strong connotations of standardisation and central control, which are often associated with policy [202]. Very often, the catalyst for social innovations is in response to rectifying these very structures of standardisation and control [202]. As social innovation is a phenomena which is context- and, or politically-bound [197], social outcomes cannot be scaled as neatly packageable and standardised products. Reinvention and adaptation of the social innovation, especially in the public sector, will be of greater importance than standardisation [202]. Scaling social innovation in public sector contexts is more of a process-related issue.

An extensive literature exists, conceptualising systems or institutional embedding as adoption and diffusion [203, 204]. A review, by de Vries et al [205], conducted of studies related to public sector innovation adoption and diffusion across the fields of public management, public policy and e-government, found Roger's [203] innovation theory to be the most commonly used. Rogers defines adoption as 'the process through which an individual passes from first having knowledge of an innovation, to the formation of an attitude toward the innovation, a decision to adopt or reject, implementation and use of the new idea, and finally to confirmation of this decision'. Diffusion is defined as: "the process by which an innovation is communicated through certain channels over time, among members of a social system" [203].

As stated by Dietrich et al [196], the adoption of an innovation is strongly affected by the utilitarian or instrumental function it provides to its users. Instrumental factors influencing this include the innovation's characteristics (complexity, relative advantage, cost and compatibility) and system characteristics (resources, structure, leadership) [203, 204, 206] Dearing et al [207] cautions on the over focus on attributes. He states that this 'obscures the importance of human perception in the diffusion of innovation' especially as characteristics are not fixed or stable features and neither does the process of innovation follow predictable stages but rather it is iterative, organic and messy [204, 208]. Dietrich et al [196] further argues that this singular focus on the instrumental factors lacks the explanatory potential held by non-instrumental factors, such as the symbolic, emotional and motivational, in the process of innovation adoption. In Dietrich et al's study, symbolic factors such as openness, competence and warmth along with emotional responses, particularly optimism and intrinsic motivation, played an important influencing role in the adoption of social innovation.

This concept of looking beyond instrumental factors is gaining prominence in different disciplines. Literature from organisational studies and innovation describe this category of factors using the terminology of 'non-instrumental' factors; while similarly, the health systems literature recognises these as the intangible and tangible 'software' factors in programme and policy implementation. Intangible software factors include norms, beliefs, ideas, and values held by people; the role of power dynamics and trust within social

relationships; and factors such as motivation and leadership [13, 16-18, 20]. Tangible software factors include management knowledge, skills and processes [16]. As mentioned in Chapter 1, as this study falls within the realm of health policy and systems research (HPSR), I adopt the terminology 'software' factors to refer to the process and affective factors influencing institutional embedding.

4.4 Institutional Work and Institutional Logics: A framework for studying social innovation adoption and institutionalisation

Neo-institutional theory was identified as a second theory, in the review of de Vries et al [205], that has been applied across all scholarly fields in studying the adoption and diffusion of public sector innovations. This body of theory will be the main theoretical underpinning selected for this research study as it supports the institutional paradigm on social innovation (as described in 4.2 above) and overcomes the limitations identified with other theories (as described in 4.3). Although institutional theory cuts across several disciplines, I will use it in the way it has been conceptualised field's sociology and organisational studies, with a focus on the cultural and cognitive dimensions [209, 210]. The sociological tradition in organisational studies focuses on the 'phenomenological process by which certain relationships and actions come to be taken for granted' and how shared cognitions define 'what has meaning and what actions are possible' [211]. In the following section, I first discuss the meaning of institutions and institutionalisation; then I introduce neo-institutional theory as well as discuss its application (as institutional work) in the framework chosen for this study.

a. Institutions vs Organisations

As a start, it is worth noting the difference between organisations and institutions and then defining in more detail what an institution is. Organisations are the social settings and structures in which activities come into being and evolve according to a broader institutional rules and norms [212]. Institutions operate at supra-organisational level. Friedland and Alford [213] capture the importance of the temporal, spatial and symbolic dimensions of institutions in their definition of institutions as 'the supra-organisational patterns of activity through which humans conduct their material life in time and space, and the symbolic systems through which they categorise that activity and infuse it with meaning'. In essence, institutions provide the 'blueprint' for action, cognition and emotion in which the ordered reality of everyday life is lived out and reproduced in a routinised way within those settings [214-216].

b. Institutionalisation: from a subjective to an objective reality

As described in 4.2 above, social innovation's potential for systems transformation lies in it becoming institutionally embedded or institutionalised. In this study, I will focus on the process of institutionalisation or institutional embedding social innovation as part of the health system (as opposed to studying a process of diffusion of innovation). Institutionalisation has been perceived by scholars as a process of habitualisation, objectification and sedimentation [217]. All innovation, and particularly social innovation, requires new patterns of human activity. Berger and Luckman [218] first explained back in 1967, how all human activity is subject to habitualisation –actions that are frequently repeated become cast in patterns and over time, these reproduced patterns become built into the social order and embedded within the organisational routines. The actions and patterns that were once new become perceived, by the actors involved, as an objective reality. As Berger and Luckman describe, [218] over a period of time the *'there we go again'* becomes, *'this is how these things are done*". As patterns and practices become institutionalised, it reduces uncertainty and provide organisational members with a sense of stability [219]. Thus, as innovative actions become habitualised and take on an objective reality, a greater social consensus is achieved among organisational decision-makers and the process moves beyond simple diffusion or adoption, to attain heightened legitimation. Colyvas and Powell [220] states that institutionalisation 'is driven by the self-reinforcing feedback dynamics of heightened legitimacy and enhanced taken-for-grantedness. Legitimacy is understood by Suchman [221] as a shared presumption that the actions of an entity is desirable and appropriate within the socially constructed system of norms, values, beliefs and definitions. The final stage of innovation's institutionalisation according to Tolbert and Zucker [217] is that of sedimentation; the innovation is reproduced and perpetuated across generations and spread to all the relevant population. For a new innovation to be legitimately accepted as the taken-for-granted reality, it will require a process of institutional change.

c. Neo-institutionalism in Institutional Theory

Institutional theory is a body of theories that focuses on the 'socially constructed world', and it seeks to provide an understanding of how practices and patterns are represented and reproduced across social space, over time and at different levels [214, 216, 218, 222]. It seeks to explore how organisations operate, are structured and how they relate to each other; as well as how large-scale social and economic changes occur [223].

In organisational studies, DiMaggio and Powell [214] describes and distinguish two branches of this area of study: old institutionalism [224, 225] and new institutionalism [209, 226, 227]. The old institutional stream

understood institutions to be based on values, held together by multiple loyalties and the rational pursuit of goals. It provides an explanation of how organisations play a role in producing new ideas, and social systems and how these attain acceptance via overcoming vested interests through power and political co-optation.

The neo-institutional branch of institutional theory (from 1977 onwards) highlights the importance of cultural-cognitive dimensions, routines (the unreflective taken-for-granted scripts) and behaviours. It has an emphasis on legitimacy and regards the institutional environment not to only be limited to a single organisation but rather to operate at field level (all the organisations that constitute a recognised area of institutional life)[209]. Instead of considering institutions as constrainers of human action as by old institutional theorists [228], neo-institutional theorists recognises the important role of actors, operating as agents of change, to transform and reshape institutions. Social innovation scholars have used various sub-theories within neo-institutionalism to better explain social innovation and to connect macro-level systemic challenges to micro-praxis (the actions of actors) [42]. Three theoretical bodies of work are of value in the study of social innovation: a) Institutional Entrepreneurship (see 4.4.1); b) Institutional Work (4.4.2) and c) Institutional Logic (4.4.3).

d. A social innovation framework informed by institutional theory

In this study, I use and adapt a social innovation framework, developed by van Wijk et al [229], which encapsulates social innovation as an 'agentic, relational, situated and multilevel process to develop, promote and implement novel solutions to social problems in ways that are directed towards producing profound change institutional context" [43]. This framework is suitable for this research study for several reasons:

- The framework allows for various theories of neo-institutionalism to be drawn upon, as well as relevant related theories from positive organisational scholarship and positive psychology.
- It recognises that institutions operate at multiple social levels, and actors are nested within these levels at individual, organisational, field (collection of all organisations focusing on an area e.g. health) and societal level [213, 230].
- The framework regards institutional embedding as central to social innovation, and thus accounts for the dynamic process of institutionalisation [197].
- It accommodates the focus on software factors at micro, meso and macro levels which influences the process of institutionalisation [196].

In the sub-sections to follow, I provide a deeper exploration of each of aspect of this framework, drawing on the relevant bodies of theory.

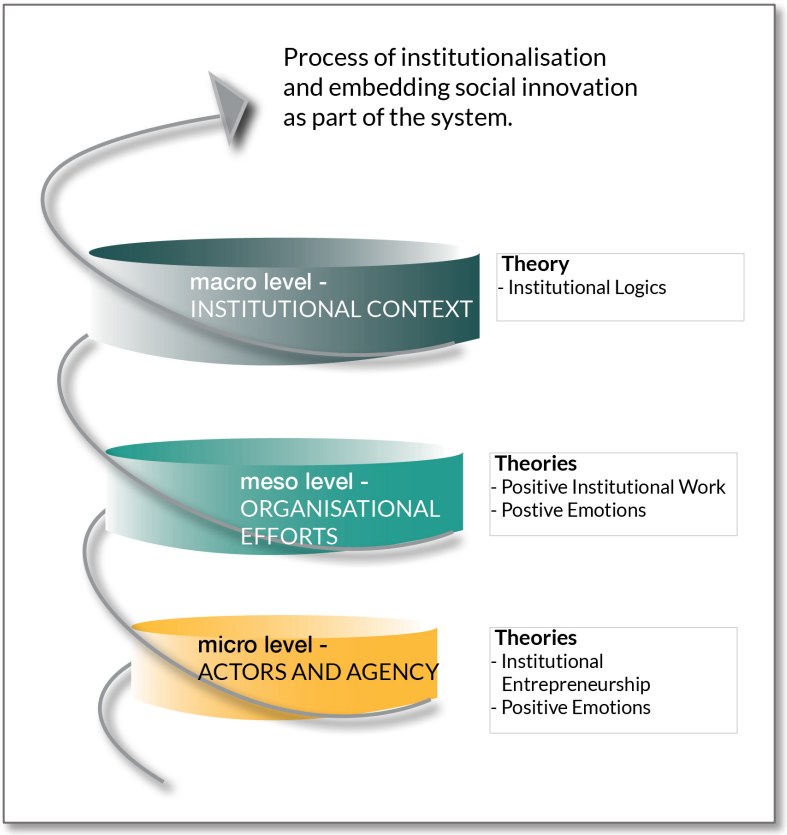


Figure 4-1 (2-5): *Modified study framework [43]*

4.4.1 Micro-Level: Understanding Actors and Agency in Institutional Work

The interplay of actors, agency and institutions have become an important area of investigation in neo-institutional theory, particularly regarding social innovation. Investigations have focused on understanding how individuals or groups of actors drive change in existing relational and social structures despite constraints [1, 231, 232] and how these actors are capable of 'the renegotiating of settled institutions or the building of new ones' [43]. The theory that emerged is that of Institutional Entrepreneurship.

Institutional entrepreneurship was first introduced in 1988 by DiMaggio [45] who conceptualised institutional entrepreneurs as organised actors with sufficient resources, who see in themselves an opportunity to realise an interest that they value highly; in particular that of institutional creation or change. This concept seeked to reintroduce actors' agency into institutional analysis, as scholars of the old institutional theory strand have often overlooked the role of actors in focusing mostly on the influence of exogenous influences to affect institutional change.

Battilana et al [45] provides further definition to the concept of institutional entrepreneurship by referring to institutional entrepreneurs as "*actors who initiate divergent changes in the institutional context and who actively participate in the implementation*'. This definition highlight two conditions that should be met for actors to be considered institutional entrepreneurs. First, the actor or actors must initiate changes that break from the accepted institutionalised templates; and second, they actively participate (agentic actions) in the changes either through implementation or by mobilising resources. It is key to remember that these actors operate within highly predetermined institutional beliefs, scripts and patterns of action [45]. Thus, what makes institutional entrepreneurship a particular interesting area of study, is the 'paradox of embedded agency' [233]. It explains how despite the constraints imposed on actors by institutions, they can still adopt a perspective that allows for reflexivity and the capacity to think and act in ways that transcends the sum of the cognitive influence of institutions [45, 234]. They are thus capable of affecting change within institutions. This paradoxical notion conceptualises agency as being distributed within the institutional structures and patterns that have been socially constructed. Actors can thus be regarded as knowledgeable agents with the agency to act in ways contrary to the prescribed or taken for granted social rules, norms and beliefs [235]. But how can this agency be better understood? This next section will provide a deeper explanation of agency before returning to the characteristics of institutional entrepreneurs displaying agency.

Agency has be conceptualised in multiple ways as motivation, intentionality, interest, choice, autonomy and freedom [236]. But from an institutional perspective, agency is viewed as a multidimensional, non-linear, relational construct that is subject to evolution and operates on a continuum [236]. Agency includes the ability to make choices independently of existing social structures [237] and the ability to take strategic action that will result in either social structures being altered or reproduced [49, 215]. Emirbayer and Mische's [238] definition of agency as a socially embedded process captures the three temporal dimensions of agency: the habitual, the practical evaluative and the projective (See table 4-2 below).

Table 4-2: AGENCY AND ENABLING CONDITIONS [238]

Temporal orientation	Dimension of Agency	Entails:	Enabling conditions
Past	Habitual element	Schematization of social experience	Institutional Entrepreneurship – social position, social skill, capacity for reflection and collective engagement.
Present	Practical evaluative element	Contextualisation of social experience	
Future	Projective element	Hypothesisation of experience	Positive Emotions e.g., hope

The **habitual element and the practical evaluative dimension** of agency lies within the past and present temporal orientations respectively. The past provides a rich foundation for actors which if reflected upon, engaged with, and iterated upon could serve as templates for future action. The importance of the past is well

articulated by Brueggemann who states that memory helps us to not accept the present as the only reality but rather, by memory and the act of remembering, new possibilities may emerge. [239]. Memory of the past could be the canvas upon which a new innovation can be sketched. Thus, past institutional experiences, patterns and practices can serve as valuable resources for actors to leverage and apply in the creation of a new institutional structure. Within the current context in which the actor may find him or herself, agency is displayed by 'being able to make practical and normative judgments among alternative possible trajectories of action, in response to the emerging demands, dilemmas, and ambiguities of presently evolving situations [238].

Scholars have been studying the characteristics of actors (institutional entrepreneurs) who exercise agency in institutional settings. Three characteristics or enabling conditions characterise the actor's capacity in relation to the two above-described dimensions of agency (by either leveraging the past or by navigating the current situation). These three characteristics are: the actor's social position, social skill and capacity for collaborating and building relationships with others.

Social position influences the point of view actors hold regarding their organisational field, their perspective and their access to resources [238]. The social position of institutional entrepreneurs provide them with legitimacy in the eyes of diverse stakeholders, to bridge the differences between stakeholders and give them access to dispersed or untapped sets of resources [240]. As is described by Battilana [240] social position encompasses three aspects: the individual's position in the organisation (informal, formal and tenure of position); his or her social groups status (other groups he or she may belong too) and their inter-organisational mobility (exposure to different organisational contexts). Suddaby et al [241] broadens the notion of social position by calling it: 'embedded social position'. This refers to actors' awareness of both the capacities and constraints of their social position. Linked to social position, authors propose a second explanatory variable that influences an actor's capacity to be an institutional entrepreneur; that of social skill [241]. The notion of social skill suggests that some individuals have a highly developed cognitive capacity that make them more capable of motivating cooperation and collaboration in other actors [242]. Individuals with high cognitive capacities are also able to hold broader worldviews or cultural frames that give them a larger conception of their institutional environment [242]. Actors holding a lower social position, those who does not possess the formal authority to drive change, may rely to an even greater extent on their social skill to achieve or drive change [241].

In addition to social position and social skill variables, agency is developed through a relational process; enabled by dialogue and engagement with others in collective organisation [163, 238]. This view helps to further the understanding of institutional entrepreneurs beyond that of actors being lone heroes 'with

superhuman foresight and enough resources to spark the process of institutional change' [243, 244]. Thus, it is not only the individual actor's social position or social skill that results in agency. Rather as found by Dorado [244], a small group of collaborating actors can serve as a locus of agency and central to motivation, opportunity identification and resource access.

A third dimension of agency that actors display, is that of the projective or future-oriented dimension [238]. It is this creative reconstructive dimension of agency which gives shape and gives direction to future possibilities emerging. Actors attempt to reconfigure the taken-for-granted schemas and patterns, to imagine alternative possible responses to challenging situations they confront. In essence, they demonstrate a capacity to go 'beyond themselves' into the future, to construct a vision of where they want to go and how they can get there [238]. Casting a vision or an imagination of the future holds the potential of ' unleashing a community of power and action that will not be contained by imperial restrictions and definitions of reality' [239]. This projective or future-oriented agency displayed by actors holds particular importance to innovation and change within institutions and systems [238, 245].

Scholars have further studied the enabling conditions of this projective dimension of agency, such as positive emotions. Ten positive emotions have been identified namely joy, gratitude serenity (contentment), interest, hope, pride, amusement, inspiration, awe and love [246]. In general, these positive emotions are regarded as a human-based resource in organisational life with the capacity to foster greater organisational resilience [247]. As theorised by Fredrickson, positive emotions have the ability to broaden and build individual capacity [246]. At an individual level, 'broadening' leads to an increase in cognitive (better engagement with new information), psychological (resilience, optimism) and physical capacities (rebounding from stress); while at a social level, it enable actors to be more inclusive, expand their circle of trust, and have greater perspective-taking and compassion for others [246, 248]. This broadening aspect of positive emotions enable people to have wider perceptual access, wider semantic reach and more inclusive and connected social perceptions [246, 248]. As understood from past research, positive emotions broaden and build actors agentic capacity as institutional entrepreneurs to engage future orientated possibilities for change and transformation.

One particular positive emotion namely hope, has a strong association with future-oriented agency and requires further attention as a possible software factor for consideration in the social innovation framework. Hope has been studied from a variety of academic disciplinary traditions but two of greatest relevance for this research, is that of positive psychology [249, 250] and Positive Organisational Scholarship [251-254]. Hope is unique as where most positive emotions arise in conditions people appraise as being safe, hope arise in negative circumstances where people fear the worst but continue to yearn for better [255]. The conception of hope goes beyond naïve or wishful thinking, but fully recognise its 'unalloyed reality' [256]. As stated by

Fredrickson, 'hope creates the urge to draw on one's own capabilities and inventiveness to turn things around' [246]. Hope, as an emotion, is conceptualised as being comprised of cognition and affect. This plays out at both an individual and organisational level. Hope theory, as put forward by Snyder [249] has described the operation of hope at an individual level. Snyder and colleagues [257] defined hope as ' a positive motivational state that is based on an interactively derived sense of successful agency and pathways.' More simply framed by Ong [258]: hopeful thought reflects the belief that one can find pathways to desired goals (pathway thinking) and become motivated to use those pathways (agentic thinking) to achieve those goals [249]. Two categories of individuals are described in this work: high-hope and low-hope individuals [259, 260]. As compared to the low-hope individual, the high-hope individual show more decisiveness about the pathways to achieve their goals, they are flexible thinkers and they are able to derive multiple plausible pathways to achieve their goals [249, 261]. When challenges impede them or unexpected surprises arise, they embrace agentic self-talk such as: 'I can do this' and 'I am not going to be stopped' [249, 261]. These high-hope individuals also demonstrate friendliness, happiness and confidence [249, 261]. The individual-level effect of hope has been described as threefold: improvement in physical and psychological wellbeing, enhanced stress resilience and enhanced cognitive capacity through increased awareness, greater ability to take on board the perspectives of others, higher adoption of new ideas and greater interpersonal closeness [262, 263].

In summary, the first level of the framework draws on the theory on institutional entrepreneurship. Institutional entrepreneurship provides a guiding understanding of the enabling conditions (social position and social skill) and software factors (such as positive emotions) that influence the agency in actors, and in so doing, stimulate change within institutional structures through social innovation.

4.4.2 Meso-level: Institutional Work as Positive Institutional Practices

The meso-level of the framework deal with actions and efforts happening at the level of organisation, and institutional work is yet again suitable theoretical underpinning to understand this level. The theory institutional work, put forward by Lawrence and Suddaby in 2006 [49], describes the 'purposive actions of individuals and organisations, aimed at creating, maintaining and disrupting institutions'.

At the micro foundations of institutional work is the cognitive work actors engage in to generate cognitive schemas support an existing or new institutional order [49]. The study of institutional work is thus concerned with three aspects: the awareness, skill and reflexivity of individuals (as mentioned in 4.4.1); the conscious action of individuals and groups and the role of action as practice. Three concepts are inherent in institutional

work: (i) the awareness, skill, and agency of individuals; (ii) a view of institutions as constituted by the actions of individuals and collective actors and (iii) recognising action as practice [243]. DiMaggio and Powell suggested that the practice approach helps understand the relationship between individuals and institutions [214]

Institutional work also explains institutional change. Lawrence and Suddaby [49] have identified various types of institutional work practices involved in the disrupting, creating and maintaining institutions.
The first category of institutional work, focused on creating institutions, builds upon the notion of institutional entrepreneurship and it is centred around the practices employed by actors to reconstruct rules or boundaries, and to reconfigure belief and meaning systems [243]. The second category institutional work, that of maintaining institutions, is concerned with practices to ensure adherence, embedding or reproduction of existing norms and beliefs [49]. The third category, institutional work focussed on disrupting institutions, casts a light on the relationship between an institution and the social controls that perpetuate it, and how actors seek to undermine these arrangements for the purpose of deinstitutionalisation [49, 264]. Table 4-1 below summarises an array of institutional work and practices which could possibly play a role in the adoption and institutionalisation processes [49, 223, 265]. I draw on Table 4-1 later in Chapter 7 and 8 and extend the understanding of selected types of institutional work.

This stream of work has held strong relevance to social innovation [42]. It explains how actors, through micro-level actions, their day-to-day physical or mental efforts or practices, can challenge and change the very institutions that seek to constrain their action [163]. Institutional work is a way to explain the process of institutionalisation and institutional change [266, 267]. Studies pertaining to institutional work and social innovation, frequently draw reference to the disruptive work or institutionally-contested work social innovations undertake to deinstitutionalize existing structures such that the creation of new institutional structures can emerge [181, 264, 268].

For analysis at the meso-level of this framework, I will focus on identifying the types of institutional work and associated practices that influence the institutionalisation process.

Institutional Work	Type	Definition
Creating strategies	Advocacy	The mobilization of political and regulatory support through direct and deliberate techniques of social suasion
	Defining	The construction of rule systems that confer status or identity, define boundaries of membership or create status hierarchies within a field
	Vesting	The creation of rule structures that confer property rights
	Constructing identities	Defining the relationship between an actor and the field in which that actor operates
	Changing normative associations	Re-making the connections between sets of practices and the moral and cultural foundations for those practices
	Constructing normative networks	Constructing of interorganizational connections through which practices become normatively sanctioned and which form the relevant peer group with respect to compliance, monitoring and evaluation
	Mimicry	Associating new practices with existing sets of taken-for-granted practices technologies and rules in order to ease adoption.
	Theorising	The development and specification of abstract categories and the elaboration of chains of cause and effect
	Educating	The educating of actors in skills and knowledge necessary to support the new institution
Maintaining strategies	Enabling work	The creation of rules that facilitate, supplement and support institutions, such as the creation of authorizing agents or diverting resources
	Policing	Ensuring compliance through enforcement, auditing and monitoring
	Deterring	Establishing coercive barriers to institutional change
	Valourizing and demonizing	Providing for public consumption positive and negative examples that illustrates the normative foundations of an institution
	Mythologizing	Preserving the normative underpinnings of an institution by creating and sustaining myths regarding its history
	Embedding and routinizing	Actively infusing the normative foundations of an institution into the participants' day to day routines and organizational practices
Disrupting strategies	Disconnecting sanctions	Working through state apparatus to disconnect rewards and sanctions from some set of practices, technologies or rules
	Disassociating moral foundations	Disassociating the practice, rule or technology from its moral foundation as appropriate within a specific cultural context
	Undermining assumptions and beliefs	Decreasing the perceived risks of innovation and differentiation by undermining core assumptions and beliefs

Table 4-1: *Types of Institutional Work [265]*

More recent institutional work scholars deepened the study of practices within the context social purpose organisations. Practices are defined as 'embodied, materially mediated arrays of human activity organized around shared practical understanding' [269]. However, a practice-orientation to institutionalisation does not only seek to explain how an outcome is achieved, but rather seeks to give deeper insight into the 'internal life of the process' [270]. Nilsson [271], in his social innovation research, merged institutional work theory with that of positive organisational scholarship, to become what is called positive institutional work. He defines concept of positive institutional work as 'the creation or maintenance of institutional patterns that express mutually constitutive experiential and social goods' [271].

This concept of positive institutional work (practices), like the concept of positive emotions mentioned in 4.4.1 above, is informed by Positive Organisational Scholarship (POS). The affirmative orientation held by POS is based on a much deeper held value or belief of individuals and institutions being inherently eudemonic, with intrinsic goodness [272]. POS adopts an affirmative lens through which organisational processes, dynamics, perspectives and outcomes are viewed [273]. The notion of 'positive' encompasses four dimensions: first, opportunities, resources, attributes, and emotions that are life-giving and in so doing, result in human flourishing [274]; second, outcomes that are positively deviant [275]; third, it represents 'an affirmative bias that fosters resourcefulness, broadening and building capacity of individuals, groups and organisations [246, 272, 276]; and fourth, it is associated with virtuousness [277]. From POS literature, positive organisational practices are understood as behaviours, techniques and routines that represent positive deviant practices, those with an affirmative basis and with an connotation of virtuousness [278]. These positive practices have been shown to lead to greater positive affect among actors, which in turn results in more positive individual behaviour [278]. Ultimately, positive practices enhances the effectiveness of organisations to achieve their goals; such as, financial performance, turn over, client satisfaction, quality of care, resource adequacy [278]. Positive practices that were most predictive in achieving organisational effectiveness included, fostering respect, gratitude, compassion, forgiveness, inspiration, and meaningful work [278]. Similarly to the effect positive emotions have on an individual level; positive practices also elevate organisational performance through its amplifying (that which is good), buffering (against the negative or challenges) and heliotropic effects (*moving towards the light despite the darkness*) [278]. In social innovation, the notion of 'positive' holds value as actors are undertake social innovation efforts as a means to bring about positive changes in institutional structures. In this way they strive to rectify the systemic failures that led to the social challenge occurring in the first place.

Approaching organisations and institutions from a positive orientation is not without critique. The postmodern rejection of any universal aspect of human nature, and thus adherents to that view, critique POS, as 'denying reality', 'ignoring the negative', 'reckless optimism' and 'failing to explore issues of power' [279-283]. Critical theorists, such as Fineman [280], further suggest that the positive bias fails to account for the social, political and subjective identities of, and power processes at play between, organizational members. Poonmallee et al [283] states that 'POS has the potential to become an even more sophisticated co-opting mechanism for maintaining the status quo around existing structures because it can create a culture of silence around issues that are truly contentious and critical by considering them as 'negative' and especially so in the context of historically marginalised groups'. These scholars all suggest that conflict and negative experiences are essential processes in organizations for effective or positive change.

The decision made to adopt an affirmative bias in this study, using POS literature, was deemed appropriate for several reasons. POS does not seek to deny a critical perspective, rather its affirmative bias seeks to make 'formerly invisible phenomena become visible' [284]. Traditionally in organisational studies, a more deficit-based understanding has prevailed. Tailoring an example presented by Caza to healthcare [279], a deficit-correcting model may consider organizational or health system effectiveness as a matter of maximizing potential despite constraints. In contrast, an affirmative model would seek to identify inherent values in organizational life that go beyond effectiveness (and health outcomes) to result also in the flourishing of all health system actors. Caza[279] further states that if a researcher believes that individuals are self-interested and individualistic, he or she will be constrained in his or her approach to investigating organisations, and also in the conclusions that may be drawn about how individuals could be motivated to perform. For this study, then, the decision to use POS was based on the intention to identify phenomena that may have been systematically denied in health system scholarship, and the judgement that this approach does not reduce the critical thought associated with robust scientific inquiry.

The combination of two theoretical streams, institutional work and POS, can account also for the experiential dimension of practices – going beyond just what actions actors take but also acknowledging the lived experience of organisational actors in taking these actions [223, 271]. As an example, Nilsson [271] highlights how institutional legitimacy (e.g. for a new innovation), in the context of social purpose organisations, is not merely based on its symbolic appropriateness in line with current institutional norms, values and believes. Rather, legitimacy can also be attained in the experience of actors. For example, participation is not merely legitimised by everyone attending a meeting, rather it is legitimised by the individuals' experience of the meeting. The notion of experience is further expanded upon as something not held by the individual but rather as shared in relationship to another. A practice such as 'experiential surfacing' applied in the context of meetings, gives participants access to their interior states and allows positive states to be transmitted [271]. In essence, it helps participants to move beyond the institutional rules and conventions, that prescribe how to act, feel, or think, and helps them to share honestly and trustingly outside of the social structure. In so doing this gives way to a greater generative capacity for new institutional emergence. Within the relational context, an experiential dialogical inquiry can be created by inclusively extending group boundaries to give exposure to a diversity of ideas, people or institutional fields; and allowing people to jointly explore assumptions and potentials [271]. These inquiry-based relationships can foster a sense of institutional agency among participants for an issue, one that is not solely depended on advocacy [238, 285]

In summary, the theory on positive institutional work, through positive practices, holds value in understanding the 'inner life' of the adoption and institutionalisation process of social innovation occurring at the meso- or organisational level. As described previously, there has been an over emphasis on instrumental

or hardware factors influencing these processes. Yet, positive institutional work, through acknowledging the experiential dimension can provide more complementary insight as to the role of software factors influencing this process.

4.4.3 Macro-level: Institutional Logics

For this next level of the framework, dealing with the macro-level context, I draw on a second and distinct theoretical body of work emerging from neo-institutional theory, that of institutional logics. Like institutional work, institutional logics hold an important influence on the adoption or institutionalisation process of social innovation.

The concept of institutional logics was first put forward in 1991 by Friedland and Alford [213] and then, subsequently expanded upon by Thornton and Occasio [286]. Logics are the supra-organisational principles and patterns. These logics include the symbolic systems, the taken for granted resilient social prescriptions, the implicit assumptions and values that influence the organisational reality [213, 287]. Logics are both material and symbolic in nature; inclusive of structures as well as practices but also ideation, meanings, metaphors and symbols [213]. A core assumption of institutional logics is that 'the interests, identities and values of individuals and organisations are embedded in logics and they provide the context for decisions and outcomes' [288]. Logics thus underpin and shape whether organisational practices are appropriate in given settings at a given time [289-291]. Different logics can influence the success of the adoption and institutionalisation process of social innovation.

Adopting an institutional logics perspective has been valuable in various research studies to identify and describe contextual factors that have an influence upon implementation, performance and innovation of organisations and individuals. This includes taking a closer look and analysing the various institutional orders that are at play, as well as the influence of the historical background on logics. As an example, Greenwood et al's [290] study found how market logics in Spanish firms were heavily influenced by nonmarket logics, those of the regional state and the family. These nonmarket logics originated from the historic legacy left by the highly centralised Franco Regime and the Catholic Church. Raynard [292], similarly describes how Chinese state logics, arising from the communist legacy and socialist roots of the Mao and Deng's regimes, influence and shaped how corporate social responsibility initiatives manifest across the country and the type of activities they conduct.

Studies have also described how logics across different geographies and sectors play an important role in constraining or enabling action in healthcare. In a comparative case study of primary care innovative initiatives in Denmark and Canada, Waldorff et al [293] demonstrate how multiple logics, competed and complemented each other, to impact action and outcome of these initiatives. Logics that constrained action in both countries were the deeply engrained in the professionalism of primary health care, which meant that expertise of non-physicians were not recognised in the design or implementation. It also required both a state logic co-existing with a professional logic, and both had to be satisfied simultaneously.
However, logics do not only constrain action, but they also enabled action. In Denmark, municipal governments were given an opportunity to be involved in the design of a primary care intervention. This aided in segmenting or breaking from the dominant medical professionalism (expert driven) logic and allow for an alternative community logic; in which citizens were also given an opportunity to participate in the process of public health reform. Reay and colleagues [294] also demonstrate how a new business-like healthcare logic was introduced in Alberta, Canada and how it challenged the field which was previously organised according to the medical professionalism logic. Instead of finding competition between what would be considered to be two rival logics, they were able to demonstrate how micro-level actors, through pragmatic collaborative activities, were able to maintain their separate identities. This allowed them to accomplish their work and meet their respective standards and in so doing, institutional change was advanced and not stifled.

Taking a closer look at social purpose organisations, authors have explored how logics influence the success and outcome of these initiatives. Vickers [295] found that a multiplicity of logics contributed to the success of innovative social purpose organisations. Three different logics were at play in these organisations: a state logic as prescribed by health policies and regulations, a market logic such as generating revenue, and a civil society logic such as the participation needs of communities. They were able to hold the tension in logics; that of sharing knowledge and creativity with the public sector, while holding their competitive advantage in the market. They were also able to affect change within the broader institutional system by creating an organisation structure that reduce the rigidities of professional boundaries and hierarchical cultures; and by creating a space and opportunity for co-design and co-production with non-experts, such as users. Contrary to the success achieved in Vickers' study, a case study by Van den Broek et al [296] explained how competing logics negatively affected the replication of a health innovation aimed at empowering nurses. This programme was first developed and implemented achieving success in the United Kingdom but was then replicated in the Netherlands. In its naming and communication, this project called "Productive Ward: Releasing Time to Care" embraced two competing logics. A business logic of efficiency and productivity on the one side and a professional nursing logic of safety and quality of care on the other side. However, despite initial enthusiasm from the nurses, the programme did not achieve more than just ceremonial adoption as in its implementation process, the business-logics were dominant, and this led to suspicion of nurses about the sincerity of the

programme to truly improve patient care. These studies highlight how logics can support the achievement institutional change but also how logics can hinder successful implementation. Appealing to the logics of stakeholders and users, commitment and ownership of the innovation can be enhanced.

In conclusion, traditionally context have been considered an important influence in public health interventions, but more attention is needed to deeper more symbolic systems at play. An awareness of and identification of institutional logics in the adoption and institutionalisation of innovation can hold explanatory potential for the success or failure of social innovation to become part of the taken for granted system.

4.5 Conclusion

This chapter sought to critically examine the institutional perspective of social innovation, and how existing theories of adoption and diffusion are not well-suited understanding how social innovation becomes embedded as part of the taken-for-granted system. Based on this, I adopted and modified a multi-level framework, informed by institutional theory (institutional entrepreneurship, institutional work, and institutional logics). It is expected that his framework can support in identifying the software factors that influence the adoption and institutionalisation of social innovation as part of the health system. The software factors of relevance include for example, positive emotions held by actors operating as institutional entrepreneurs; positive organisational practices with an experiential underpinning and the navigation of competing institutional logics. Hardware or instrumental factors (e.g., material resources) are not discounted in the institutionalisation process; however, this study will seek to focus on developing a deeper understanding of the software factors that affect the embedding of social innovation within the health system.

5 CHAPTER 5 – MALAWI COUNTRY CONTEXT

5.1 Introduction

Malawi is a small central African country with a population of 18.6 million [297], landlocked between Mozambique, Zambia and Tanzania. The country is frequently misunderstood in development circles which view the country solely through the frame of economic indicators, instead of accounting for the rich human, cultural and social capital reflected the daily lived reality of its people [298]. Edison Mpina [299] accurately captures dichotomy inherent in Malawi: *"Land of lake and sunshine, do the abortions you have had signpost your direction into the next millennium and beyond? Shall we live a life of seasonal and geographical disruptions, food and medical, aid, regionalism? Or are these tragedies mere punctuations marks to a continuum of unity, freedom, plenty in farms, peace and calm and sunshine on Lake Malawi?".*

Health policy and systems research (HPSR) scholars caution against context-free widely generalisable knowledge as relying on this type of knowledge holds a danger to distort the development agenda of low-and middle-income countries [17]. Thus, in undertaking case study research on a contemporary phenomenon, such as social innovation in a real world setting, the case cannot be separated from a review of literature to better understand the situational, structural, cultural and environmental factors of the context [82, 300].

The purpose of this chapter is to enhance the contextual understanding and interpretation of the case under investigation. This literature will inform Chapter 9. This chapter presents a review of the key historical texts as written by Malawian authors (e.g., D Phiri) as well as non-Malawian scholars who have studied or lived in the country for several years. Findings from these texts were supplemented with relevant peer-review and grey literature (reports and newspaper articles) detailing the health system and management culture of the country.

In reviewing relevant literature four key areas were identified to be relevant to this social innovation under investigation within the context of the Malawi health system: (1) the country political history and culture; (2) the role of traditional leadership in society; (3) the structure and delivery of healthcare and citizen participation in health; and (4) the influences of personhood, management culture and religion.

5.2 Country overview

Table 5-1 below provides an overview of the key country indicators in terms of development and health.

Table 5-1: MALAWI COUNTRY & HEALTH SYSTEM CHARACTERISTICS	
Country Development Characteristics	
Total population Size [297]	18.6 million (2019)
Rural population (% of total) [301]	82.8% (2019)
Gross National Income per capita, Atlas (Int $) [302]	$380 (2019)
Human Development Index [303]	0.483 (2019)
Fertility Rate [304]	4.2 (2018)
Poverty headcount at $1.90 (USD) (international poverty line) [305]	62.2% (2016)
Literacy rates [306]	Men – 83%; Women – 72%
Population % with piped water **Population % with flush toilet** [306]	17.1% (6.7% of rural population) 3.3%
Population % with electricity at home [306]	10.7% (3.2% of rural population)
Population % with mobile phone in household **Population % using internet on their phone** [306]	47.5% (39.6% of rural population) 6%
Health Outcomes	
Life Expectancy at birth [307]	63.7 years
Maternal Mortality Ratio [308]	439 (per 100,000 women)
Under-5 Mortality Ratio (per 1000 live births) [308]	55.7
Top-3 Causes of Death & Disability [309]	HIV/AIDS, Neonatal disorders, Lower Respiratory Tract Infection
Top- 3 Drivers of Death & Disability [309]	Malnutrition, Unsafe sex, WaSH
Health Financing	
Health Expenditure (% of GDP) [310]	9.33% (2018)
Current total health expenditure (THE) per capita (PPP) [311]	$119.53 (2018)
Donor contribution to THE [312]	61.6% (2018)
Government contribution to THE [312]	25.5% (2018)
Out of Pocket Expenditure (% of THE) [312]	12.9% (2018)
****Proportion of population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%)** [313]	4.2% (2018)
User fees [314]	Fee for service for all non-EHP services (public, private, not-for-profit)
Healthcare Access & Quality	
Healthcare Access and Quality Index [309]	32.2
Population living within 8km of health facility [314]	76% (2016)
Nurse, midwife density (per 1000 population) [315]	0.43 (2018)
Health System Governance & Operation [314]	
Guiding Policies on Health Provision	The Malawi Constitution Health Sector Strategic Plan II (2017-2022) National Community Health Strategy (2017 – 2022)
Public: Private Provision	60 % health services provided by government 40 % health services provided by private providers (*for profit & not for profit*)
Structure	Decentralised – 3 regions (South, Central, North); 28 districts; 250 Traditional Authorities; multiple villages

Government Health Facilities	4 Tertiary Hospitals (specialist services) 26 District Hospitals (outpatient, inpatient & surgery) 11-40 Primary Health Centres per district (Public, PFP, PNFP) (ambulatory & maternity services)
Progress towards SDG Goal 3.8 (Universal Health Coverage)	No national health insurance, but Essential Healthcare Package implemented within 52% public health facilities (free at point of care) & at health facilities where Service Level Agreements have been established with CHAM health facilities.

5.3 Relevant Contextual Factors

From a literature review on Malawi, four factors were identified as key to better inform the understanding of the case study under investigation: (1) the country political history and culture; (2) the role of traditional leadership in society; (3) the structure and delivery of healthcare and citizen participation in health; and (4) the influences of different cultures on management practices.
Each will be discussed in the sections below and drawing relevance as to their influence on the health system and healthcare delivery.

5.3.1 Political History and Political Culture

"*You have to know the past to understand the present*" [316]. The political history and culture of Malawi has had a significant influence on modern day health system governance and policy making. Malawi's political history can be categorised into four distinct phases: Pre-colonial era (prior to 1981), the colonial era (1891 – 1964), the post-colonial one party era (1964-1993) and the democratic era (1993 and beyond) [317].

The pre-colonial era dates to about 1000AD when the Chewa people, a Bantu tribe, approached the lands now part of Malawi. They saw, from a distance, what resembled flames of fire, and called the land Maravi, the '*land of flames'* [318]. Over time various groups settled in different regions of the country, resulting in the country today being one of the most ethnically diverse populations in the world [319]. Governance in the pre-colonial times was the role of traditional leaders, or chiefs (see section 2). After being mostly undisturbed for several hundred years, life started changing first with the arrival of the Arabs, followed by the Portuguese traders in the 17th and 18th century. The increase in commodity trade also fuelled slave trade in the region. The arrival of the Scottish missionaries in the 19th century (1895), led by Dr David Livingstone, first sought to bring an end to the slave trade. Several more missionaries from Scotland responded to Dr Livingstone's call

for support and came to Malawi to invest in education by setting up mission schools. Under the Livingstonia Mission, thousands of Malawians were educated, sometimes to the concern of African elders. Both the Christian influence and education had an important impact on politics in the later years, as political activists against colonial rule drew their inspiration from the Bible [318]. However, the climate and associated tropical diseases, especially malaria, for which there was no treatment at the time, took the life of many missionaries [320]. Over time, the missionaries built one of the biggest hospitals in British Central Africa and a significant reduction in mortality occurred the 1890s with the advancement in bacteriology. In attempt to stop the Portuguese from entering the area and to protect people from the slave trade, Livingstone made a request his government to declare the area a protectorate. Despite having little material resources from which Britain could benefit, Nyasaland (as renamed by the British) was formally declared a British Protectorate in 1907. During the colonial era, healthcare continued to play an important political role. Colonialists, throughout the 1930s and 1940s, insisted on the removal of all user fees and the free provision of health services. This was done to gain popular support to curtail African indigenous healing beliefs and providers whose potential to organise rebellion could undermine imperial legitimacy. Healthcare was also used to enhance the quality of labour provided by the local population. As Messac [321] states "*Africans could not be charged health fees because the major aim of medicine was to foster a depoliticised ontology of healing that could engender quitetus*" Between 1926 – 1936, the number of non-European outpatients treated in hospitals and dispensaries rose from 143,260 to 737,227 as the number of hospitals and dispensaries constructed by the colonial government increased. Chemotherapeutics to combat tropical diseases reached Nyasaland in the 1950s and these medicines helped increase the demand for care from the local population who were at first distrusting of biomedical approaches [318]

Despite the well-meaning intentions of missionaries like Dr Livingstone to safeguard people against slavery through protection from Britain, the consequences of colonial rule had detrimental effects on land ownership and local entrepreneurial development. Over time, a resistance movement grew among the youth and young missionary educated leaders in the country against the British protectorate rule. As these anti-colonialist leaders were regarded to be too young by the chiefs and the older guard to move the country towards self-government and independence, the hope for the nation was placed in 63-year-old Dr Hastings Banda, a medical doctor working in London, England. On his return to country in 1958, protests against colonial rule escalated and finally on 5 July 1964, the Union Jack was lowered, and Malawi (renamed) became an independent nation [318].

Following independence, the provision of free healthcare disappeared instantaneously, and a three-pence fee was introduced for persons attending all public hospitals and rural health centres. President Banda did not take long to recognise that the introduction of user fees would become a threat to his political legitimacy and

subsequently he removed the fees for those who could not afford to pay. Hospitals took a central role in the country's foreign policy. At least 50% of the medical supplies imported by Malawi were from Southern Rhodesia, as importing supplies from the United Kingdom would raise costs by 45%. [321]. The central government kept thus strong relationships, despite international pressure, with the white-supremacist government in Southern Rhodesia to ensure supplies.

Banda's 30-year rule had a strong and lasting influence on the country's modern-day political culture. Signs of his autocratic tendencies and desire for centralisation of power were soon revealed after independence, as opposition and critique were not tolerated [319]. Dissident voices were imprisoned, killed or fled from the country [318]. From 1964 – 1994, all aspects of political life were controlled by the Malawi Congress Party (MCP) and no democratic elections took place. In 1971, Dr Banda was proclaimed president for life [318]. The MCP government's centralised and top-down approach to governance and policy making reduced the voice of citizen demands or popular interest on policy making [322, 323]. Over time the MCP became increasingly detached from the lived reality on the ground especially with respect to issues in social spheres such as health, education, and livelihoods. The political culture of fear, retribution and control has had a long-lasting impact on the Malawian people. Although Malawi is known for welcoming everyone to its lands, Malawian openness to share and discuss the situation truthfully is limited until a firm foundation of trust has established. (Personal Observations, 2015-2019).

Grace Sharra accurately captures the impact Banda's rule has had on people (a language and literature teacher in Dedza, Malawi 1987):

> *"We wear the mask or sigh with relief when its dusk, for that's when we smile with hearts bleeding and flooring like Nile.*
> *We wear the mask and duck the questions that eyes ask, for we hide the skeletons so mean that suck our lives but remain lean.*
> *We wear the mask and sometimes in glory ask and they pretend not to see, that everything but free.*
> *We wear the mask and the horror still last for dreaded dreams yet to be hailed*
> *For long dead souls yet to be buried.*
> *We wear the ask and somehow we last, and they see and look away, afraid of what our eyes may say"*

Banda's era was not without popular support. 'Dictatorship by consent' characterised his rule [318]. Banda built his power base not out of a single tribe but rather out of a whole class of people who felt left out from the rise of the young educated Christian men – those uneducated, non-Christian and enmeshed in the traditionalist sectors of society [320]. Initially, the country achieved steady economic growth with visible signs of this throughout the country - a new capital was established in Lilongwe and new universities; roads and hospitals were constructed. President Banda allowed the British settlers to keep their land. Customary

land was converted to leasehold and provided for commercial tobacco growth – one of the country's biggest export products [320]. Nation building was a key priority for Banda and he placed a strong emphasis on traditional culture - Chichewa became the national language, moral values within the context of the 'good village' were held in high regard, traditional dances and other traditions were promoted and multimedia with western influences were censored [320]. It wasn't until the 1980s, once global commodity prices plummeted, that social conditions in the country started to worsen and resentment for the government grew. Citizens, civil society organisations and particularly the Catholic church (see 5.3.4) played an important part in ending Banda's 30-year rule and achieving a transition to a multi-party democracy.

The multi-party democratic era started with President Bakili Muluzi, representing the United Democratic Front (UDF) taking office in 1994 following the first elections held in over 30-years. The new government was liberal and loosened the strict control imposed by the previous regime on the economy. In 1995, the country adopted a new constitution, within which the right to healthcare was inscribed as a responsibility of the State. [324]. During the 1990s, Malawi was the recipient of the highest value of British aid in sub-Saharan African and non-governmental organisations flourished until such time when constitutional change proposals started appearing [320]. President Muluzi was trying to secure a third term, beyond the two-term limit within the constitution. Further challenges mounted - in 1998 and 1999 several cases of public sector corruption came to light and in 2001 -2004, droughts and government mismanagement of maize inflicted the country with devastating hunger and malnutrition.

Concurrently, the HIV/ AIDS epidemic in Malawi continued to grow steadily after the first case was identified in 1985. Due to the government's slow initial response, the epidemic peaked in 1998 at a prevalence of 15% and at the time, HIV related patients occupied 70% of hospital beds in Malawi [325]. Despite President Muluzi's acknowledgement of the epidemic, it left significant damage to Malawi's social and economic infrastructure and had a marked impact on the human resources availability and productivity of public service delivery [326]. By 2018, the HIV prevalence in the country has decreased to 9.2% [327] but HIV is still the most donor-dependent area in the health sector, with 95% of the funding provided by donors [314].

The political culture cultivated in the current day multi-party democratic Malawi has been described as archetypal of a competitive-clientist settlement [328]. The democratic transition in Malawi saw the breakdown of the elite bargain that was established by President Banda and a new informal elite bargain formed. A strong notion of kinship exists among the professional and political elites working in the government and development sectors in Malawi. They share similar socio-cultural values, friendship and trust, and mingle in Malawi policy circles [329]. As Adhikari and colleagues found in their research, many of these relationships

stem from attending the same schools, churches, or their children attending the same schools. Malawi's highly personalised political parties are held together by patronage and informal relationships but this does not limit what Englund [330] described as 'Chameleon-politics', with an ever-increasing fluidity across party lines and shifting allegiances.

President Bingu wa Mutharika came to power in 2004 with the task of getting the country out of its economic crises and addressing the rampant famine. His strategies initially proved successful with food production increasing and the country returning to steady economic growth. Yet, as per the history of his predecessors, the good times were not to last. During his second term, government spending and the increasing national deficit led to the International Monetary Fund demanding the devaluation of the Malawian Kwacha (currency) in line with market realities. The president resisted and as a result donors held back their budgeted support. The Reserve Bank started rationing US dollars, leading to a severe shortage of fuel in the country. Simultaneously, the authoritarian tendencies experienced in the Banda regime made a comeback with bills being passed to limit the media and allow police searches of people's houses on suspicion without reason. The government also accused donors of supporting civil society in opposition to its rule. In 2011, protests erupted in the country against President Mutharika and civil unrest continued until his sudden death in March 2012 [318].

Vice President Joyce Banda, an activist and businesswoman, was sworn in following Mutharika's death. President Joyce Banda, through her promises to strengthen human rights and fight corruption, quickly became the favourite among donors again [318, 331]. As described above, throughout Malawi's history health provision has been significantly dependent on the political will of the day. In 2012, to show her political will in support to reduce the high maternal and child mortality in the country, President Joyce Banda launched the Presidential Initiative for Safe Motherhood and this initiative attracted strong international support from donors and other politicians. One of the aspects of the policy was to ban traditional birth attendants in favour of skilled birth delivery. The policy approach was to draw upon traditional leaders (chiefs) at grassroots level in support of the utilitarian top-down implementation of this policy (see more in Section 2) [332].

President Joyce Banda's popularity disappeared overnight when the Cashgate scandal broke in 2013. People from within the government had looted the governments accounts and transferred funds to existing or fictitious companies [318]. Shortly after Cashgate, President Joyce Banda lost the 2014 presidential elections, and as a result the Safe Motherhood Campaign ended and all visibility and advocacy on maternal and child health issues were again reduced to invisibility at a national level [332]. Malawi has, however, made good strides in reducing maternal and child mortality in the country. Malawi has reduced the maternal mortality

ratio to 547 and the infant mortality ratio to 53, down from the baseline for the Millennium Development Goals (2000) of 1120 and 103, respectively. [333].

Malawi has a high level of dependence on external donors, with foreign aid comprising 40% of the overall national budget and 60% of the total health expenditure [334]. Significant effect political events such as the Cashgate scandal, dramatically influenced the availability of resources for health as funders became hesitant to invest in the country. Yet, as Messac [321] states, the country has remained a darling among donors:

> "*Painted in hues of frustrating yet sympathetic backwardness, Malawi has remained a choice substrate for modernisers of all stripes from the utopian visionaries of market fundamentalism to the haloed humanitarians of the international aid industry. If Conrad's Congo was the 'heart of darkness', twenty-first- century Malawi is the 'warm heart of Africa'.*

Following Cashgate, Malawi's biggest donors, including the United Kingdom and Norway, withdrew their funding support to the government and changed their strategy. It is estimated that only 20% of health resources goes through the government system, with the remaining 80% of support for health service delivery being channelled directly through NGOs, International NGOs, and private contractors. As a consequence, it has become easy for donors to implement programmes by bypassing the Ministry of Health in the process, resulting in poor coordination and duplication of health programmes in the country [329]. Donor projects are frequently top-down prescriptions of 'what is consider as constituting international development', and at times failing to address true community needs. A small portion of donor funding takes a long-term perspective, with most funding channelled into short term initiatives and once activities are terminated the donor moves on to a new area or new project [329].

A final note on the political history of the country is regarding most recent events. Since 1993, elections have been held in high regard by all Malawians, but elections have not been without contention. More recently, after the May 2019 elections, the country experienced 6-months of demonstrations opposing the elected president stemming from allegations of electoral fraud and questioning of the impartiality of the National Electoral Commission. The well-organized demonstrations (personally observed) impacted public service delivery of healthcare as they slowed down the approval of the annual budget and frequently ground the major cities to a halt [335, 336]. While the demonstrations had the above-mentioned negative impacts, the fact that Malawians demonstrated so vigorously illustrates a shift away from the passive culture, as described by Kamwambe, that embodied Malawi due to the free speech limitations imposed during the Banda era: "*Malawians must decide to abandon the useless culture of a lack of proactiveness to identify sources of problems in the institutions they manage and , once problems are known, to summon enough effort, apart from just complaints and rhetoric to do what is appropriate to correct the wrongs.*"

Following a judicial process disputing election results, Peter Mutharika, who was first announced as the Presidential winner of a second term following the national elections were renounced. Lazarus Chakwera instead became President of Malawi. In the Malawi Vision 2063, President Chakwera has placed the nation on a journey to advance its political independence through attaining economic independence "*Donors and debts continue to support our development programmes. While we appreciate donor support over the years, we realise as a nation that this is not sustainable. Time has come to change our mindset and develop this country ourselves. We need a mindset change that embodies a national consciousness built around belief in our own capabilities, home-grown solutions and a positive value system. A system that recognizes unity of purpose, hard work, self-reliance, patriotism, integrity and hate for hand-outs." [337]* This turn towards becoming a self-reliant nation has been further emphasized through a renewed momentum to strengthen the national identity. In 2021 stakeholder consultations have been ongoing to draft a new set of 'Transformative National Values' towards an enhanced national identity, reconciliation, and development – a set of values that will unite Malawians irrespective of political, religious and cultural differences [338]. In conclusion, reawakening national identity and self-reliance are goals towards a fully independent Malawian, led by Malawians. '*The Malawi we want is possible and will happen!*'[337]

5.3.2 Traditional leadership and society

Like other African nations, Malawi has a structure of parallel governance comprised of a system of direct modern democratic rule as exerted by its elected officials and a system of indirect rule through chieftaincy.

In Malawi, chieftaincy represents an institutionalised form of traditional rule characterised by kinship - legitimacy by descension passed from one generation to the next and authority over a specific geographical area [339, 340]. Chieftaincy dates back to the precolonial period, where chiefs were the heads of the villages regarded as "seniors, guardians, keepers of the peace and spokespersons of the village in dealing with outsiders" [341]. Once the British formalised their colonial rule in the country, their first objective was to weaken the powers of the chiefs and govern independently. However, they soon realised that the small number of British commissioners in the country were not sufficient to govern efficiently. A system of 'indirect rule' was subsequently introduced. Traditional chiefs were incorporated into the administrative structure as executive agents of the government, responsible for functions such as collecting taxes, maintaining law and order and reporting to government [340].

The role of chiefs in local government has changed and evolved based over time, based on the government of the day, as attempts were made to delink them as government agents. However, the importance of their role has not diminished in modern day Malawi.

Along with the governmental administrative geographic areas (3 regions and 28 districts) that exist in Malawi (see section 5.3.2 below), the country is further divided into 250 defined territorial units or traditional authority areas. Each traditional authority area (ranging between 1000 – 90,000 people) is in turn made up of a number of villages (ranging between 100 – 2000 people) [342]. As 84% of Malawians reside in rural areas the village remains the smallest social unit by which cultural and socio-economic activities are organised [301, 340]. Within these rural areas traditional leaders exercise their governance, power, authority, and influence. There are six levels of hierarchy in chieftaincy recognised in Malawi, each defined based on the size of the territory over which they have jurisdiction. These include paramount chiefs, senior chiefs, traditional authorities, sub-chiefs, group village headmen (overseeing 2 – 10 villages) and village headmen (also known as village chief) [343].

Traditional leaders play two main roles. They are guardians of tradition and gatekeepers between government and the village. As guardians of tradition, Malawians view their chiefs with the highest respect and place them at the heart of their customs and culture [339]. They are in charge of safeguarding the country's traditional norms, values and practices from one generation to a next (and safeguard them in the face of external, often westernised influences) [343]. The chiefs are in charge of all local matters and traditional functions such as allocation of customary land, facilitating ceremonies, setting local or domestic disputes and maintaining village infrastructure such as footpaths [343]. It is important to have appreciation of the deeply communal, cohesive, and tight-knit nature of Malawian society at a local village level. The strong sense of community is reflected in the fact that 80% of rural residents live in the same district they were born; they frequently visit each other's homes and value the attendance ceremonies such as weddings and funerals in their villages. Malawians hold their traditional leaders in greater regard as compared to their elected leaders (the president or members of parliament) [344]. When Malawians are in need, they are less likely to turn to the state for help but they will rather seek support among their fellow villagers, turning to relatives and to their village heads for assistance [345]. In two Afrobarometer studies conducted on traditional leadership, 74% of Malawians reported that their traditional leaders had significant influence in governing their local community; 71% of Malawians believe that their local chiefs have interest in their lives and among five other African countries surveyed, Malawians were reported to be the most trusting (61%) of their traditional leaders [344, 346].

Traditional leaders hold a high degree of informal power in everyday Malawi life, especially as gatekeepers to government and of foreign aid [343]. Under indirect chief rule, Malawians relate to the state as members of a

village and interact with the state though the chief. For Malawians, traditional leaders hold a substantially better leadership reputation than their local government councillors, based on them being 'closer to the people', more willing to listen and more accountable than politicians [346]. Traditional leaders also serve as an important channel through which social and cultural change can be brought into effect in the country [339]. The elected government depends on the chiefs as a way of finding out about the village population. In return, chiefs are paid a government salary or stipend known as a 'mswahala', ranging between US$3 -130 per month based on their level [347]. Chiefs are key actors in facilitating the identification and selection of community needs and priorities, setting the development agenda, identifying beneficiaries for targeted government programmes, mobilising community participation in support of projects or policy implementation and acting as intermediaries between the people and government agencies, donors and non-governmental organisations who wish to carry out activities in their areas [340, 343].

Traditional leaders play an important role in terms of improving health outcomes at a local population level. An example of their influence can be found in evidence from the Presidential Safe Motherhood Campaign, adopted by government during the Joyce Banda era. Under this policy initiative, chiefs played critical role in the reduction of maternal mortality (as mentioned in 5.3.1). Authors describe several ways in which chiefs used their authority to accomplish this [332, 348]. Chiefs embodied a traditionalist and modernist approaches to encourage pregnant women to deliver in health facilities. These included conducting village awareness campaigns, encouraging healthy pre- and post-natal practices over traditional birth practices, keeping a register of all pregnant mothers, participating with the local health facility in health service planning, and passing bylaws. Under these bylaws, the families of women were fined US$6-7.5, the equivalent of 4-5 chickens, for failing to deliver at a health facility. As Walsh et al [348] found in their research, the chiefs were respected as a source of wisdom when it came to their promotion of health issues and respected in terms of their devotion to their communities.

A second example of influence of traditional structures on healthcare in Malawi is regarding health aid. Since the 1990s, the international development discourse has been promoting community participation, demand-driven service provision, community ownership of development projects. Chiefs are the entry way for donors or international organisations to the communities, providing them with permission to implement their projects in their geographic territory. As donors increasingly demand documentation of impact and results, chiefs have become imperative in providing the pre- and post-intervention implementation data [343]. Marty et al [334] found that poor health conditions alone do not drive health aid allocation in Malawi. Rather aid allocation is influenced by traditional authority's characteristics. Traditional authorities were model likely to receive health aid if the area had a lower wealth-index, already existing health infrastructure (health facilities), a greater proportion of the major ethnic groups or if it the president's birth area [334].

5.3.3 Healthcare delivery and decentralisation progress towards citizen participation

ON THE WARDS

Bodies fill the beds,
and spill over onto stone floors – decrepit mattresses sagging
despite the lack of weight.
No blankets or pillows here,
just a headache and a stiff neck,
skeletal forms exuding cachexia,
snaking along pale walls in one great cue, as if lined up for admission
to some hot new film.

It's a world beyond saving,
or, at least, prohibited by cost: a careening ship
with all lifeboats lost,
a smoke alarm bleating
yet all exits are blocked.
A place defined by words
like futility,
inevitability,
and 'I'm sorry,
he's gone'.

The poem by Jacobs [349] provides good insight to the reality of healthcare delivery in Malawi. Like many other African nations, Malawi is struggling to provide accessible, affordable, and quality health services amidst a colliding burden of infectious and non-communicable diseases. The leading causes of death and disability combined are HIV/AIDS, neonatal disorders, Lower Respiratory Tract Infections, and Malaria [314].

Three key documents underpin the country's approach to health care. First, the constitution enshrines public provision of healthcare as a right for all Malawians. Second, two health policies, the Health Sector Strategic Plan (2017-2022) [314] and the National Community Health Strategy (2017-2022) [350] , express the country's commitment towards achieving Goal 3.8 of the Sustainable Development Goals, that of Universal Health Coverage and guide the implementation of interventions. Health service provision is organised at four levels: the community level and primary level which includes health posts, maternity units, rural health centres; secondary level, comprised of hospitals providing in and outpatient services and, at tertiary level, four central hospitals providing specialist and subspecialist services as well as teaching and research.

Three sectors in Malawi are responsible for health service provision. The public sector (government) provides 60% of health services and the private for-profit (companies) and the private not-for-profit sector (religious

institutions and non-governmental organisations) provide 40% of health services. In the public sector, the Ministry of Health and the Ministry of Local Government and Rural Development are jointly responsible for health service delivery. Currently, there is no social health insurance fund in Malawi, but the country has adopted an Essential Health Package (EHP) – a minimum package of health services which are supposed to be provided free of charge at all government health facilities. The Ministry of Health (MoHP) policy [314] states that every Malawian should reside within an 8 km radius of a health facility. 76% of the population meet these criteria as of 2016. As 84% of Malawians live in rural areas, the demand for care is dispersed, and the underserved are mostly those living in rural areas.

The Christian Medical Health Association (CHAM) is the largest private, not-for-profit provider of health services in the country. CHAM owns 29% of the health facilities in the country, and 75% of facilities located in rural areas. The Government of Malawi has entered into Service Level Agreements (SLA) with CHAM health facilities to provide EHP on behalf of government, especially to rural areas, as only 52% of government health facilities are able to deliver the EHP. Despite this innovative partnership to extend coverage, SLAs have mainly been focused on maternity and child services, and not the full EHP. For most rural populations wishing to access care from CHAM facilities, out of pocket co-payment still exists.

From a patient perspective, several factors influence access and use of health services in Malawi. The Program on Governance and Local Development [351] conducted research on health access in Malawi and found that the majority of Malawians (70%) accessed care from a public health facility for their last medical visit, 14% went to a private practice and 15% went to CHAM health facility. Nationally, 15% of Malawians report that they are still unable to attend to their medical health needs, often due to cost of care [351]. It is mostly women who are limited in access to care due to cost, geographic distance barriers and lower levels of education [352, 353]. Facility-level issues also affect people's use of health services. These include poor attitudes of health workers, a lack of availability of medicines and long waiting times (an average of 2 hours per visit) [354, 355]. A recent study by Dullie et al [356] on patient reported quality of care using a country modified version of the primary care assessment tool found patient reported low quality of primary health care performance due to poor relational continuity, comprehensiveness of services available and first contact access. Other factors described by Munthali [354] affecting the use of health services include beliefs in traditional medicine and traditional healers as well as religion. Members of the Zionist church would not seek formal care but rather to their local congregation for prayer when they are ill.

Malawi's health system is decentralised. The Health Sector Strategic Plan II (2018 – 2022) states: "Health service provision and management shall be in line with the Local Government Act 1998 which entails devolving health service delivery to local government structures." Decentralisation holds an important

political ideal for Malawians. Following the end of one-party autocratic rule in 1994, to that of a multi-party democracy, a key demand by the public was to have greater accountability, responsiveness and transparency of government [357]. This was envisioned to be achieved through extending opportunities for citizen participation in policy making and development [322]. In 1998, the Local Government Act (LGA) was adopted and within this act the National Decentralisation Policy (NDP) was entrenched [358]. The NDP was premised on the principle of *'mphamvu ku anthu'* ('power to the people'). Its goals were to improve service delivery to citizens, enhance government accountability to the public, and strengthen democracy at a grassroots level [358].

The health sector in Malawi was one of the first to start the process of decentralisation and is considered one of the best devolved sectors [333]. In 2005, the MoHP developed 'Guidelines for the Management of Devolved Health Service Delivery". These guidelines were to provide greater autonomy to the district councils/ assemblies. This has led to a division in role and function between the national level, under the governance of the Ministry of Health, and the district level, under the governance of the Ministry of Local Government and Development (see Figure 1). Within this arrangement, the MoHP takes of a stewarding role of the health system, providing policy guidance, and technical support but it is not in charge of health services implementation.

Planning and implementation are also divided between the national and district level. At the national level, various departments within the MoHP contribute to Annual Health Sector Implementation Plans and Budget for the next fiscal year, which is to be in line with the targets set out for achievement in the Health Sector Strategic Plan. In developing the plans, input is gained from the country's development partners and donors and final plans are approved by the MOH Senior Management Group before presented to the Ministry of Finance. The Health Sector Working Group (HSWG), comprised cross-sectoral stakeholders including donors and academia, is responsible for monitoring the overall implementation along with Technical Working Groups (cross-departmental thematic groups) providing technical input. At the district level, it is the dual responsibility of the District Health Management Team (DHMT), under the District Council, to develop annual district implementation plans and budgets, monitor their implementation, and to deliver primary and secondary health service (see Table 5-2). Districts, via their Local Government Financing Committee's, receive health sector funding in two ways: block grants from the Ministry of Finance, which originate from tax revenues and external sources, and basket funds from the Ministry of Health, which originate from donors and other pooled fund sources. Many non-governmental organisations operating at district level receive funding directly from donors for vertical or discrete programmes [359]

Progress towards moving governance functions from the national to the sub-national level in Malawi has been achieved, but the full envisioned extent and impact of decentralisation is yet to be achieved. Up to 80% of the health funds have been devolved to district level. Additionally, the recruitment of human resource for health drug procurement was devolved to district councils but was centralised again due to challenges experienced by council [333]. It has yet to be reversed. Authors note that several other challenges hinder the achievement of full decentralisation. The first challenge is the lack of role clarity and weak coordination between the MoHP and the district administration. The second challenge is that of accountability. Districts operate under a different system, that of Local Government. The District Health officers, the highest health officials in the district, report directly to the District Commissioners. This means that they are only partly answerable to the MoHP. [314]. The third challenge relates to the fragmentation of service delivery, where government has often been unable to ensure adequate supply of infrastructure (clinics, ambulances) and essential materials (drugs and supplies) and thus depends on other actors to delivery care. [328].

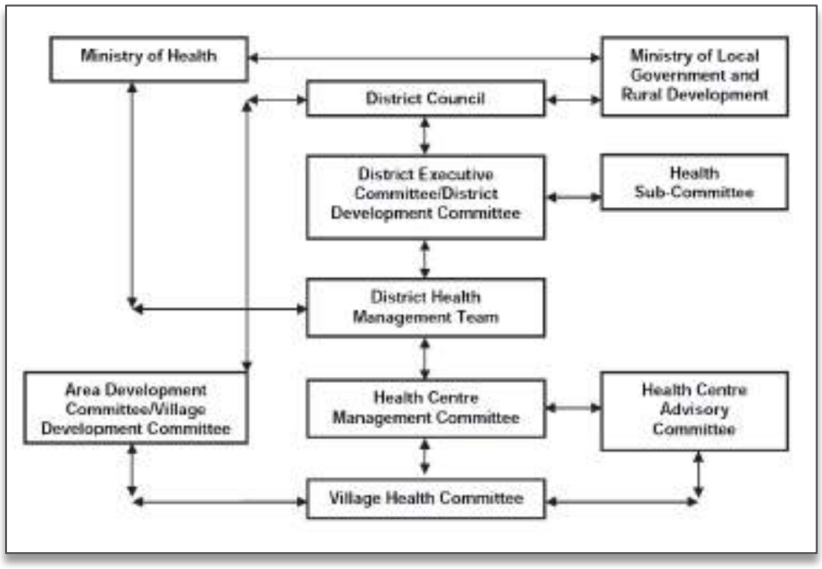


Figure 5-1: *Governmental structure of the healthcare system in Malawi* [351]

Table 5-2: ROLES AND RESPONSIBILITIES IN HEALTH SYSTEM GOVERNANCE [314, 328, 360, 361]				
Level	**Area**	**Responsible Ministry**	**Structure**	**Function**
National	Health	Ministry of Health (MOH)	Health Departments	• Development of policies, guidelines, strategies • Coordination and planning across programs and stakeholders • Setting standards and monitoring adherence to guidelines and policies • Monitoring and evaluating health systems • National projects and central hospitals • Internal and external communication on matters related to the health sector. • Capital investment and expenditure (including contracting, drug procurement and distribution) • Provide technical support to the District Health Management teams
National	Finance	Ministry of Finance		• Providing funding to national and district level
National	District Health	Ministry of Local Government & Development (MoLGD)	District Executive Committee (DEC)	• Responsible for formulating and implementing the District Development Plan (DDP), including health • Service delivery & public health (including water quality, sanitation, and hygiene) • Recurrent expenditure and procurement for district hospitals and clinics (except drugs) • Monitoring standards • Contracting CHAM health facilities through Service Level Agreements DEC is chaired by District Commissioner (DC), District Health Officer is member. The Health Sub-Committee interacts & respond to DEC members regarding district health needs. DEC also includes NGO representatives.
District	District Health	MOH	District Health Management Team	• Prepare District Health Implementation Plan based on needs & priorities identified by health facilities, ADCs & VDCs Members: District Health Officer, District Nursing Officer, District Environment Health Officer, Programme-specific coordinators, Development partner representatives
Health Facility		MoLGD	Health Centre Advisory Committee	• Bridging the communication gap between community and health staff • Inspection of facility conditions and drug stock • Formulating recommendations on facility equipment • Complaint management • Provide feedback & report issues to DHMT Members: 10 community members
Traditional Authority (Senior Chief)	Community Development	MoLGD	Area Development Committee (ADC)	• Represents all VDCs in a Traditional Authority (TA) area. • Development planning and implementation - Set priorities, identify, and prepare project proposals addressing community needs which cover more than one VDC

				• Organise monthly meetings together with VDCs from their area; to supervise, monitor, and evaluate the implementation of projects at TA level • bring together community members and resources for self-help projects; and to improve on and prioritise project proposals for VDCs for submission to DECs.
	Community Development	MoLGD	Area Executive Committee (AEC)	• Advise the ADC on all aspects of community development within the territorial jurisdiction of a Traditional Authority. Members: Extension workers from different government departments and NGOs operating in the area
Group Village Headman	Community Development	MoLGD	Village Development Committee (VDC)	• Development planning and implementation • Prepare project proposals to submit to ADC • Community mobilisation and action
Group village headman	Community Health		Community Health Action Groups (CHAG)	• The health-arm of VDC, representing different VHCs • Collective voice on community health issues • Provides support to VHCs to ensure effective functioning Members: 60% village members, 40% VDC members (10-total)
Village	Community Health	MoLGD	Village Health Committee (VHC)	• Promotes primary health care activities in the community • Work with Health Surveillance Assistants (HSAs) to deliver preventative and promotive health services • Develop Community Health Action Plan • Recruits' volunteers Members: HSAs & community members from respective village

As mentioned above, a key goal of the decentralisation process was to achieve greater citizen participation in public affairs and policy. In 2017, Malawi launched its new National Community Health Strategy (2017-2022) which states that the role of communities is to use, provide and monitor community health services, and that community-based organisations (NGOs, civil society groups and faith-based groups) play an important supportive role to communities. Community Health Workers (called Health Surveillance Assistants (HSAs)) have become the first point of contact for communities with the health service, and, along with community health nurses, midwives, and volunteers, form the Community Health Team.

Four formal structures exist for citizen participation, each aligned to the levels of traditional leadership and village geographic areas. The structure the closest to the community is called the Village Health Committee (VHC), established, and run by HSA's. The VHC develops a community health action plan for its respective village, and this is fed upwards to the Community Health Action Groups (CHAGs), the health-dedicated arm of the Village Development Committee (VDC), operating at the level of the Group Village Headman.

CHAGs are comprised of representatives from different villages. The CHAG feeds upwards into the Area Development Committee (ADC), which operates at Traditional Authority Level. The District Council responsible for all district health affairs receives input from communities directly via the ADC and indirectly via the Health Centre Advisory Committees (HCAC). As per government policy, each health facility is mandated to establish a HCAC, comprised of 10-elected community members. For HCAC, chiefs and local government councillors are not eligible. HCACs were found to play an important bridge between the community and health facility, often advocating on behalf of community for services or reporting issues to the District Health Management Teams [351, 362].

In terms of the effectiveness of community structures in health, evidence has found several problematic areas. First, these often structures lack the authority, resources and decision-making power they need to have a significant impact for example [363]. Second, there is often a lack of technical capacity within these committees, especially in the basic processes associated with accountability, negotiation skills and reporting [363]. Third, the extent and effectiveness of community participation depends on the motivation of the health surveillance assistants and the effectiveness of community mobilisation was found to be greatly dependent on the motivation of the local chief [363]. Fourth, the weakness in the government monitoring and supervision system often result in communities not having access to this monitoring or budgetary information. [363].

In terms of decentralisation across different sectors in Malawi, authors remain critical of the effectiveness of citizen participation as it remains constrained by a prevailing top-down approach to policy making [364]. Chingaipe [364] states "*At very best, citizen participation takes the form of consultation in which bureaucratic policy makers take a leading role in identifying and framing policy problems and deciding policy responses while people are expected to provide simple feedback*". At the stages of policy implementation, a greater degree of participation is observed, and this is ascribed to the 'self-help spirit' of Malawians.

In terms of keeping government accountable, community structures have not succeeded as they lack the capacity for effective monitoring of finances, operations and standards [364]. Research reports have described further accountability challenges such as favouritism in resource allocation, increased cases of corruption, government's non-compliance with local government rules and vulnerability to elite capture of community structures especially by chiefs and local politicians [339, 364-366].

5.3.4 Influences of personhood, management culture and religion

"Africa is not a monolithic entity; rather, it is a vast continent with great diversity. . . Therefore, any grand theoretical generalization about Africa would not just be superficial, but also dangerous" [367].

The final section of this chapter examines the cultural factors and values influencing management and governance in Malawi, and as such, it is expected to affect the implementation and institutionalisation of initiatives. As described by Hofstede and Hofstede [368], the notion of culture includes a collective phenomenon, consisting of the unwritten rules, learned within and shared by people living in the same social environment. It is well accepted by scholars that national culture influences the culture of organisations and institutions. It is thus valuable to review the influences that affect decision making or influence the action taken within Malawian organisations, such as the government, especially in the light of studying the process of health systems and policy change.

i. Malawian moral personhood

Malawi, being a southern African nation, is influenced by the broader African concept of ubuntu. Ubuntu is a moral theory that regards each person's humanity as inextricably bound up in that of another [369], in turn linked to the vision of a good society [370]. In its essence, it encapsulates a way of life, one rooted in values such as humaneness, inclusivity, a spirit of caring and community, harmony, hospitality, and respect. Botha [371] states that ubuntu doesn't reject individuals but rather respects them within the realm of collectivism and communal responsibility. Metz [372] posits that in Ubuntu 'communal relationships are the highest good' and further defines the notion of 'harmony' as the key principle that enables the formation of relationships, shared identity and which guides right action [372]. This Afro-communitarian logic of Ubuntu stands in contrast to the Western model of being, which is based on Greek philosophy that revered an essentialist (mechanical), individualist and intellectualised model of being [373]. As per Lindland [373], the Western Protestant religious formation of Malawi, led by Scottish missionaries, tried to introduce this way of individualistic being in the country but it stood in opposition to an African model of being that constructs people in dynamic, collectivist and embodied terms. Karp [374] further identifies several differences between an atomistic European or Western model of personhood and the more relational model of personhood he observed in Sub-Saharan Africa. A European person is defined as separate from others, powers and functions are restricted to the single person and relationships hold a functional value. He suggested that an African person does not hold the same distinctions between the "I" and the "other" and personhood lies in being a member of a community. Englund, following his research in a district in southern Malawi, found individualism to be an inversion of what it means to be a moral person [375].

In Malawi, the notion of ubuntu is thus referred to as 'umunthu', meaning "being a person" or personhood. Umunthu symbolises all that is good and worthy in human life (truthfulness, generosity, respect) and is a recognition of the sacred or Divine in each human being [376]. Articles describing the cultural ways of different Malawian ethnic groups, that of the Tumbuka and Chichewa tribes, share a similarity. For the Tumbuka, personhood is based on becoming, a process that emerges as life evolves from birth to death, and spiritual dynamism in which collectivist notions extend beyond just people but to include ancestors and even animals all in a holistic whole [373]. This more dynamic model of being human plays an influencing role on personal behaviour, who they relate with and how they should relate to [373]. Similarly, Sindima [376] describe the organising logic and principles of the life of the Chewa, the largest Malawian tribe, as personhood or identity founded on the outside ie. 'other-selves-other-than-oneself'. The selves-other-than oneself can refer to the material referent (such as nature) or the identity bestowed upon by the community. There is thus a deep sense of togetherness, co-membership and co-belonging with societal structures and sharing in a deep institutional logic. Importantly, and contrary to the Western notion of community as a collection of atomistic individuals coming together for self-interested reasons, the community for the Chewa refers to an act of being bonded to another and sharing life in one common symbol, living in communion and communication with each other. This form of bondedness further leads to a sense of shared responsibility, in which everyone is responsible for everybody else around them. Within villages, members consider themselves brothers and sisters because of their common ancestral roots and raising a child is a collective responsibility. It is further reflected in traditional Malawian proverbs such as '*mutu umodozi susenza denga'* meaning 'one head does not hold a roof' [377].

A global study conducted on the changes in individualistic values and practices over 51 years, showed a 12% rise in individualistic practices in 72 out of 78 countries. Of note, Malawi was noted as one of the few countries in which individualistic practices declined over time [378]. Mali and Malawi were the only African countries with this decline, signalling a uniqueness in their experience and values. As per Hutchinson [379], "Malawi is a country so different and unique from others in Africa (concerning the idea of moral personhood)". Sindabe describes other key elements and practices inherent in Chewa culture [376]. First, respect is central in the meaning of personhood and to respect a person is to recognise the sacred "*moyo*" within them. This respect is marked not only by affirming the presence of another person but being willing to enter into that person's world through dialogue. It is believed that unless there is an understanding of who the person is, the subject at hand, will not be successfully communicated [376]. Second, Chewa traditional wisdom also frowns upon people rushing into business when they first meet, to the extent of seeing it as dehumanizing behaviour towards another person. Upon meeting to discuss a topic, experiential sharing (sharing of *moyo)* is required [376]. Third, personhood is something to be attained over a lifetime and marked

by aspects such as generosity. Anyone who lives for him or herself, marked by wealth and status, without sharing it with others is regarded on par with an animal. In a bonded life, sharing is considered a key organising logic that holds all of creation together [376].

Scholars have expressed multiple critical views about Ubuntu as an African concept in general. It has been critiqued for denying the humanity of non-autochthonous individuals [380] or for fostering conformity at the expense of a democratic national culture [381]. Some of the critiques include the use of ubuntu as an object of political interest whether to drive positive reform, as in the case of liberation struggles of black Africans from white rulership (apartheid and colonialism), and as an excuse for wrongful political actions on the part of governments [382, 383]. In South Africa, it has become heavily criticised as a concept to advance an Africanist agenda when it best serves the elite [382, 384]. However, as per the quote at the start of this section, it is important not to make the mistake of considering Africa as a monolithic entity. The experience of ubuntu in the context of South Africa, from which most of the literature critiquing the concept arise, is not the same as that in Malawi. Concerned Malawian scholars have also noted the misuse of the concept of ubuntu in the achievement of political ideals. Tambulasi et al [385] said that ex-president Kamuzu Banda, of the Malawi Congress Party, as lacking 'ubuntu blood running through his veins'. This was based on his behaviour of gaining financial wealth only for himself and not upholding the rights of individuals or the broader society. The subsequent political regime, under ex-president Bakili Muluzi, was explicit in its statements of ubuntu and this leader justified his corrupt actions as ubuntu. Tambulasi et al [385], in a similar vein to Metz, also argue that ubuntu does not preclude the adherence to an open and harmonious society, one in which holds to democratic ideals of equality, transparency and accountability.

This study takes note of the complexity associated with ubuntu as a political construct and uses ubuntu as a moral construct (as described above).

ii. Management culture

Beyond the social domain of everyday life and the political domain, ubuntu's value as a moral theory is to be considered concerning how it influences an organisational environment and thus processes such as implementation and institutionalisation. Malawian management culture is a confluence of the broader African culture and Malawian personhood (as described above) alongside influences the colonial education and management system.

In management literature, ubuntu has been described as an alternative to libertarian stakeholder theory, which seeks to explain the moral grounds for how different parties relate to each other [386]. In stakeholder theory, the moral consideration of different parties is based on the power, influence and 'stake' they hold, and parties come together through strategic and instrumental relationships that can achieve a specific goal. Woerman et al [386] describes ubuntu as a relation holder theory, in which the primary goal is to foster harmonious relationships that are constitutive of good. In this approach, strategic decision-making is distributed to all parties through a democratic collaborative engagement process. It does not require complete agreement by all parties but rather places value on the process whereby all views can be aired and discussed. This approach also allows for ample time to ensure the right decisions are made and thus has the practical implication of taking a longer time to ensure adequate engagement [386]. In addition, engagement processes are facilitated not by a lone leader holding a transactional vision, but by the leader operating as the servant of the group. This approach contrasts with the engagement process upheld by libertarian stakeholder theory, in which engagement is a 'means to an end'. In an ubuntu relationholder theory, engagement is for the goal of generating harmonious communal relationships [386]. Nnadozie [387] states that "Collectivism associated with harmony and cooperation means working for the benefit of the whole, based on a long-term vision, rather than the benefit of constantly changing individuals".

Studies in sub-Saharan African and Malawi have ascribed project implementation failure to inappropriate (western) project organizational structures and insufficient time for harmonious relationship management. This failure to account sufficiently for ubuntu between project stakeholders, includes inadequate engagement of all parties and prescribing individualist piecemeal solutions instead of solutions for a community context [388-390].

A further factor that is stated to have an impact on Malawian management culture is Western culture, brought to the country via the colonial structures of governance and education. The history of colonial influence in Malawi has already been discussed in (5.3.1). Colonialism is described to entail the dominance of one culture over another and cultural dissimilarity. With British rule, British rules, values, and beliefs entered management and governance in Malawi. Within the colonial context, British managers considered the Malawian labour force to be lazy, but studies suggest that Malawian workers were rather retaliating against forced work, minimal pay, imposed taxes and land occupation by the British. The assumptions underpinned in Western management thought, those of individualism, modernity and Eurocentricity, were in direct conflict with African chieftaincy that valued communalism, traditionalism and ethnocentrism [391]. The establishment of Western Missionary schools also brought with it a different educational curriculum, one of reading and writing, in contradiction to the traditional oral ways where elders were responsible to impart knowledge to the

youth. Western curricula had little sensitivity or awareness of African traditional values. Western Missionary schools further made English the medium for public and official communication as well as training.

Through British education, western management philosophies were transferred to Malawian managers. As Malawi has developed post-independence, it has continued to invest in education and the country has also been affected by ongoing globalization. The country currently has 4 public universities and over 28 private universities, with a total enrolment estimated between 40,000 – 50,000 [392]. It is further estimated that roughly 1.5 million Malawians have attained tertiary education [392]. With Malawi's historical ties to the United Kingdom and good tertiary education, the country has lost a significant number of its health professionals, mainly nurses, to emigration, resulting in severe health worker scarcity in the country [393, 394]. This outflux of its health professionals has resulted in the loss of intellectual capital, public educational investment and a current overall public health staff vacancy rate of 45% [314, 395], all of which negatively impact the availability of timely, quality health services in the country. On the other hand, the country earned US$ 186 million in 2018 in remittances from its diaspora [396]. Malawi is becoming increasingly interconnected as mobile phone subscribers have been increasing (30% of population, 2017) but regarding internet connectivity, Malawi still lags significantly behind other African countries [397, 398].

As Mbeta [377] accurately states, due to this confluence of influences Malawian managers often find themselves standing on one leg in their native, traditional culture and with the other leg in acquired Western culture. Malawian management culture has been described as being collectivist, but it with remnants of its colonial history and this is reflected in several ways in Malawi [399, 400]: first, in the high regard managers have for their subordinates as people, with a view of workers as a network of people rather than merely human resources; second, in that people will rather seek to maintain relationships in favour of individual development and third, in the strong emphasis in Malawian society on prestige, status differences, creating relationships of dependency and respecting hierarchy. There is also a greater value placed on observing protocol than accomplishing work-related tasks [399]. This value system has been described that tends to generate conformism and tolerance of mediocrity as it is frowned upon to stand out like 'tall poppies' [401]. Acknowledgement is also given to the residual legacy of fear in voicing opinions, as generated by the Banda regime.

iii. The influence of religion

Lastly, religion shapes people's minds, values, belief systems and behaviour [377]. Religion has a significant impact on Malawi society as 83.4% of the total population is Christian followed and 12.8% are Muslims [402]. Before Christianity and Islam came to the nation via the Scottish missionaries and the Arab slave traders, Malawians were considered religious people. The Kaphirintiwa Myth of the Chewa people holds firm to the

presence of a divine creator, God, who made the first man and the first woman. The belief in a deity was also expressed through ancestral worships of spirits [403]. Scholars support the view that western religions gained ground in Africa because of these pre-existing beliefs [404]. Scholars further indicate that missionisation can no longer be regarded as a top-down process but over time Africans have exerted their own agency that has led to the inculturation, or blending, of western religion and indigenous beliefs into a new set of values and belief systems [377, 405]. Indigenous beliefs, especially those related to witchcraft, have led to Malawians viewing success or failure in a work context as caused by traditional spirits.

An area where the church and Christian beliefs have played an important role in social and political activism was in bringing about change in governance. The tipping point event that led to the end of the Banda 30-year autocratic regime can be attributed to the Catholic Church. In March 1992, they released 16,000 copies of a public letter, read by 15 million Catholics throughout all the churches of the country, criticising the government. The letter became the 'moment of truth' for the nation as it referred to human rights, especially concerning health and education, as being integral to the Gospel. This letter undermined the government's position and subverted President's Banda's spiritual authority within the country [406].

Throughout the country's democratic era Roman Catholic Bishops have remained the moral compass of the nation. Ahead of the 2019 tripartite elections, a pastoral letter was again calling for a change in the business as usual approach in Malawi, sharing leader qualities that the electorate must consider and calling for major improvements in the country's health, education and agricultural sectors [407]. In terms of healthcare delivery church health centres, under the umbrella of the Christian Health Medical Association of Malawi (CHAM) is responsible for 29% of health service delivery in the country. Although Malawians perceive mission hospitals and health facilities to offer the highest quality of care, access is often hindered due to user fees [345].

5.4 Conclusion

This chapter examines several contextual factors in terms of history, current events and governance structures that have an influencing role on social innovation's development, implementation, adoption, and institutionalisation. In subsequent chapters, the relevance of these factors will become better understood in analysing the data and interpreting the findings. It further assisted to inform recommendations of relevance for Malawi and other similar countries, as presented in Chapter 10.

6 CHAPTER 6 – CASE DESCRIPTION: A SOCIAL INNOVATION THROUGH AN INSITTUTIONAL LENS

6.1 Introduction

This study is an exploration of a single social innovation– Chipatala Cha Pa Foni (CCPF) [English translation – *Health Centre by Phone*]. CCPF is a toll-free health and nutrition hotline accessible to all Malawians. The hotline, staffed by qualified Malawian nurses, provide telephonic health information to callers. In addition, text messages with health tips and reminders are sent to subscribers covering a variety of health topics. This case study focuses on how this social innovation initiative was adopted and institutionalised as part of the public health system in Malawi.

The findings from this study are presented in four results chapters, with the latter three chapters each addressing a different level of the social innovation conceptual framework (Chapter 4). This framework integrates micro, meso and macro-level aspects of institutional theory, positive organisational scholarship and positive psychology. Chapter 7 focuses on the micro-level, exploring the role of actors and agency; Chapter 8 focuses on the meso-level, exploring positive practices and emotions and Chapter 9 focuses on the macro-level, dealing with factors within the institutional context.

This first results chapter analyse and present the development and evolution of the social innovation, the actions over time and the organisations involved. The CCPF initiative will be examined using Nilsson's heuristic for social innovation outlined in Chapter 4 [42]. This heuristic assists with explaining why this initiative can be deemed a social innovation and identify outcome areas where the social innovation required changes in the institutional dimensions of the health system. It provides a broad understanding of the 'what' of social innovation before applying the study framework to understand the 'how' of the adoption and institutionalisation process.

Data sources that informed this chapter include document reviews (organisational monthly progress documents, evaluation studies, organisational reports) and key informant interviews with actors who were involved at various stages of the initiative, over 8 years (2011 – 2019).

As part of my time in Malawi, I was able to film and produce an 8-minute video about this social innovation, the use by beneficiaries and the Ministry of Health's commitment to this initiative.

6.2 Overview: History and Timeline of Development

During the Millennium Development Goal (MDG) era (1990 – 2015), Malawi was reported to have one of the highest maternal mortality ratios in Africa. Maternal mortality peaked in 2000, at 971 maternal deaths per 100 000 live births [408]. Despite maternal mortality decreasing significantly by 2010, it remained at 484 / 100 000, still falling short of the MDG Goal 5 target of achieving a 75% reduction [408]. Factors described at the time as being drivers of maternal mortality in the country included: high rates of HIV in Malawi; poor resourcing of health centres to facilitate skilled birth attendance especially due to overseas and rural to urban migration of health workers namely nurses and midwives; high fertility rates and the low socio-economic conditions limiting access to healthcare resulting from literacy and nutrition [408]. It was within this context (as presented in Chapter 5) that that the Chipatala Cha Pa Foni (CCPF) was initiated in Malawi.

In 2009-10, Concern Worldwide International hosted an innovation competition "Share an Idea, Save a Life" which solicited creative ideas within Malawi on how maternal and child health indicators could be improved. A total of 6047 submissions were received and these underwent a selection process, leading to 30 semi-finalists with the final winner receiving a $10,000 award [409]. A young Malawian citizen with a background in information technology put forward a solution to improve maternal and neonatal health. His idea was to provide Malawian mothers and communities access to maternal and child health information via mobile phone service. The innovator stated in an interview that his idea intended to bridge the gap between the community and the health facility, a gap caused by significant geographic distances, long waiting times at health facilities and a lack of personalised care. He hoped that by connecting health experts with mothers, through mobile technology (voice and text messages), health information informing personal decision-making could become more readily available.

The winning idea was taken up for implementation by an international non-governmental organisation (NGO) headquartered in the United States but with operations in Malawi. The idea was first implemented in 2011, within a catchment area of a single district in Southern Malawi. According to the main field implementer, upon implementation, adjustments to the idea were made to meet community demands and overcome challenges encountered. One of the main adaptations the initiative had to make, upon request from the Malawi Medical Council, was to replace the community health workers first used to provide health information, with the qualified nursing staff.
After 2-years of implementation, an impact evaluation assessment was conducted (see findings in Box 6-1).

Box 6-1 Key Findings – Impact Evaluation of Pilot Implementation (2013) [410]

- 20% of women aged 15 – 49 years used the service
- CCPF has a statistically significant impact on RMNCH knowledge, behaviour and antenatal care use.
- 94% of users were satisfied with the service experience and 98% satisfied with the text messages they received
- 75% of calls to CCPF were resolved without requiring a referral to the health centre, thus encouraging appropriate health-seeking behaviour.

As outlined in detail in Figure 6-1 below, the initiative underwent two parallel processes with a variety of organisational actors involved: a) scaling out which entailed growing in reach and number of people served, and b) embedding the initiative within the government health system through adoption and institutionalisation. This visual presentation was derived from analysing organisational documents, monthly meeting reports and stakeholder interviews.

6.2.1. Scaling out – Growing in size and reach

Starting in 2013 - 2016, the implementing NGO (with the support of other bilateral agencies and private funders) extended the geographic reach of the initiative to include 8 other districts. Simultaneously, the NGO extended the focus of the initiative beyond maternal and child health to also include other primary care focus areas. Raising awareness of the service in other districts was primarily achieved through establishing partnerships with bilateral development agencies operating in respective districts. This process continued until 2019 when the initiative reached coverage across all 28 districts in Malawi. Following the 2019 natural flood disaster in the country, disaster prevention information was also included in the service offering. The hotline's operational centre (housing the staff and technology) was first established within the pilot district (within the premises of the district hospital) but was later moved to the capital, Lilongwe. As the service offering and reach grew, technology upgrades were implemented, the number of nursing staff increased, the health information given was packaged and standardised, community mobilisation expanded, and communication promotion of the initiative both nationally and internationally grew (See Table 6-1). During this time, a key partnership with a telecommunications company (Airtel) enabled the scaling out. The company provided a free of charge (zero-rate) offer for all mobile phone calls made to the service as well as, free health information text messages (text message blasts) that could be sent to all registered service users. To grow the initiative to a national scale, funding and support were received from a variety of multi- and bilateral donors and private sector firms.

A second independent impact evaluation study was commissioned in 2018 to determine the effectiveness of the initiative in 9 intervention districts as compared to 9 non-intervention districts. Utilising a mixed-method design, household surveys were collected from 1,234 respondents in 13 districts, focus group discussions and an external quality assurance review was performed. Box 6-2 below highlights the key findings.

Box 6-2: Impact Evaluation Findings (2018) [411]

- CCPF had a statistically significant impact on SRH and HIV indicators (increase rate of HIV testing, contraceptive use, condom usage and knowledge of post-exposure prophylaxis).
- CCPF had a statistically significant impact on maternal health (increase knowledge about the delivery date, higher planned pregnancies, higher usage of antenatal care in the first trimester).
- CCPF had a statistically significant impact on child health (higher child vaccinations, more children sleeping under an insecticide-treated bed net, better child feeding practices).
- CCPF had a statistically significant impact on nutrition (increase knowledge about the six food groups and the importance of eating all six daily).
- 87% of users reported following the advice given by the CCPF hotline nurses.
- 87% of callers who were referred to a health facility for further investigation, reported seeking care.
- 98% of CCPF users reported service satisfaction.
- 57% of users said they would still call if it was a paid service.

Process A Steps & Actions to Scaling out (Growth)		Process B Steps & Actions to Scaling Up (Adoption & Institutionalisation)	Organisations involved
Innovation Contest *'Share an idea, Save a life"*	2009 - 2010	**Engagement:** MoHP attends finalist presentations at innovation contest.	**Host:** Concern Worldwide **Government:** Ministry of Health and Population (MoHP) **Community:** Citizen innovators
Service focus: Maternal & Child **Housed:** District hospital **Workforce:** HSA's overseen by district hospital nurses. **Community mobilisation:** volunteers & traditional leaders **Language:** English & Chichewa	2011 - 2012 	**Participation:** Staff from district hospital support hotline.	**Implementer:** VillageReach (implementer) **MoHP:** District Health **Community** - Traditional Leaders & volunteers **Partners:** Boabab Health Trust, Concern Worldwide Save the Children
Research: First independent impact evaluation	2013 		
	2014 	**Advocacy:** Presenting CCPF at Reproductive Health Technical Working Group (TWG).	**Implementer:** VillageReach (implementer) **MoHP (Central):** Reproductive Health, Planning **Community** - Traditional Leaders & volunteers **Partners:** as above
Service focus: Add nutrition **Partnership:** Merger with Airtel Dial-a-Doc service & calls free of charge. **Workforce:** Add nurses with nutrition specialisation. **Advocacy:** 'health & nutrition hotline	2015 	**Engagement:** Minister of Health attend CCPF community event. **Advocacy**: Min. of Health & Reproductive health director present CCPF at World Health Assembly (Geneva).	**Implementer:** VillageReach (implementer) **MoHP (Central):** Reproductive Health, Planning **Community** - Traditional Leaders & volunteers **Partners:** Airtel, GZI
Service focus: Add adolescent-specific topics **Workforce**: staff training (health topics) **Community mobilisation:** radio & text message blasts **Advocacy:** written stories of CCPF users & branding as Airtel-CCPF **Technology:** Software upgrades Language: Tumbuka	2016 	**Engagement:** Visit by Reproductive Health Director & Head of CMED to Balaka hotline. **Participation:** Appointment of Technical Advisor to MoHP-Planning (CMED) & training delivered to hotline staff. **Leadership**: First Steering Committee Meeting on government transitioning. **Advocacy**: Min. of Health & Reproductive health director present CCPF at World Health Assembly (Geneva).	**Implementer:** VillageReach (implementer) **MoHP (Central):** Reproductive Health, Planning **Community** - Traditional Leaders & volunteers **Partners:** as above + Johnson& Johnson, Vitol Foundation

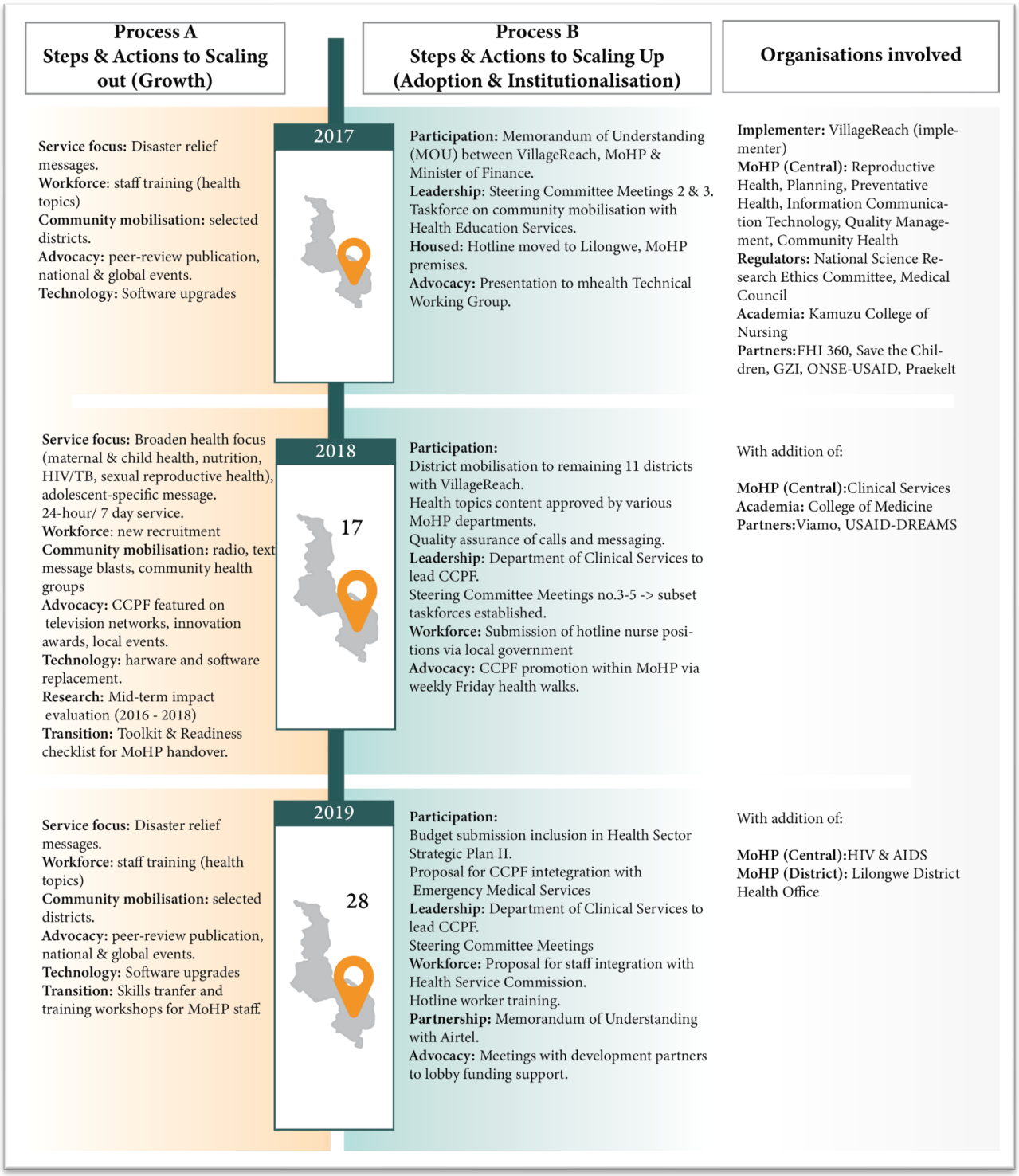


Figure 6-1: *Timeline, Actions and Actors*

6.2.2. Scaling Up – Institutional embedding through adoption and institutionalisation

As early as 2009 -2010, the Malawi Ministry of Health and Population (MoHP) were engaged in the innovation competition hosted by Concern Worldwide. Historical accounts by study respondents indicated that the challenge put forward to citizens to develop ideas surrounding improvements in maternal and child health was identified by the MoHP during the national annual health sector strategic planning meeting. Representatives from the Department of Reproductive Health were engaged in the finalist presentations where 30 citizens put forward ideas to be adjudicated for the $10,000 prize.

Starting in 2011, a non-Malawian NGO was tasked with implementation. The NGO embedded the initiative within the district health structure - notably the district hospital where pilot implementation took place in the Southern Region of Malawi. This fostered close relationships between the NGO, the district health management office, and the staff working in the district health office. The NGO project manager recognised the importance of not only engaging district level structures but also the structures and actors located at the central level if the national-level scale was to be achieved. This engagement was achieved through utilising existing available structures such as Technical Working Group meetings (quarterly or bi-annual forums hosted by various technical departments within the MoHP open for attendance by all country actors working in the respective area). Relationships were fostered with directors of two key technical departments/ divisions within the MoHP (the Reproductive Health Department and the Central Monitoring and Evaluation Division (within the Department of Planning)). As noted by a study respondent, it was through the engagement of these senior government actors that further backing and political support for the initiative was provided by the then Minister of Health. As to be explored in Chapter 7, the early actions of a small group of key actors, called institutional entrepreneurs, were key in the initiative being formally adopted by the MoHP in 2017 through a Memorandum of Understanding (MoU).

The actions of these key actors from 2014 – 2017, significantly supported the MoU being established between the MoHP, the Ministry of Finance and the NGO are further described in Chapter 7. Ahead of the formal adoption signing, symbolic actions paved the way. The relocation of the hotline centre from a district hospital in Southern Malawi to the central government MoHP premises in the capital, Lilongwe (Central Region); the recruitment and appointment of a technical advisor to the MoHP (seconded from the implementing NGO) and the hosting of the first cross-sector, cross-departmental steering committee meeting.

Once the adoption was formally agreed upon, 2017 – 2019 was marked by joint efforts from the MoHP and the NGO to embed the initiative within the public health system i.e., a process of institutionalisation commenced such that the initiative can achieve widespread legitimacy. Table 6-1 presents a more detailed

analysis of the efforts undertaken in this period as well as the challenges encounter. The process of adopting and institutionalising an innovation within the public system was not without resistance and challenges. Factors that hindered the institutionalisation process included: leadership critique, perceived ownership, positioning within government structures, creating new roles and positions within the government health system, procurement of basic supplies not often provided by the public sector, political cycles, and election disruptions. These factors will further be explored in Chapters 8 and 9.

This process of institutionalisation was not yet completed by the end of the data collection period of this study in July 2019, but this study demonstrates that several steps were taken towards this goal (see Table 6-1). The positive institutional and organisational practices that supported this process are explored in Chapter 8, while chapter 9 examines in closer detail the factors in terms of competing institutional logics, which could be a hindrance in this process being successfully completed.

TABLE 6-1: EFFORTS IN SUPPORT OF INSTITUTIONALISATION (2017-2019)

Components of CCPF Innovation		Efforts undertaken by NGO in support of institutionalisation	Efforts taken by the MoHP in support of institutionalisation	Challenges encountered
Leadership & Management	The leadership and daily implementation of CCPF to change from the NGO to the government.	- Technical advisor appointed to support the government to execute the necessary actions for institutionalisation, including the steering committee. - Promotion of CCPF at District Health Management level conducted by hotline nurse supervisor and government representative. - Partnerships managed by NGO transferred to government. - Ongoing canvassing of donor support. - A government transition readiness checklist developed and conducted to identify areas where training is required.	- Department within government appointed to lead institutionalisation process. - Steering committee meetings hosted. - A future 'house' / position discussed within government on where to base CCPF and an officer to oversee operations (not appointed). Opportunities identified included: • Establish as a unit with Clinical Services Department • Incorporate CCPF with Emergency Medicine Unit • Establish an independent unit. • House at district level • House within another department - Officer to promote CCPF through engaging district health officers. - A new MOU signed (2018 & 2019) including the private telecom.	- Critique from other departments – weak leadership from appointed department & NGO visibility still too pronounced as the 'face; of the initiative, thus hindering the project from becoming a government programme. - District Health Management Teams engaged very late (only from end 2018) - Delayed identification of a government house and operational manager for the initiative.
Human Resources	28+ nursing staff to be placed on government payroll and appointed as government workers.	- Nurses employed by NGO were put on government pay-scale. - Additional funding located from health donors.	Various avenues tried: - Create new staff positions as part of MoHP establishment. - Recruit nurses via district-level nursing positions. - Health donors approached for funding.	- Strong resistance from Department of Human Resources to include CCPF staff as part of government establishment. - District Health recruitment not successful. - Discontent among hotline nurses over future job insecurity.
Infrastructure (including technology)	Hotline building to be maintained. Hardware and software to be fully operated by ICT government officers.	- Funds were raised to support the construction of a hotline centre on the MoHP premises. - A new software developing company was procured to upgrade software functionality. All computer hardware was upgraded. - Training engagement with ICT officers commenced (not completed).	- A location secured on MoHP premises in Lilongwe for hotline building.	- Procurement for other infrastructure sundries e.g. drinking water for staff, stationary etc challenging. - Government ICT staff are not dedicated to the MoHP but rotate through all the various ministries. Thus, even if current ICT-MoHP officers are trained, they may be moved to another department or will not have the time available to assist when an emergency arises. Appointing a dedicated ICT government officer to be trained not successful.
Technical & Monitoring	Technical oversight, support and training given to nursing staff.	- Hotline health topic areas expanded with funding / partner support. - Technology software upgrades assist in improving monitoring procedures.	- Technical officers from various departments engaged in monitoring call quality, providing training to hotline nurses and reviewing health information text messages, to ensure it is in line with government protocols.	
Funding	Funding required for staff salaries and infrastructure.	- Full operational costing of CCPF included in government budget. - Solicited funding from international donors operating in Malawi.	- Incorporate CCPF budget as line item in Health Sector Strategic Plan II. - Government to lobby the health donor group.	- Budget approval was delayed due to election year (2019). - Budget shortfall, especially for staff salaries, cannot be met by government.

6.3 Institutional field shifts required by Chipatala Cha Pa Foni (CCPF) as a Health System Social Innovation

This section expands upon the summarised findings in Figure 6-1 by providing a more in-depth description of the CCPF initiative as a social innovation from an institutional perspective (based upon the underpinning theory used for this study as presented in Chapter 4). Nilsson's (2019) proposed that a heuristic for social innovation based on the institutional work lens (Table 4-1) is a good framework for describing a social innovation. The heuristic demonstrates five performative areas in which social innovations have to conduct institutional work to embed it, and achieve the accompanying shifts required within the existing structures, namely: a) roles, b) social identities, c) resource flows, d) authority flows and e) meanings. The strength of this heuristic lies in it supporting the reader to gain a greater understanding and appreciation of this initiative as social innovation. In addition, the heuristic also identifies potential challenges and required shifts needed by the institutional dimensions of the public health system in Malawi.

Recognising social innovation as an intervention as well as a process means that both will influence the existing institutional dimensions. Firstly, this section presents the institutional shifts (in institutional roles and resource flows) brought about by the innovation. Secondly, it presents institutional shifts in the dimensions of authority flows, social identities, and meanings, through the social innovation process that was undertaken to adopt and institutionalise CCPF as part of the government health system of Malawi (2011 – ongoing).

6.3.1 Roles

Within the CCPF social innovation, role construction and role deconstruction were required. Role construction occurred as actors who would otherwise not have an opportunity to participate in health intervention, received an opportunity to share their experiential and cultural knowledge. As described in section 6.2 above, participation and knowledge sharing occurred via the mechanism of a public innovation contest. From over the 6000 citizen ideas submitted, two winning ideas came from two young (20-30-year-old) Malawians, a computer scientist working for a technology NGO in Lilongwe and the other a schoolteacher working for an educational NGO. Both innovators leveraged their non-health expertise and merged it with their lived experience of the day-to-day reality in the context of Malawi to put forward their creative ideas (as highlighted by the quotes below). Finalists in the competition received input from technical experts to develop and expand their ideas further before the final adjudication. The final solution was an assembly of the ideas presented by each of the Malawian innovators. In this way, citizens were given the role of health-intervention creators, a role and function usually reserved for technical experts or policymakers.

> *"Yes, it was essential to bridge the gap. The challenge was that people were not going to health facilities, so how do we encourage them to go and how do we improve health outcomes in that scenario. And so, I felt, we were trying to walk a long distance to the hospital and queue for a long time because the health care workers have to serve a lot of patients and they only have limited time to see a patient, so they don't get quality time. And the healthcare services are not personalised to the clients, the mothers and children. So, I felt if any time they can call and talk to a medical expert, they can have a lot more information about you and through that, gather information so individuals who call you can gather individual observations but from there you can analyse and see the trends and have messages you can communicate back to that community and those are the improvements that you can see, and communicate back to the community. And how would you do that? Voice is one good way as anyone can express themselves by talking and then those who can read can also receive SMS* (text messages) *and get the messages that way. Ja and that was more the idea..."* Interviewee 025 (Innovator)

> *"I got to know it through a newspaper advert. So, I submitted 1 page, there was my idea. I think initially they had, around 6000 submissions, and after the screening, they came down to 100. And I think they invited the 100, the 100 first, the best submissions. And from the 100 I think they came down to 30 and eventually, they picked my idea and (partner)'s idea, which I think were merged to become the project, the way it is run now, I think. In between they) supported us to further develop the idea, to question it, and, to provide technical understanding on some areas*." Interviewee 008 (Innovator)

For this new innovative idea to work, the second type of institutional shift was required - that of nursing role transformation. During the pilot of the project in the catchment implementation district, Health Surveillance Assistants (HSA - *community health workers*) were initially appointed to attend to incoming calls from the community. They were overseen by nurses from the local district hospital. However, using HSAs to fulfil this role and function were deemed inappropriate by the Medical Council of Malawi. The council stated at minimum, health information needs to be provided by a qualified nurse. Healthcare delivery is highly professionalised and risk-averse and so providing care is regarded as something only to be done by qualified professionals/ experts to minimise the risk of harm to recipients.

The nursing profession is a deeply institutionalised domain within its own right, with clear regulation, norms and attitudes around what being a nurse and delivering nursing care entails. The respondents responsible for the pilot implementation explained that CCPF required the role of nurses to be changed from being in-person care providers of hands-on care at the bedside location to providing telephonic consultations remotely. CCPF would require a role transformation for nurses to provide remote care, without the visual component of seeing a patient but merely through discussion and conversation, facilitated using technology.

This role transformation was, and still is, an area where significant institutional resistance and opposition towards the project was experienced. There was a perception that moving the nurse from the bedside to the telephone will result in a compromise in his or her clinical skills, knowledge, and attitudes - areas defined by the Medical and Nursing Council of Malawi as core to nurses being licensed and registered in the country. As said by a regulator: *"Yeah, so many concerns at first because you know, we associate nurses with only the clinical aspect, so people started having worries, what about their clinical skills, how will they aah be up to date in terms of skills."* Interviewee 019

At the time the innovation came into being, there was neither a clear policy framework governing mhealth or telemedicine initiatives in Malawi. Respondents involved in regulation reported that they were concerned with not being able to see a patient face-to-face to observe physical signs of illness, and only depending on dialogue, would result in misinformation and incorrect decision-making. To mitigate this, it was deemed that CCPF nurses could not be seen as providing consultations but merely providing health information and advice to callers (project evaluation document). A final concern expressed by government respondents, regarding the role transformation, was the fact that health facilities in Malawi were already facing an acute shortage of nursing staff to deliver hands-on care. Removing more nurses from the frontline was a concern, especially if the possibility exists that these nurses may not be used optimally while waiting for the phone to ring.

Despite the contentions regarding role transformation and the efforts implementing actors had to undertake to gain the necessary support for this role shift, two factors allowed for this to happen. First, the implementing team drew on the existing legitimate function of nurses as providers of health promotion and education. Second, they emphasised the limitations hindering access to health care experienced by Malawians: geographic distances, over-congestion of health facilities and limited (if any) patient-provider consultation time (interviews). A strong advocate (institutional entrepreneur) explained how he built the case for support for the initiative: *"So to me, I thought they were reaching more people without maybe people walking to the hospital because we haven't reached where the hospitals are closer. You know maybe others have 15 km, others have 10km, so I find it very interesting at least we are assisting many people and we are still trying to minimise congestion at the hospital because those people are feeling just many things. They would have covered the hospital anyway. They will be in the queue to be told it is just minor, but you would have spent your time in the queue, and this is decongesting the hospital. So, to me, I found that is very interesting."* Interviewee 014 (Government)

The theory of change put forward by the innovation was that access to care can be improved by providing timely health information, in so doing ensuring that care is sought appropriately, and unnecessary consultations are prevented.

Figure 6-2 (left): *CCPF Nurse operating the hotline (removed for confidentiality)*
Figure 6-3 (right): *CCPF Beneficiaries (removed for confidentiality)*
Image credits: L van Niekerk (2017)

Although approvals were received from the Nursing Council and the Ministry of Health (2011/12) to transform the role of nurses, the institutional challenge associated with this issue would surface again in later years. In 2018/19, as part of the institutionalisation process, the Malawi Ministry of Health and Population (MoHP) needed to incorporate the hotline nurses as workers of the public health system. Until this date, hotline nurses were employed directly by the NGO. Within the existing role delineations of the staff establishment, no allowance was made for nurses operating in this role and this has resulted in a major challenge for the initiative. As expressed by a government representative *"Is it feasible to just have qualified health workers and to train a health worker here is expensive. They should be answering phones and yet we have a high vacancy rate in our hospitals. My thinking said 'ah, are we ready for this?!". It is a very good initiative, yes, but is Malawi ready for this, that government should actually start creating positions for that and yet we are failing to address the challenges in our hospitals?"* Interviewee 052

Upon completion of this study, the implementing actors are still trying to find creative ways to enable the absorption of these nurses by the government (data gathered in July 2019).

6.3.2 Resource Flows

The second area of institutional work conducted by the social innovation initiative was to decentralise the resource distribution channels.

As noted in Chapter 5, a large portion of the Malawian population live in rural areas and these communities face several socio-economic challenges such as low-income generation, a lack of electricity and low literacy. Rural societies function within deeply embedded traditional and patriarchal cultural structures and this further influences their accessibility of health services, especially for women. Before the social innovation's implementation, health information, especially in rural areas, was a resource owned by health professionals and only accessible to most of the rural population through visiting a health centre. For low-income rural populations, especially women, lacked internet access, which could serve as an alternate means to receive health information.

Through the implementation of the social innovation initiative, access to health information has become more distributed. First, this has occurred due to information being sent to users (via text messages) and allowing users to call the hotline free of charge with their specific health questions. Second, the hotline was later opened to all Malawians, and not just mothers. The partnership with a private telecommunications provider (Airtel) enabled a dedicated phone number to be used free of charge by people calling the hotline for advice and information. It also enabled text messages, customised to the user's specified health interest, to be sent to thousands of people simultaneously.

Both interview and observation data provided insight as to the effect that enhanced distribution of health information had on community actions and distributed agency. In one of the villages visited during fieldwork, it was learned in an interview with a traditional leader, that the innovation became part of the Traditional Leader's strategy to improve the health of the 70,000 people he governed and specifically to reduce maternal mortality.

At the start of the implementation of the social innovation initiative, the leader had several challenges to address. A limited number of mobile phones existed within the community and these mobile phones were mainly owned by men. To overcome this shortage, the community raised funds to purchase several mobile phones and provided these mobile phones to selected women in the community called 'secret mothers'. These women would identify any pregnancies in the community and provide the mobile phone to women who may want to call the hotline (Figure 6-4). In addition, health information communicated via text messages was transcribed onto the walls of buildings all over the village (Figure 6-5). For the traditional leader, this became a strategy to raise awareness among men and women in the community about healthy maternal care practices, dispel selected cultural beliefs and practices that were responsible for poor maternal outcomes, and simultaneously implement bylaws to hold the community accountable when they were not adhering to these healthy practices.

> *"Yes.., then after that, it also you know, aaaah…, simplifies the role of traditional leaders now, the CCPF, instead of us moving around in the community, telling pregnant women to go and deliver in the hands of a skilled personnel, telling pregnant women to start ANC in the first trimester, telling them whatever message that we want to pass on to the women, was now simplified just because most of the women could just you know, call the CCPF, then listen to the messages, and also it eased the work load (…) for the personnel at the health facility, instead of attending a long queue of pregnant women who were just going at the facility just to ask for advice, now, those women could get the advice from the phones, and also you know, could give the kind of…. enthusiasm to the pregnant women, to say, when I get at the facility, what I wish to get is A,B,C,D just because they have already heard from the CCPF, instead of now, when the doctors would want to…to tackle some other issues, they would even saying no…no….no…no…, it's not that, that is not my problem, I have already heard*

from the CCPF, my problem is A,B,C,D, go and go and deal with A,B,C,D instead of Z,Y,Z." Interviewee 019 Traditional Leader

Figure 6-4 (right): *Health messages painted on the walls of village homes (removed for confidentiality)*
Figure 6-5 (left): *Women accessing health information via their mobile phone (removed for confidentiality)*
Image credit: L van Niekerk (2017)

As mentioned by community leaders and field implementers, the social innovation initiative had to overcome some initial doubt and resistance from the community. *"The reaction was like, this is new, first, you now…, and it was new, globally M-Health is also very new, of course maybe now it can be 10-15 years, but we considered it as new, and there were some questions to say from the communities for example, how can a phone call be free? Because as you know Malawi phone calling tariffs are just very high, and I remember facing a lot of challenges that we were getting from the communities, to say, this might be linked to this you know…., these satanic things and all that, and it was a bit challenging to make people fully understand what Chipatala cha pa Foni is, and maybe in meetings that we just had, we could still see that people need to be oriented on what M-Health is."* Interviewee 007

The social innovation initiative was one of the first projects in Malawi to leverage technology in support of health care provision and in so doing, the dominant community institutional logic on care provision was challenged. Communities were hesitant to believe that phone calls to the hotline were indeed free of charge, as phone charges are usually considered a significant expense for low-income socio-economic communities. Also, the community was concerned by remotely located health professionals, capable of telephonically providing information such as when the women's expected date of delivery would be. The community associated this type of future knowing with occultic fortune-telling practices and witchcraft. Community mobilisation campaigns were strategically hosted by the implementation team to attain legitimacy for the innovation at the community level and to overcome any concerns.

The decentralisation of health information, as a resource, by the social innovation initiative has led to greater distributed agency among community members, who now, based on evaluation reports, are more capable to make informed decisions and have improved health-seeking behaviour.

6.3.3 Authority flows, social identities, and meanings

Institutional shifts did not only occur as a result of the social innovation initiative but also due to the social innovation institutionalisation process (interview data). The process of adopting the social innovation and institutionalising it was made possible through a team of cross-sectoral actors from the implementing NGO,

the Malawi Ministry of Health and Population (MoHP), traditional leadership and community structures, the private sector firm, and multiple other partners from across private and development sectors.

Of note was that this social innovation process did not follow a linear implementation journey but rather a more iterative and adaptive approach, making changes based on the demands and responses from the community, government and regulatory agencies. Neither did the implementation and institutionalisation processes occur in a stepwise nature. Rather, events and actions to implement, develop and grow the initiative occurred at the same time as focusing on the adoption and institutionalisation of the social innovation initiative as part of the public health system (See Figure 6-1). Among multiple approaches used during the near-decade of implementation and institutionalisation, one structure, that of the Steering Committee Meeting (SCM), was significant. It facilitated institutional shifts in three key dimensions: authority flows, social identities, and meanings (meeting reports, interview data).

In 2016, the first Steering Committee Meeting (SCM) was hosted by the MoHP's Central Monitoring and Evaluation Division (CMED), within the Department of Planning. This structure served as a platform and process to facilitate authority flows - 'who decides what'. As one of the first technology-enabled and cross-disciplinary boundary initiatives in the country, and with the awareness that financial resources are distributed across various health system actors, it was important to move away from top-down command control approaches of decision-making and implementation. Key actors (institutional entrepreneurs) facilitating the SCM ensured that authority and decision-making processes were convened in a manner that would go beyond participants giving input in the simple form of 'yes or no'. Rather, this meeting structure provided an opportunity for relational decision-making by all involved, through rich dialogue, discussion, and participation (Chapter 4 & 8). The SCM, although convened by the MoHP, became a symbol of shared engagement and collaboration. As expressed by a partner of the project: *"Definitely the stakeholder collaboration. I think that there is a steering committee and VillageReach has been the glue that has kept all the stakeholders together, make sure the communication lines are open and make sure everyone is on the same page. I think that has helped to bring it to where it is now.* Interviewee 026 (Partner)

The SCM was horizontally and vertically inclusive. Participating actors were from 10 departments within the MoHP, different levels of the implementing NGO, the director to the hotline nurses, across sectors – private companies, bilateral development agencies, non-governmental organisations, academia, and professional associations.). All actors who participated in the SCM structure were given transparent access to information related to the innovation such as actions implemented, the latest monitoring data and listing all the challenges faced. Participating actors could thus propose ideas, suggestions, and solutions for how the innovation may continue to develop and adapt to become institutionalised. The SCM's function thus transcended mere

decision-making but also served as a co-creation space (See Chapter 8), facilitating ongoing innovation of the initiative (personal observation). The personal or professional networks of individual actors, availability of resources whether financial or in-kind and the opportunities for advocacy and promotion at different partner-hosted forums, were all generously contributed by the attending actors.

> *"The collaboration that is there between our partners, VillageReach and Ministry. I think that has strengthened because we can discuss. If there are issues, we sit and discuss them among ourselves. Like I said, even the steering committee has incorporated various departments, so it is like everybody is aware. Not like, they are left out, and then they will be surprised 'I don't know that this is happening' so there is such transparency and the involvement of different people."* Interviewee 010 (Government)

A second institutional shift that was facilitated by the SCM was fostering a sense of social identity and emotional solidarity across the diverse actors. The SCM facilitated this relational engagement by convening cross-identity interaction that has led to a sense of 'we are in this together. The new identity created by the social innovation overcame the diversity and distinction between individual institutional identities at the table and assisted with addressing implementation and institutionalisation challenges.

Although this sense of collective identity was shared by implementers, partners and across the Ministry of Health at the central level, the same level of emotional solidarity and identity was lost over time within the initial pilot district and was not created to an adequate extent in other districts. As CCPF is an innovation that directly reaches citizens via their mobile phones, district health structures were not needed as a gateway to the community. It was easy to neglect their involvement in the process. However, documents and interviews revealed that the implementation approach took a turning point in 2015, partly due to leadership change within the implementing NGO. Before this date (2011 – 2017), strong emotional solidarity was expressed by study interviewees (field implementers, traditional leaders and community representatives, frontline health workers and officers of the district health office). During the time the innovation was embedded in one district and steadily coverage was slowly expanded to 2 – 3 additional districts per year. In 2017, the innovation's physical location of operation moved from the pilot district to the capital, Lilongwe, as a symbol of the integration of the innovation at the central government level. This was followed by a very rapid scaling process intending to cover all 28 districts in the country by 2019. In the process of aiming to institutionalise the innovation at the central level, actors operating at the district level, experienced these changes, as them being left behind. Thus, cultivating an institutional identity required continuous relational practice across both central and district levels. The quotes below reveal how central level actors had strong solidarity towards the initiative but the same was no longer present at the district level.

"For nursing, we have supported that. We have our nurses there. For the nursing department, we support that because it is part of us." Interviewee 009 MoHP (Central)

Yeah…. I think they have stopped because see anybody, they don't see the Chipatala cha pa Foni, even though if they come at the hospital and see on the building Chipatala cha pa Foni, then they are proud that…we have been asking and we have been answered from Chipatala cha pa Foni, have you seen the block, it's there at Chipatala cha pa Foni? Now it's not there they don't know where it has gone, they don't know whether people are still alive or not. Interviewee 031 (Frontline worker)

I think it was introduced here but they have been working in the vicinity of the office. In Zomba, I don't have more information on it. Because in Dedza we use to distribute the flyers, we wrote the letters to all the church communities so that all people should know about that number then it was easy. But here in Zomba, they have never come to my office to introduce themselves that they have started working here in Zomba with the project. Interviewee 034 MoHP (District)

A third institutional shift facilitated by social innovation was in terms of meanings (the explanations for the way things are) [218]. The government health system, as an organisational structure, is one organised according to functional roles and disciplines e.g., a nursing department oversees functions relating to nurses. Yet, findings suggest that the CCPF social innovation cuts across siloed operational, organisational, disciplinary, and sectoral boundaries. By 2018, it grew to become a service beyond a maternal and child health focus. It became a technology-enabled service delivered by a single health provider (nurse) that provided information on all health topics, 24-hours a day, 7-days a week, covering all people groups (children, adolescents, working adults, elderly). The institutionalise process of this social innovation did not come without tension in meanings. This tension occurred as the social innovation's approach to healthcare, one which is more whole-person and holistically oriented, was in contrast with the traditional siloed (vertical) healthcare approach, organised according to functional areas. The social innovation initiative required consultation and participation of more than 10 different departments within the MoHP, to ensure that the service can be implemented according to existing health policy standards and guidelines (document reviews). A situation that caused significant tension in meanings, and which continued to do so, was where to organisationally 'house' this initiative (in which department) such that leadership could be provided. The innovation's house evolved from being within the Central Monitoring and Evaluation Division (CMED) of the Department of Planning, to later to the Department of Clinical Services. However, frequently respondents questioned whether it would not be better housed in the Health Education Unit (Department of Preventative Services) or the Department of Quality Management. A steering committee meetings (SCM), participants proposed several alternate options such as creating a dedicated unit for the initiative within the

government structure or merging it with a new emergency medicine unit that was to be established. Despite this not being resolved at the time of data collection completion, as observed, it did stimulate the reflexivity of MoHP actors to think more creatively about the structure needed to support this social innovation in the health system.

> *"To me, I think, integration is key involving those people…. because the health centre or a health facility, there are different players that are interested in their services that are being delivered. So those service providers bringing them together as what we have done, people from different departments being in one team to discuss on how we run this health centre, it's something that I feel like…it's interesting…it's an innovation on its own."* Interviewee 015B MoHP

> *"So, from the way I understand that, at first, I think there were discussions around where CCPF should be positioned, should it be positioned at the district level, in this case, the Lilongwe DHO. Or should it be attached at the hospital level, at the Kamuzu Central Hospital? Or, if it should fall within the Clinical Services Directorate. So, I think members who were present at the transition meetings suggested that it shouldn't be tied to any of these three, it should be an individual entity of its own. It is not going to be a department, but it is rather going to be like a unit. That's the way, the management division came about, upon noting there are these deficiencies they had to create that unit to support the entire government vehicle. So, CCPF office from our discussion will be taken as such a unit independent from all these internal departments or structures so that it can easily support all the programs and departments that exist."* Interviewee 002 (Implementer)

6.4 Conclusion

The CCPF initiative was developed through two concurrent processes, one of scaling out in which the innovation was extended its geographic reach and scope; as well as a second process by which the innovation was scaled up, adopted, and institutionalised as part of the public health system. This latter process will be further explored in greater detail in Chapters 7, 8 and 9.

For the process of institutionalisation and institutional embedding to occur, the social innovation required shifts and changes in five key institutional dimensions. CCPF is a social innovation initiative or intervention, shifted the roles and resource flows of citizens from passive beneficiaries to creators of intervention development. The initiative also supported beneficiaries to become active decision-makers in their health, by having access to quality health information. The initiative further shifted the prevailing beliefs around the roles and power of health workers by challenging the functional role of nurses and by distributing power associated with making health decisions more equitably across society (beyond the locus of the health centre).

CCPF as a social innovation process led to ongoing efforts by actors to support the initiative's institutionalisation as part of the taken-for-granted system. To institutionalise the social innovation required more shared authority flows and creating a distinct social identity and meaning within a much larger institutional context (see Chapters 7 and 8). Engaging in these efforts did not come without tensions, conflicts, and challenges. Relational structures, such as the steering committee meeting, promote dialogue and collaboration between cross-boundary actors and support the process of institutionalisation and national ownership (see Chapter 9).

7 CHAPTER 7 – EXPLORING SOFTWARE FACTORS AT THE MICRO-LEVEL: ACTORS, AGENCY, AND INSTITUTIONAL WORK

7.1 Introduction

This chapter explores the micro-level of the proposed social innovation framework. Using the theory of Institutional Work, that of institutional entrepreneurship (as outlined in Chapter 4), an analysis was done of the role of selected actors and their agency that led to specific actions and efforts. Findings from the interviews and observations showed that the process of embedding the CCPF social innovation as part of the public health system in Malawi occurred as two distinct processes. First is, adoption followed by institutionalisation. This chapter will be concerned with the role of actors in the adoption process. Subsequently, Chapters 8 and 9 will be concerned with the institutionalisation process.

The purpose of this chapter is to:

- Examine the identified actors, through the lens of institutional entrepreneurship (Chapter 4), who were involved in the adoption process.
- Analyse the agentic actions and efforts (institutional work – See Chapter 4) of these actors in the adoption and institutionalisation of a social innovation initiative as part of the public health system.

7.2 Actors Characteristics

7.2.1 Overview: Sectoral and organisational representation

Before describing the characteristics of individuals, this section provides an overview of the organisational entities involved in this case study. Social innovations by nature redefine boundaries and blur lines across different sectors and society [133] as evidenced by the CCPF social innovation initiative. This initiative was made up of organisations from across the government, private (not-for-profit and for-profit) and the community sector (Figure 7-1). However, at the centre of this initiative was a single organisation, the implementing non-governmental organisation (NGO). This organisation's role can be described as being a 'bridging organisation' [47]. The implementing NGO played a key functional role in the formation of new institutional arrangements and re-establishing new power relationships. The NGO acted as a broker between the diverse interests, visions and resources of the different constituent organisations involved. Over the

evolution of the innovation, different organisational entities were involved at different times, but the implementing NGO remained constant.

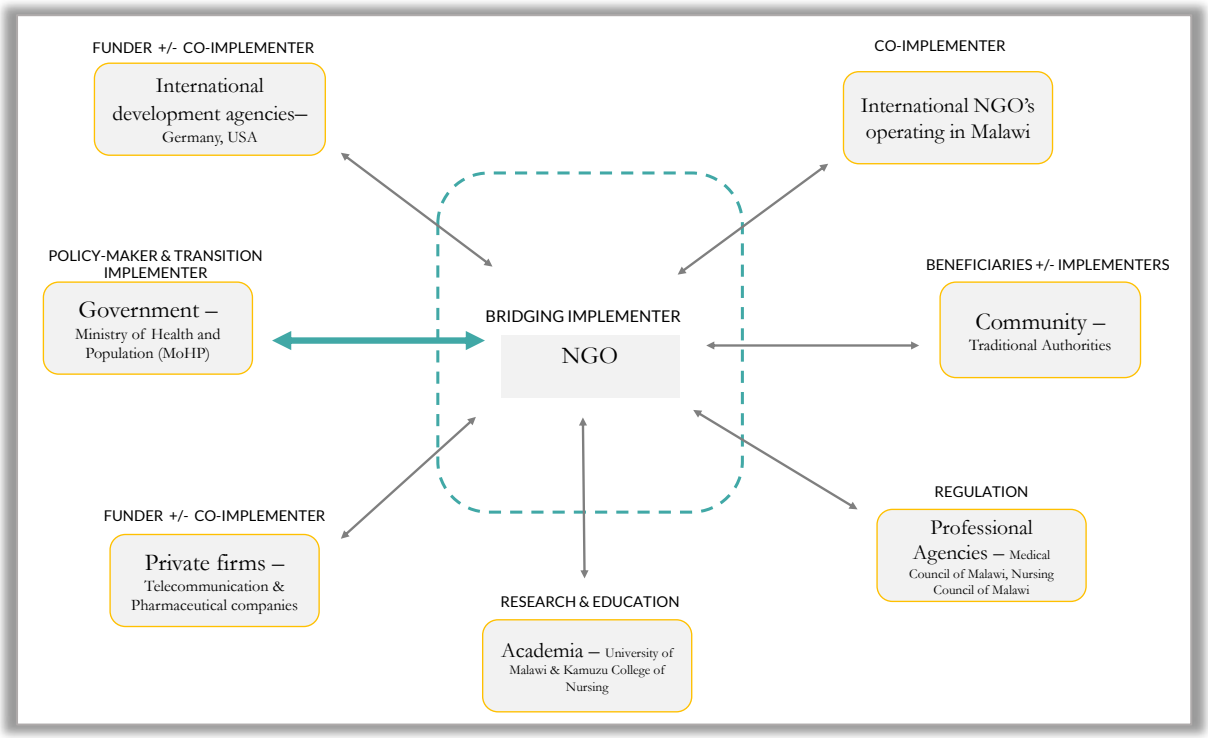


Figure 7-1: *Actor Groups involved in the CCPF social innovation by sector and roles played.*

In its role as the 'bridging organisation', the implementing NGO fulfilled three important functions that contributed to the longevity of the social innovation. First, the NGO was a partnership broker. The NGO involved all relevant health system partners in the initiative as they were aware that as a single entity, they could not realise a vision of scaling this innovation nationwide. By brokering different partnerships, they were able to unlock different forms of resources (finances, skills, time) from a diverse set of actors to contribute to the growth, adoption and institutionalisation of social innovation. Chapter 8 explores further how this implementing NGO was able to achieve the unification of actors to hold a common vision. As one CCPF partner expressed: *"…. I feel the way they involve other partners, taking them on board, working together with government from start, it is probably a key success.*" Interviewee 048B

Second, the implementing NGO acted as a stopgap to sustain the innovation across its lifecycle. Growing beyond the pilot phase was subject to additional grant funding, which came with different timelines and commitments. It was necessary for the implementing NGO to self-fund the initiative when other partners were not able to do so, and until the government was able to mobilise and commit resources towards the

initiative (only 5-years after the initiation of the project). As an NGO implementer expressed: *"Yeah, with Concern Worldwide and then there was some little funding here and there, but not enough to cover it, so Village*Reach *had to step in during that time. Then we started getting these other grants. It has been very piecework in terms of donors, there has been a lot of people and a lot of reporting challenges that come with that. But it is also great cause there have been a lot of people along the way who have been huge champions of it which I think has made a huge difference."* Interviewee 007

Third, the implementing NGO played a role in brokering trust among all the partners involved. They were responsible for holding all the partners in unity but also giving confidence to these partners, especially those who committed resources, that the innovation was being well implemented, monitored, and maintained. The role of the NGO was expressed by a project partner as follows: *"Village Reach has been the glue, so now I don't know when Village*Reach *hands over, transitions CCPF to the government, I hope that that glue will continue through the Ministry. I hope that they will be able to still take up that role that Village*Reach *managed to do so well in just making sure that all the stakeholders are on the same page, and the communication lines are open, and you know, that stakeholder management that Village*Reach *set the standard on, I hope that the government will be able to take up that and run with it."* Interviewee 026 (Partner)

7.3 Institutional Entrepreneurs: Characteristics and Capacities

The next section takes a closer look at actors who acted as institutional entrepreneurs and the agency that they demonstrated to make this social innovation initiative part of the taken-for-granted health system.

The first step of the analysis entailed identifying actors, from the cohort of 54 actors interviewed, who matched the classification of an institutional entrepreneur. First, the definition of institutional entrepreneurship was used as proposed by DiMaggio [412] (See Chapter 4) but this definition was not sufficient for identification purposes in this study. Due to the multisectoral nature of this social innovation, all actors interviewed would be identified as institutional entrepreneurs, even those who only provided material resources like funding. To more accurately identify and analyse institutional entrepreneurs who were key in the adoption and institutionalisation process, the definition proposed by Battilana et al [45] was used (see Chapter 4). By applying this definition to all 54 interviewees, nine actors met this definition (See Table 7-1): three from the non-governmental sector (implementing NGO), six from the government sector (Ministry of Health and Population) and one from the community sector (Traditional Authority). Each in their distinct capacity played an agentic role for a select period between 2012 – 2019, either in facilitating the adoption or the institutionalisation process

(Table 7-1: Characteristics of Implementing Actors *(removed for confidentiality)*

7.3.1 Characteristics of Identified Institutional Entrepreneurs: Subject Positions and Agency

Of the nine institutional entrepreneurs identified, three were female. The age representation for the three institutional entrepreneurs working in the implementing NGO was younger (35 – 45 years), as compared to the six government institutional entrepreneurs (majority older than 45 years of age). Eight of the institutional entrepreneurs were Malawian nationals, with only one non-Malawian national. The NGO institutional entrepreneurs came from different career backgrounds such as nursing, project management and tourism. They had each worked in a variety of organisations and settings before joining the NGO. Except for the country director, the other two institutional entrepreneurs, employed by the NGO, held mid-level positions without extensive organisational authority. Although they did not have a senior organisational position, they did both have a well-regarded position within their communities and thus they had the ability to attract the engagement of the local community in support of implementation.

All the government institutional entrepreneurs held mid-level to senior organisational positions – that of deputy directors, directors or heads of technical units, but none of them were at the top of the government hierarchy. Rather, their position however gave them access to and influence with the most senior (top-level) government leaders (Senior Management Committee) who could make decisions regarding resources and policy and programme adoption. This influence played a vital role (see more in this Chapter). Government institutional entrepreneurs had a longer organisational tenure, ranging from 14 – 26 years, as compared to NGO institutional entrepreneurs. During their tenure, government institutional entrepreneurs all had a similar career trajectory. They started their careers working at the frontline as providers of clinical care at a district hospital, then preceded to management positions at the district level, before receiving an opportunity to work at the central policymaking level. The government of Malawi has been their sole employer throughout their careers however, they all had multiple experiences with new projects entering the health system. Their length of tenure within the system provided them with strong professional connections and alliances.

There was only one community institutional entrepreneur identified, who similarly to the government institutional entrepreneurs, had a high social position. He was the senior chief over the jurisdictions of 70,000 people. Ahead of becoming involved with CCPF, he was engaged in multiple projects, those initiated by non-profit organisations and by the government.

Several other factors may have had an influencing role on the receptivity of institutional entrepreneurs to the innovation. Almost all institutional entrepreneurs (7/9) had a post-graduate educational qualification and government actors received their outside of Malawi. Institutional entrepreneurs also indicated that their experiences working in other countries or attending workshops, conferences or travelling abroad had had an influencing role on their openness to new ideas and initiatives: *"I think if we go to different conferences and we hear about innovations in those other countries, so when we come back, in these meetings of ours that we talk about, we share with our partners and see. If there is somebody who can support and say this is an innovation worth trying so that we can improve on our indicators. Because we are all wanting to see improvement in our indicators"* Interviewee 010

For the majority of institutional entrepreneurs, it was not their first opportunity to engage in novel and "innovative" initiatives. Several prior projects and experiences were listed. *"For me, what I can associate with to say what encouraged me to think like this is, I have been very lucky. I have been given opportunities to work in different setups. I have worked in the hospital, close to the patient and met the challenges of that. I remember sometimes when I worked in the paediatric ward, we had few oxygen concentrators, but we needed more children to be on oxygen. We had to come up with an innovation to see how best, how we can multiply the outlets from the same oxygen concentrator. I was, I remember me initiating an exercise to say maybe we have in some distributors and the head of my apartment brought into that. I was allowed to be a district health officer in the central region...That spirit has been with me all along, but it is because I have been given the opportunities to work in [innovation]. Quite often people talk about the Ministry of Health or the health system in Malawi operating in a resource limiting environment. Even though I see that sometimes, I don't believe it is resource-limited. It just requires your innovation to see how best you can do with the little you have."* Interviewee 015 (Government)

Especially for government institutional entrepreneurs, their history with innovation in the past brought significant knowledge and made them more open to taking the risk associated with innovative initiatives. These experiences, whether through exposure to another context or previous innovative endeavours, support the habitual element of agency as described in Chapter 4. Past experiences and exposures outside of the accepted institutional context provided schematisation or templates upon which these institutional entrepreneurs were able to draw to inform their institutionalisation efforts of the social innovation in health initiatives.

7.3.2 Characteristics of Identified Institutional Entrepreneurs: Positive Emotions and Agency

Despite widely diverse career backgrounds and trajectories, institutional entrepreneurs had a second set of personal characteristics in common. All nine identified institutional entrepreneurs displayed the future-oriented or projective dimension of agency [238], namely having a future-orientated or visionary mindset.

They were able to see possibilities beyond the reality of resource constraints and challenges and this ability aligns with the understanding of the positive emotion of hope, as described in Chapter 4. These institutional entrepreneurs not only demonstrated a belief in possibility, but also a deep conviction (agentic-thinking) that their efforts (pathway-thinking) can contribute to achieving the envisioned possibility [249, 258]. In essence, they believed in their own inherent power to realise an innovative possibility in which they held an interest.

> *"I think if I talk about doctor [name], his commitment is mainly based on what he sees he can get out of CCPF. He believes that this is more than a health work line, it's a work of government to look around creating synergy within all the different programs and projects that are running through CCPF as a way of strengthening the systems. So, even the ideas that he has for CCPF go beyond the provision of mere health information. He is the one who is championing the incorporation of emergency medical services. So, he sees the potential I think because he can see that potential he is kept committed and because he has a purpose at the end of it all."* Interviewee 002 (NGO)

This high level of hope within these individuals supported them to have the inner resolve and willpower to overcome negativity and discouragement, not letting challenges deter them, but to hold steadfast to their conviction that their efforts could bring about change. They derived energy and satisfaction from overcoming what others may have thought was impossible, was expressed by the two government actors below:

> *"Quite often people talk about the Ministry of Health or the health system in Malawi operating in a resource limiting environment. Even though I see that sometimes, I don't believe it is resource limited. It just requires innovation to see how best you can do with the little you have…. I believe in challenging; some people are challenged to solve problems. Some people when they look at problems, they just look at them and cry. While others they look at problems as opportunities, they can do something…."* Interviewee 015

> *"…there are people who would not agree and there are people who would even discourage you. But like I said, it is always good to be objective. You see that some people make arguments just to discourage you, always you know those who make arguments for argument's sake but when you see that there is a positive side to things, I always carry on. I am never discouraged with people that just make arguments for the argument's sake.* Interviewee 010

This group of institutional entrepreneurs also displayed and articulated their deep passion for social change and making a positive impact on the lives of others around them, as expressed by this community actor: *"Right, you know, I was interested in the safe motherhood programs because of the problems that I saw, that women were facing, now, my objective was to make sure that there is a change, from women dying while pregnant and now women not dying."* Interviewee 029

From observations and interviews, it appeared that their passion was beyond a single project but rather something foundational to their personhood. They possess a level of energy and enthusiasm for life in general, that translates into their subject area of work. This passion was also described as being informed by their childhood experiences as well as their Christian faith (as actors expressed directly). Their faith gave them a lens through which to view their lives as having a unique purpose, and they thus operated from this premise. This passion served as a strong intrinsic motivational driver for their involvement in social innovation.

> *"I have always wanted to do international health. When I was a little kid, they have a recording of me saying 'I want to be a general practitioner in a developing country.*" Interviewee 017 (NGO)

> *"Yes, you can see she is passionate when she talks about this. That is why I was convinced cause sometimes when you work with somebody and you say, no this person is passionate about this, and I am amazed they have taken the right way. They have interacted very, very positively with the Ministry.*" Interviewee 014 (Government)

> *"I have a passion to serve life…not serve life at a small scale but my scope is the biggest impact, that's why I made an oath, as a medical doctor, I will work in the public service. I want to die empty…the potential in me…technically, whatever I am…God enacted in me, God who created me…. whatever potential is in me, I will make use of it to the best of my capability. I don't believe in what I get in my pocket but what I can contribute. That's my passion."* Interviewee 038 – Government

7.3.3 Characteristics of Identified Institutional Entrepreneurs: Valuing collaborative engagement

None of these institutional entrepreneurs viewed themselves as lone heroes leading the charge but rather, prided themselves on being relational; collaborating with others to undertake efforts and building strong personal relationships. There was a willingness to engage in discussion, question and debate with their colleagues. They regarded their colleagues, irrespective of their social position or status, as sources of knowledge and that their participation in processes held great value. Each institutional entrepreneur had a learner's mindset, embracing the opportunity to gain new experiences and knowledge with openness. They believed that there was always something to be learned from different people and situations.

> *"So, I think with that I have taken, I respect each and every other person's views. When you listen attentively always there is something you can learn, and I always take it that there is nobody who is a blank slate. We are born with some knowledge, we have some information, and you should be objective and not be judgmental….and I have seen that innovations indeed do work so I am positive at constructive suggestions from colleagues, so maybe that is the nature that I am."* Interviewee 010 (Government).

"You, you need to be able to do that to be able to give somebody else ownership of something that is essentially your baby. So, you have to be willing to do that and be willing to share and be open to other partners and other people, because, because the innovations that fail are the ones, you know, organisations are so, this is ours, and so, if you know, we needed a tonne of partners along the way to make it succeed." Interviewee 017 (NGO)

"Honestly, to say the truth, I was not an expert. I didn't have an idea how to go about it. And I remember when the president [of the NGO] told me '[name]', there will be a time you will need from Balaka to Lilongwe to support this. I was honest and I said '[name]', I don't have any experience with this, but I am very much willing to learn and see how the process goes. I tend to very correct saying you didn't need to just engage one person. Interviewee 007 (NGO)

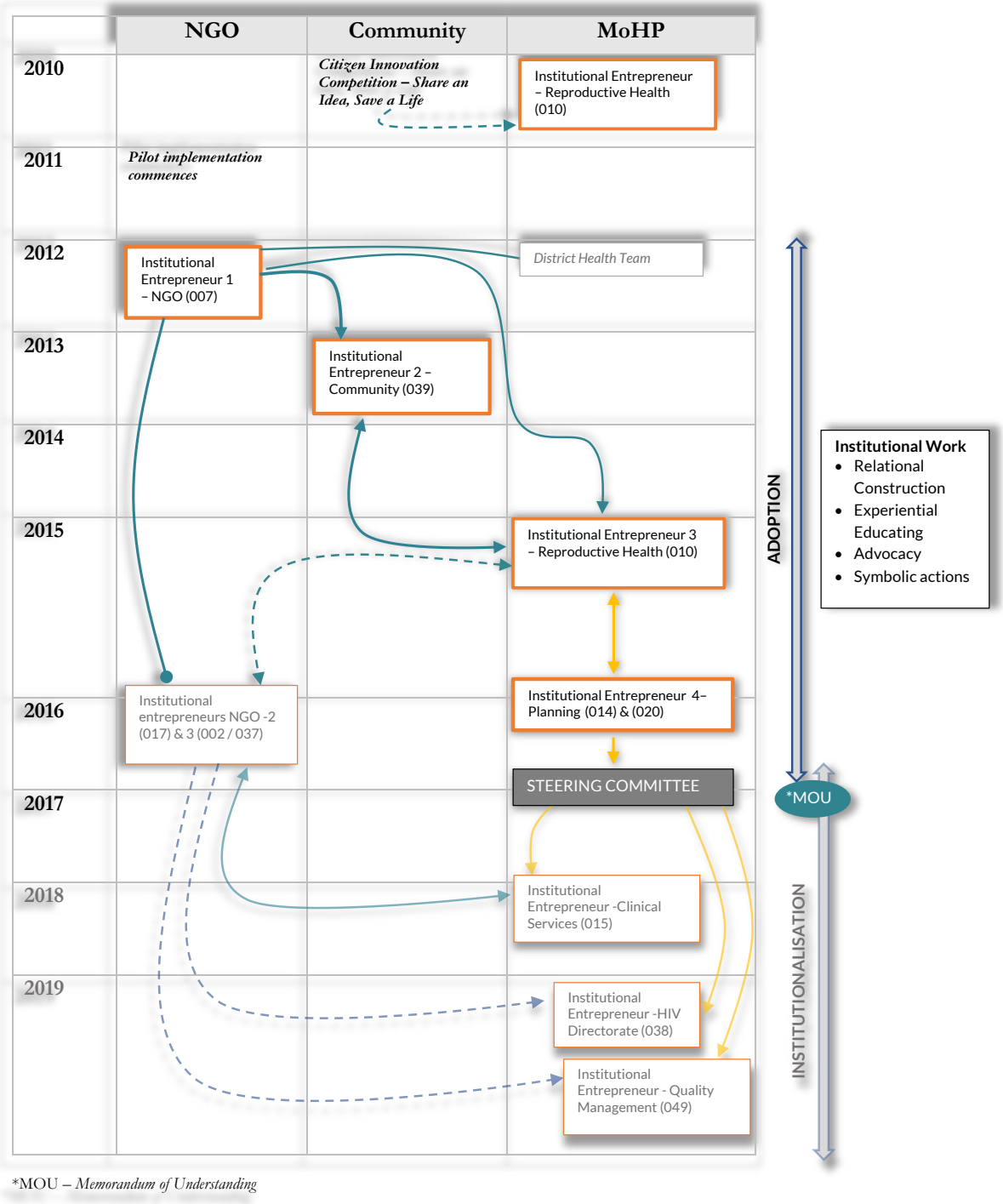
7.4 Agentic actions and institutional work of actors in support of adoption

This section focuses on analysing the institutional work conducted by actors operating collaboratively as institutional entrepreneurs to achieve the adoption of CCPF. As already described in chapter 4, adoption is understood to be 'the process through which an individual passes from first knowing an innovation, the formation of an attitude toward the innovation, a decision to adopt or reject, to implementation and use of the new idea, and confirmation of this decision [203]. The CCPF social innovation adoption started when the government (district-level government representatives) were first engaged in this process (starting 2010) and up until the point, when a formal agreement was signed in 2017, between the implementing NGO and the government.

Figure 7-1 below is an overview schematic representation of the nine institutional entrepreneurs identified, the time frame they were involved in and how their actions led to a 'domino effect' for other actors to take the next steps needed to achieve adoption and also to achieve institutionalisation, 2017 onwards.

The adoption process (2010 – 2017) was led by a 'small group' of four institutional entrepreneurs – an NGO project officer (mid-level position), a senior traditional leader representing the community and two senior-level central government officers (Reproductive Health and Planning Departments). The actions of these four institutional entrepreneurs, working in tandem, supported the formal adoption of CCPF by the Malawi Ministry of Health. The agentic and strategic actions taken by the NGO project officer and the one senior government representative were important first steps, upon which the other two institutional entrepreneurs could build upon. The traditional leader and the second senior government representative played an important role in identifying opportunities to integrate the social innovation initiative into their government work portfolios.

The actions of these four individuals as institutional entrepreneurs will be presented below in section 7.5 as well as identifying the types of institutional work that had to occur. The institutionalisation process (2017 – 2019) expanded the actor involvement to a broader base, and this process will be described in Chapter 8.



*MOU – *Memorandum of Understanding*

Figure 7-2: *Actors and connections over time*. (Source: document reviews, interviews and personal observations)

7.4.1 Step 1: Constructing Relationships

Following the citizen innovation competition in 2009-2010, the awarded idea was handed over to the NGO for implementation in 2012. At the time, the implementing NGO was a small organisation with a single office in a small town in the Southern Region of Malawi.

From its start, the NGO's project officer (institutional entrepreneur 1) and other field implementers, focused on embedding the CCPF initiative within all the relevant existing health and community structures within the local area. These structures included the district health management team, community governance committees, traditional authority structures and the district hospital. Embedding CCPF as a new creative initiative within the institutional context required leveraging existing relationships and forging new relationships for this new purpose, across all social and health system hierarchies. Within the community sector, this entailed the project officer and implementation staff constructing relationships with traditional leaders (senior chiefs at the highest level, and group village headman operating under the chief's authority). Once these leaders, acting as important gatekeepers to the community, provided their consent, the community members were approached, and community volunteers were identified. These volunteers, drawing on their relational and social capital, then subsequently promoted and informed the broader community of the CCPF service.

> *"When Chipatala cha pa Foni came, it came through government health workers, they chose from the villages that they were under their influence, one by one, after choosing, those who were teaching us came, teaching us how we can use Chipatala cha pa Foni, after that, we started visiting door to door, we went at the village headman to conduct a meeting, that, there is this program called Chipatala cha pa Foni which has come, that, every pregnant woman has to register on Chipatala cha pa Foni, and also children who are under-five, they are supposed to register, where….at Chipatala cha pa Foni, they must be receiving messages on their phones.*" Interviewee 030 (Community (translated from Chichewa))

In 2012, due to limited mobile phone penetration among rural communities at the time, these volunteers were provided with mobile phones by social innovation. The volunteer's phone could be used by mothers or other interested members of the community to contact the CCPF hotline. It was first necessary for the initiative to build relational capital and trust with the community before the initial scepticism and resistance could be overcome. This was expressed by a district-level government representative: *"We have encountered first the resistance. I remember someone said 'why should we be calling on the phones when we have some facilities just around us. So, we*

tried to highlight some of the importance of having the Chipatala Cha Pa Foni. One of the importance is that we want to reduce congestion at the hospital and at the same time, some problems can be attended to with someone at home. And later on, they understood and maybe that is why there was a positive response from month to month." Interviewee 035 (Government - District)

Relationships constructed with traditional leaders were not only an important entry point to the community but also the central government. At the time of the CCPF pilot (2011-2013), a senior traditional authority of the implementation district also served as a representative on the Presidential Safe Motherhood Committee, established by the then President Joyce Banda. This traditional leader accepted this innovation and embedded it within his community structures, even creating bylaws to enforce it. His area of the jurisdiction served as a prime example of the impact that CCPF could achieve at a community level. Leveraging strategic relationships, this traditional leader engaged with the central level government committees to lay an important foundation upon which the NGO project officer could build. He acted as a second institutional entrepreneur, driving government adoption of the CCPF initiative.

Constructing a new institutional identity for this initiative at the district level also entailed constructing relationships with the District Health Management Team (DHMT) and the safe motherhood coordinators (dedicated officers for maternal health), as expressed by an NGO implementer: *"…but that time I was part of the routine meetings with the management team, and the coordinator, the safe motherhood coordinators. They had the role of doing reproductive health, as at that time when it was the focus. Then, afterwards, we expanded to speak to the DHMT, even the transport officers, all those people.* Interviewee 007

The engagement of the local district health staff went beyond consultation, but the staff played an active role within the implementation of the initiative. Fostering quality relationships with the district health management and staff, led to support for the hotline to be situated within a district hospital. It also made hospital staff willing to provide advice for dealing with complex callers' inquiries, as well as conducting outreach activities to surrounding health centres (in addition to their normal work).

> "*After the introduction of the Chipatala Cha Pa Foni, I was part of the people who were reviewing the recorded messages by Chipatala Cha Pa Foni, so that we can review whatever the clients were responding to, and we also responded to some of their questions. I think from such time, we have been doing that until the Chipatala Cha Pa Foni moved from Balaka to Lilongwe.*" Interviewee 035 – (Government -District)

> *"I became involved…., I was chosen by the matron and the group here, that you have been chosen to be eeeh……, nine…(…)to be in that group of Chipatala cha pa Foni, we called it Chipatala cha pa Foni. So, we also trained the staff who were there at that time, about what they would do about the other diseases. So, we were given the radio, and*

the messages, both of them, and we had a checklist and you had to cross-check the list and the messages, are these messages good or not? Is it true that this woman or this man has been helped? So, we were listening and ticking the checklist. Then from there, if there are some mistakes, we have to meet as a team, the whole team. And discuss, wherever it is not good, wherever it is correct, you have to continue here… we have to give this message like this every month." Interviewee 035 – (Government -District)

Beyond the Presidential Safe Motherhood Committee, which was engaged at the central level, the Technical Working Group (TWG) on Safe Motherhood was also engaged. Within the context of the Malawi health system, TWGs are multi-sectoral meetings, chaired by a specific Ministry of Health division or department, and these meetings are inclusive of all actors working in the respective technical health area including funding agencies. The NGO project officer reached out to and built a relationship with the TWG lead for Reproductive Health. She was subsequently invited to engage in this forum.

"I think it's the technical working group, the sub-committee for safe motherhood, that is where they would come and present. There the different stakeholders implementing maternal and neonatal health meet. So, I was able to slot it, that [project officer] would come and make a presentation on CCPF, so that's where the other people heard about it. Basically, I think it is their membership to the safe motherhood committee that contributed". Interviewee 010 (Government)

The TWG lead (representative of the reproductive health department) became the third institutional entrepreneur, working in collaboration with the NGO project officer and the traditional leader, to drive the government adoption of the CCPF social innovation initiative. The initiative was not new to this government representative. In 2010, she was engaged in the innovation competition and attended the final awarding event. The participation in the TWG served as a gateway for constructing further relationships not only with central-level policymakers but also with other bilateral agencies working in Malawi. It also fostered government ownership in the initiative right from the outset.

"I think when even a pilot is taking place, the government is involved right from the start. So, I would say that that ownership is there because for a pilot to be done is presented in our governance structures. We call them technical working groups. The initiative is presented there where government and different directors are members but also our partners and that presentation of whatever pilot is taking place is always presented and on quarterly if there are any updates, people keep on being updated. These technical working groups are chaired by the government. So right from the start government knows that if this initiative is successful, it would be part of us'
Interviewee 010 (Government)

7.4.2 Step 2: Experiential Educating

In the case of CCPF's adoption process, educating work was done not only through mere information and knowledge sharing but also through experiential encounters. As the CCPF initiative was a new approach for extending access to health information in Malawi, government institutional entrepreneurs needed some persuading. Not only did they require factual evidence, as provided through the 2013 project evaluation study, but also, they required a personal experience of the initiative. The relationship with the representative from the Reproductive Health Department (institutional entrepreneur 3) was further strengthened by providing her with an experiential education encounter. She was invited to visit the project site in the pilot district in Southern Malawi. This first-hand witness account became a key turning point for government adoption as explained by the institutional entrepreneur:

> *"But when it was in Balaka I had an opportunity to visit the district to appreciate what CCPF, the Chipatala Cha Pa Foni was about. And I had an opportunity to go there with the then Director of Planning. Because I said let's go together so that you can appreciate what VillageReach is doing. So, when we went there we were able to listen to a phone call where a client was phoning and getting information and Director of Planning was amused and said 'I think this is the way to go, not only information on reproductive health but I think we can do it also with the other areas that are giving us problems'. Yeah, he cited like he said malaria and TB. This information can actually be cross-cutting so people from the communities can get information from the hotline. So, it was then that I think, around 2 years after the pilot had started, I can't remember the exact year…"* Interviewee 010

Her personal experience led to a deeper trust and value for the initiative. In turn, she purposefully leveraged her professional connections within various government departments and knowledge of the system to gather greater support for the initiative. One such relationship was with the then senior representative of the Planning Department (usually stationed within the Ministry of Finance). The Planning Department is a lynchpin within the Ministry of Health, overseeing all financial planning and approvals for technology initiatives. This representative also received the opportunity to visit the field implementation site, and similarly, this enabled a stronger conviction and trust in the initiative. This experience led him to become the fourth institutional entrepreneur involved in this project.

> *"I think (when I visited) there were 3 or 4 ladies with phones so people were calling ' I am feeling this' 'oh rush to the hospital' 'Oh do this or do that'…so I found it very interesting because to me I thought cause maybe the villagers would say oh I will go tomorrow because they don't know what they are feeling but because they have called somebody would say 'oh no that is very serious can you come and see the doctor' and the lady arrange with the doctor or maybe they will present to the doctor and say oh can you come this mother is feeling this way and the doctor 'oh make sure, tell her to come'…. So to me, I thought they were reaching more people without people walking to the hospital. You know maybe*

others have 15 km, others have 10km. So, I found it very interesting, at least we can be assisting many people and we can try to minimise congestion at the hospital.. They will be in the [hospital] queue to be told it is just minor. So, to me, I found that is very interesting." Interviewee 014 (Government)

7.4.3 Step 3: Advocacy

To support the adoption of CCPF, actions and efforts had to be undertaken by a small group of institutional entrepreneurs in the political and regulatory domain. These efforts matched the description of 'advocacy' as institutional work (see Chapter 4, Table 4-1).

One significant barrier faced by the CCPF initiative was to gain regulatory approval from the Medical and Nursing Council of Malawi. Patient consultations were not permitted telephonically or virtually, and without approval, the social innovation initiative would not be permitted beyond its pilot and testing phase. Despite not holding a high social position, the NGO project officer leveraged his social network. He also used his knowledge about the functioning of the Malawian health system to navigate the regulatory approval. Regulatory approval was given to the initiative to continue providing health information to callers and referring them to their nearest health facility as required.

"*Mmh, I think, because I am a nurse by profession, and I also studied public health of course. So, most of the guys in the Ministry and these things are medical personnel, so you talk about, even when we were doing m-nutrition we talk to Janet [surname], I know her long, long time ago. Even at the Ministry, there was [014], and those guys are in the Ministry of Health and have been working for a long time. Even [name], she is a nurse, she is a Director at the Reproductive Health Directorate. You know sometimes when you are a nurse, you easily connect. So maybe that was also just an advantage, an added value.*" Interviewee 007 (NGO)

Similarly, the government institutional entrepreneur, from the Reproductive Health Department, leveraged her political connections and friendships to advocate for the initiative with the then Minister of Health (respondent reflections). The Minister was invited to experience the initiative at an open showcase event. As the guest of honour, he was also provided with a first-hand experience of the initiative. As reported by this institutional entrepreneur, in the same year (2015), she had the opportunity to accompany the Minister of Health to the World Health Assembly in Geneva and present CCPF at an innovation showcase event as a proudly 'Malawian innovation'. This innovation was showcased at the World Health Assembly and attracted positive interest in the initiative, gaining further political legitimacy towards the initiative in the country.

7.4.3.1 Step 4: Symbolic Actions

Institutional entrepreneurs raised awareness of the initiative at the senior level within the Ministry of Health, and respondents reflected that sufficient buy-in and goodwill existed to allow for strategic steps to be taken to formalise the adoption process. The strategic efforts of the fourth institutional entrepreneur (a senior representative from the Planning Department, seconded from the Ministry of Finance) created a sense of symbolic adoption, in advance of any formal contractual adoption.

Various respondents reflected on how symbolic adoption was achieved in four ways. First, the hotline operations were moved from the district hospital in Southern Malawi to the capital of Malawi in Central Region, and into the Ministry of Health offices in downtown Lilongwe. An initiative located in one district would not symbolise 'national representation', and thus limit central government ownership of the initiative. However, by constructing a small hotline building on government premises, the project would 'appear' as part of the government.

> *"So, we did that because the ideas were that it should not only expand not only in the southern part, but it should also expand south and north. So, the idea was to put the centre and at the centre, I realise that one day we may not have the luxury of having funding from outside. Why can't we little by little make it by now be part of Ministry structure."*
> Interviewee 014 (Government)

Second, a technical advisor tasked with advising the government on CCPF was appointed by the NGO and offered a desk space within the Ministry. Again, with a dedicated person focusing on CCPF at the Ministry of Health Offices, it would promote the perspective that the initiative was owned by the Ministry.

Third, for the CCPF social innovation initiative to attain further symbolic adoption, it needed to be aligned to a specific technical department within the Ministry as is the standard process for all other Ministry-owned programmes. The department selected to align CCPF with was not chosen, at this stage in the project lifecycle, as one which will necessarily be the best fit. As this initiative cuts across health promotion, digital technology, and nursing, it could have been 'housed' within any of these departments. Rather, the Clinical Service Department was the easy choice (the path of least resistance), as there was a strong personal relationship between the institutional entrepreneur and the head of the department. This personal relationship held within it the trust needed for the head of the department to agree to take on this new initiative as its project, even before any formal contractual adoption was signed. The goal was not to achieve perfect technical alignment but rather symbolic alignment. This decision was questioned and contested by other government representatives throughout the institutionalisation process, who felt their departments would have been a better technical fit for the project.

"*I think these two departments like Planning and Reproductive Health were the champions, but we made sure that we incorporated clinical services because we knew we were using their staff and they are the ones giving all the information. Luckily enough the [head of the department] is a friend so we talked, and he didn't resist me. 'As long as my staff are the ones giving the information, I am comfortable as they are well trained. Sure'."* Interviewee 014 (Government)

The fourth strategic action taken by this institutional entrepreneur was to lead the establishment of the Steering Committee. This structure would represent all the various departments across which the innovation spans. This is a common format within the Ministry of Health and interviewees stated that the Steering Committee aided in moving the initiative beyond 'project' status, operating outside the government system, to one which is a government owned 'programme'. The Steering Committee would thus serve as the main structure responsible for driving the institutionalisation process (see more in Chapter 8)

"Because like, I told them, the best that we can do is to form a steering committee so that now we involve as many people as possible, because we know what they are doing is not only one department it was clinical service. So, I told them why can't we form a committee so that everybody, little by little, can buy into their ideas. We started meeting as a committee, now it was like a bigger group, people could give their ideas how to do it and now it became a little bit more like Ministry of Health and not like a project. Now I believe the way it is treated has been taken more or less like a Ministry programme and not a project. So, it was my idea that in this way we are guaranteed sustainability beyond a project. Because a project has a specific life span and once it is done, then what next? So, the idea is, little by little to make the Ministry ready, so that they can absorb the staff, so that when they see the impact then they can be employing people and these people will be part of the Ministry one day. So, the best is to make sure is that they are within the Ministry. It will be difficult to do it if they are located in Balaka." Interviewee 014 (Government)

The final action of this actor was to compile a cost-impact analysis for the Permanent Secretary of Health, the highest decision-making authority in the Ministry of Health. This was supported by the evidence from a 2-year independent impact evaluation commissioned by the NGO in 2013. These four strategic actions preceded the contractual signing of the Memorandum of Understanding in 2017 between the Ministry of Health, the Ministry of Finance and VillageReach, marking the formal agreement stating: "*VillageReach is positioning the CCPF program to be easily integrated into the current MOH portfolio and scaled nationally by the end of 2017*" and "*MOH will commit its operational knowledge, programming, expertise and financial resources for the same goals*" (Memorandum of Understanding)

7.5 Conclusion

The analyses of the adoption process i.e., the steps and actions that led the government to make a formal decision to embed CCPF as part of the government or public health system, demonstrated the interaction between actors, agency, and institutional work.

Four Malawian actors, each from different sectors and social positions, operated as institutional entrepreneurs. These actors did not work in isolation but rather concurrently, building upon each other's actions to advance the adoption process. These concurrent actions were undertaken strategically, as these institutional entrepreneurs drew upon their prior experience of being involved in new health system projects to guide the process. None of these actors, except the NGO project officer, received remuneration for their involvement in this process. Rather, these actors leveraged their resources (time, networks, and emotions) to invest in this effort. They each held a personal interest and passion for their participation.

Here it is also worth noting the relationship between agency and empowerment. Empowerment is regarded as an expansion of agency (the ability to act on behalf of what the person values) and the opportunity provided by the institutional structure for the actor to exert his/ her power [413-416]. Thus, the institutional entrepreneurs can be regarded as agents of power, as they used their inherent power to influence change within the system. As described, this power or empowerment they demonstrated was beyond their position within the organisational hierarchy. By operating as a collective, and through strategic vision, they were able to bring about changes in regulation and resources to support the adoption process. Blurring traditional lines of power, was a characteristic of this social innovation initiative and those involved in it.

The four actors engaged in different types of institutional work to construct a new institutional space for CCPF that was required for government adoption. This analysis will be further expanded upon in Chapter 8. The different types of institutional work identified in this chapter each supported a different dimension of the agency. As described in Chapter 4, there are three dimensions of agency [238]: the habitual dimension (informed by the past); a projective dimension (the capacity to imagine future alternative possibilities) and a practical-evaluative dimension (contextualising past habits and future aspirations within the contingencies of the present).

Educating and advocacy, have previously been described by Lawrence and Suddaby as two types of institutional work [49]. 'Educating' as institutional work entails "the educating of actors in skills and knowledge, necessary to support the new institution, and advocacy as institutional work entails 'the 'mobilisation of political and regulatory support through direct and deliberate techniques of social suasion'

[49]" (see Chapter 4, Table 4-1). This case extends the understanding of 'educating work' by drawing on the importance of the experiential dimension within this type of work. This experiential dimension involved in the institutional work confers with positive institutional work [271]. This experiential education work supported in unlocking the practical-evaluative dimension of agency; as is evidenced by the two government institutional entrepreneurs who applied their prior knowledge of the public health system to help navigate the current process; and in so doing achieving adoption. This dimension of agency was subsequently also displayed in the advocacy institutional work conducted. These advocacy efforts were not to gather widespread support for the initiative from a large group of people, nor done in an overtly public way; rather, institutional entrepreneurs drew upon their close and personal social relationships, done in a behind the scenes kind of way, to enable CCPF in gaining legitimacy in political and regulatory arenas. This advocacy work was thus targeted and strategic, operating as a quiet enabler.

Symbolic efforts and relational construction, as two additional types of institutional work, have not yet been found to be described in the existing literature on Institutional Work (see Chapter 4, Table 4-1). This case study findings thus puts forward these two types of institutional work as potentially new contributions to literature. First, symbolic institutional work contributed and related to the projective dimension of the agency. The symbolic efforts of creating visible structures (e.g., the call centre building on the MoHP premises and the establishment of the steering committee) created a sense of 'perceived' adoption and legitimacy of the initiative. This perception was created even before CCPF was contractually part of the public health system. This form of institutional work required great confidence from the institutional entrepreneurs, to visibly demonstrate the 'possibility made real' to other health system actors.

Second, relational construction was a type of institutional work that allowed for the CCPF social innovation initiative to be embedded within the community, the district- and the central government. The actions of the actors beyond that which is characterised as tokenistic consultation in public health [32, 417]; but rather it included their active involvement and even partnership in the process (especially that of the community traditional leaders). These relationships were marked by qualities such as personal affinity, connection, and depth. Findings revealed that actors from the health and community domains knew each other on a first-name basis and that they would operate outside of formal work structures, often by calling on each other at unannounced times for support. These strong relationships contributed to the creation of a sense of collective ownership of the initiative. In the early stages of the initiative, the view of the CCPF social innovation initiative changed from government actors regarding the initiative as 'their' (the NGO's) initiative, to later being called 'our' initiative. This relational engagement enhanced all three dimensions of agency in the four actors: due to their different backgrounds and social positions, they drew on and combined each other's diverse past institutional experiences and leveraged resources available to each (habitual agency), to put

towards the future direction for they envisioned for the initiative (projective agency). They held firm in their belief in the initiative's potential to achieve a positive impact for a larger number of Malawians as a government-adopted initiative, and as a collaborative group they drove the action in each of their respective spheres of influence (practical evaluative agency) to see this realised. The construction of relationships could thus be considered a software factor contributing towards the adoption and institutionalisation of this social innovation.

8 CHAPTER 8 – EXPLORING SOFTWARE FACTORS AT THE MESO-LEVEL: POSITIVE PRACTICES AND POSITIVE EMOTIONS

8.1 Introduction

Chapter 6 presented a broad overview of the social innovation initiative and Chapter 7 focused on the role of actors, and how their actions (as different types of institutional work) display different dimensions of agency. This next chapter will build upon the previous two chapters and explore the meso-level of the social innovation framework and look at software factors (positive practices and emotions) that supported the institutionalisation process.

The data collected for this study spanned a 1-year period from July 2019 until August 2019 and thus it is not able to account for the final stages of the institutionalisation process, which continued up till December 2020. The results presented in this chapter were informed by participant interviews and personal observations.

The purpose of this chapter is to present an:

- analysis of the positive institutional practices identified, applying the theoretical lens of institutional work and positive organisational scholarship.
- analysis of the role and influence of positive emotions at a group level.

8.2 Institutional Work in Institutionalisation

In 2017, following the formal contractual adoption, the social innovation moved from being stewarded by four individual actors operating as institutional entrepreneurs as part of the public health system, to becoming an organisational-level process occurring within the context of a broader group (the Steering Committee).

The focus then shifted from adoption to focusing on institutional work towards achieving institutionalisation. This institutional work supported the innovation to gain widespread legitimacy across all relevant departments within the Ministry of Health and Population (MoHP) from becoming a 'taken for granted' initiative. During this process, five additional institutional entrepreneurs (as identified in Chapter 7) played an important role in stewarding this process at different times.

Two of these entrepreneurs represented the NGO, one being the head of the organisation's Malawi branch and the other, an NGO appointed representative seconded to the MoHP to support the process. Three institutional entrepreneurs represented government, one who was appointed as the government lead and two other representatives who played a leadership role at different intervals. (See Figure 7-1). At the time (2017 – 2019) when these institutional entrepreneurs were most active, a significant part of their activities occurred in the context of a larger group – that of the Steering Committee. As a reminder to the reader, the Steering Committee structure was established at the end of 2016, before the formal adoption of the CCPF initiative by the government (See 7.4.3.1). This steering committee included 20-30 members of all the various organisations represented in the initiative, including (as displayed in Figure 6-1): all technical government departments (Clinical Services, Planning, Nursing, Community Health, Quality Management, HIV & AIDS, Reproductive Health, Preventative Health, Information Communication Technology); the implementing and other international NGOs; bilateral agencies; private sector companies; universities and colleges; regulatory bodies and community leadership.

This chapter is informed by the concept of Positive Institutional Work as put forward by Nilsson [271], who built upon institutional theory through Positive Organisational Scholarship (Chapter 4.4.2). Positive practices and positive emotions are a focus for the meso-level of the study framework (Chapter 4). This chapter draws on the interview and observational data collected mid-way during the institutionalisation process of the initiative (July 2018 – August 2019).

Chapter 7 described the characteristics of the institutional entrepreneurs involved in the initiative, including the positive emotions they displayed. In the sections to follow, this chapter not only presents the types of institutional work (broad categories) that actors engaged in to support the institutionalisation process, but also the more specific positive practices through which this was achieved. It also takes a closer look at the role of positive emotions at a group level, to consider whether group-level emotions could be identified as a software factor influencing the institutionalisation of social innovation.

8.2.1 Innovation as Institutional Work: Creative Embedding Practices

The first phase of innovation entailed creating the CCPF itself and implementing the pilot (2010 – 2013). A second process of innovation was required to institutionalise the social innovation initiative as part of the public health system. Personal observations collected of the steering committee meeting processes, actor participation, reactions, and contributions, revealed that there was indeed a second phase of innovation taking place. It was the task of the steering committee members to determine how the goal of institutionalisation could be achieved, and this required multiple divergent and creative solutions.

The CCPF social innovation was initially designed outside the formal health system, albeit with linkages at the district level. By nature of it being an 'innovation', its setup and operation were different from the usual processes and structures of government-run healthcare delivery (as discussed in Chapter 6). Thus, trying to embed the social innovation within the existing government health system structures and processes was not expected to be a straightforward process free of complexity, challenges, or resistance. In addition, moving from a localised district-level based innovation to one capable of operating at a national scale, required significant changes and adaptation of infrastructure, technology, and human resources. Observational and interview data showed that this second process of innovation was less about institutional disruption (disruptive institutional work), as compared to the first process that led to the creation of CCPF (Chapter 6). Rather the process was more about developing creative embedding strategies to support the introduction of CCPF within the existing institutional boundaries and constraints of the health system. Within the context of the public sector, system integrity had to be maintained and could not undergo a total redesign, as emphasised by one government participant (among many others): *"I think it is both…the innovation, it cannot be rigid, it has to be flexible, like for example now, we are taking Chipatala cha pa Foni into the ministry of health or the health systems in Malawi…it's something that, it has not been there but there are policies, so the innovation cannot be exactly the way it was, it has to be modified a bit to suit in to the system but at the same time the system has to respond to welcome this, it has to adjust in some areas to make sure that this is set. So, it's both ways…"* Interviewee 015

Findings revealed several practices associated with the Steering Committee Meeting structure (SCM) which unlocked the creativity needed to support this 'innovation in institutionalisation' process. Specific practices found to be important in this experience were: the steering committee was a facilitated space, allowing for active engagement [418, 419]; there was vertical and horizontal inclusivity [420] and there was shared leadership [421-423]. These factors supported in unlocking the creativity required for the institutionalisation process. I discuss each of these factors in greater detail next.

The chair of the steering committee meetings played an important role in 'facilitating a shared space' for discussion, collaboration and relational engagement among the various partners involved in this initiative. This facilitated space enabled a second innovation process to be unleashed. As observed, it was within this space that participants and partners of the innovation reframed the challenges faced in institutionalising this project, rather as opportunities for new creative emergence (see more below). In none of the meetings observed, were participants ever overcome by negative emotions associated with institutionalisation challenges (See Table 6-1 for a list of challenges). Rather the very act of gathering at regular times appeared to provide the motivation and energy to continue with the process.

Meetings such as these, allowing for diverse cross-sectoral engagement, were not completely unique in the Malawian health system as multiple MoHP Technical Working Groups (as highlighted in Chapter 7) gathered at regular intervals around topic areas. However, from observation data, that which was unique was the vertical and horizontal inclusivity it fostered across levels of hierarchy and power. Actors involved in the steering committee stem from different MoHP technical departments, universities, bilateral agencies, private companies, the NGO implementation team, district health officials, frontline hotline nurses and on occasion community beneficiaries. Phrases such as '*this is ours*' was often used by the members of the steering committee when interviewed. This notion appeared to transcend mere talk but was believed by all members, irrespective of the duration or extent to which they were involved in the steering committee.

Several factors were identified from observational and interview data that could plausibly explain how this sense of inclusivity was created in tangible, experiential ways to members:

The government lead for CCPF showed awareness and recognition from the outset that people from different backgrounds were needed to achieve institutionalisation. There was a humility displayed by this leader / institutional entrepreneur, who felt that this process could only succeed with all actors being openly welcomed to the process, and at any stage. Malawian management logics also had a role to play in this approach, as will be discussed further in Chapter 9. Within meetings, traditional power dynamics and hierarchies were set aside and this allowed for everyone to engage at a more power-equal level.

> *"The values, that I think played a role, the first one would be inclusiveness, to make sure that everyone is included and is participating in the establishment of Chipatala cha pa Foni. Another one is honesty. We must be honest, as honest as possible amongst ourselves. Where we are not able to do something, we should be able, to be honest, that this one we are failing to do, this one we can do and partnership is another thing that is…come out very clearly that, you cannot do something alone. Whatever, whether you have got money, or you got resources, you need other people also to push you in another area or to cushion in other areas. So, the partnership and collaboration are other values that I take to be very key,, and respect is another thing. I don't underrate people as far as I am concerned and I think when we meet as a group, we want to work in that fashion. When you come into that meeting, you will see that people that are mixing up there, are at different levels in terms of their hierarchies.*" Interviewee 015

The 'honesty' expressed by the government lead in the quote above, was reflected in the level of transparency with which project related information was shared with the members of the steering committee. From meetings observed, there appeared to be an unfiltered sharing on the status of the institutionalisation process, even if it could reflect negatively on some of the implementation team members. For members who could not attend, minutes were shared and every month a progress report was sent. From observation, this

appeared not to be usual practice when it came to projects developed by non-Malawians or non-governmental partners. The transparent sharing of information, challenges and progress during meetings also appeared to contribute to trust among members, a sense of ownership and thus, consequently, a feeling of psychological safety – as is required for creativity to emerge [424, 425].

These meetings included representation from the hotline nurses (frontline workers), beneficiaries and lower cadre district officials. As noted in personal observations, these actors showed confidence in sharing their opinions or even contradicting or opposing the views of some higher social position government officials. As expressed by a district actor, the opportunity to participate generated a lot of positive sentiment: *"To me, it was really very, very good because I contributed a lot.…. So, to me, it was really a good meeting. The second meeting was still very good, I enjoyed it because I still contributed a lot."* Interviewee 051

The steering committee members were not a constant group with an equal level of involvement and participation. The strength of the ties between group members and the project was not uniform. As observed, members did not all know each other ahead of being involved in this initiative, some members only participated in one or two meetings, and new members were often added. Yet, the lack of uniformity in the strength of the ties between the members didn't hinder creativity, rather it enhanced it. New members brought different perspectives, thinking and ideas with which to approach the institutionalisation challenges (Table 6-1) and observation and interview data both showed that acquiring a sense of ownership of the initiative was possible if the opportunity for participation was facilitated, irrespective of the strength of the ties and the duration of involvement.

> *"It is through the meetings we had; I think we had the first meeting. I don't know where I was first involved but I found it already there. My colleague was the first one to be involved in one of the meetings and I also have been to attend one of them. Ja. It was quite good. And after that, it is like we are moving together, with the clinical department. Ja, so we share ideas and when there is a meeting we go and then see how we are moving forward."* Interviewee 009 (Government)

The steering committee meetings often took on the format of solution-finding and brainstorming sessions. Active discussion and engaging in creative behaviour were encouraged for identifying possibilities and generating ideas that could assist in overcoming the institutionalisation challenges encountered at different time points. Each meeting concluded with goal setting, clear task identification (action steps to be taken), how the task can be accomplished and timelines by when it had to be achieved. In some instances, smaller 'task-force' actor sub-groups were established to distribute the operationalisation of the institutionalisation activities. In other instances, the ideas and suggestions were taken forth to be implemented by the Technical

Advisor and the Government Lead. Goal setting further assisted in creating transparent and clear expectations among all actors involved.

From document reviews, observations and interviews, example areas that were frequently tabled for creative brainstorming and solution finding by the group included: finding a suitable 'house' for the CCPF social innovation and second, finding an avenue by which CCPF nursing staff could become government employees. Within the institutional context, the 'house' of the innovation was key for ensuring access to funding (different departments have different budgets) and to give the perceived credibility as a cross-departmentally owned initiative. The importance of this was highlighted by a government interviewee: *"Yes, …the last time I was talking that this is a system that will fit with the health promotion unit. If it stays there, it is well funded because all programs that are coming with IEC (information, education and communication) will support the initiative to sustain. So, there is an opportunity depending on how we align and assign, and I think with decentralisation yes, it's another way to start thinking, how do we link up and what will be the role of the districts to sustain this sort of a program."* Interviewee 049

The initial housing of the innovation within a specific technical department attracted critique and even more so by 2019, when members of the steering committee felt of its leadership, that "*they do not take this as a priority*". In addition, the mandate of central level MoHP was to steer policy and not drive the implementation of initiatives. The implementation of several ideas for a more suitable 'house' were tried following discussions in the steering committee meetings: integrating CCPF as part of the to-be established new Emergency Medical Services Unit; setting it up as its own technical unit; establishing it at the district level, which is charged with the implementation of health services.

Similarly, different proposed ideas were attempted and implemented to embed the hotline health staff as part of the government structure. Ideas tried included: creating new permanent positions as part of the MoHP establishment, creating non-established temporary positions, recruiting staff at the district level or retaining employment with the NGO through donor funding. By the end of the data collection period (mid-2019), no definitive solution was yet found that would allow these 29 nurses to become government employees. The different ideas tried and tested were not radical in nature, rather they can be considered as minor creative contributions [426]. These ideas were recombinations or extensions of existing opportunities, that theory highlighted as is common with social innovation (Chapter 3).

Another practice in the institutionalisation process, as identified from observational and interview data, was shared leadership. Although a government lead for the initiative was appointed, his leadership style was not one of vertical leadership (one person projecting downward influence on followers). Instead, he demonstrated a more collective approach, opening the opportunities, through the steering committee structure, for other

government members also to lead. This gave way for a process of mutual influence on the initiative by emerging leaders and increased creativity. Notably, two new government leaders, operating as institutional entrepreneurs, emerged. As highlighted by the interview data below, they played a key role in finding creative combinations (e.g., Quote 1 – link to existing HIV services); identifying windows of opportunity that could be leveraged (e.g., Quote 2 - the different budgetary processes in an election year); alternative courses of action and workarounds of existing institutional structures (e.g., Quote 3 - linking it to other new initiatives like medical emergency services). Both these chairs leveraged their deep understanding and prior experiences of institutionalisation (habitual agency) coupled with seeing clear opportunities that could support CCPF's institutionalisation (practical-evaluative agency) and also future possibilities, to create greater synergy with other government-run programmes (future-oriented agency) [238]. As highlighted in the study framework in Chapter 4, agency at a micro or individual level can have an important influence in affecting macro-level systemic changes.

> Quote 1: *"They need to think outside the box in terms of being the platform, linking those on the phones, linking them maybe to specific programmes. In HIV they have already their toll-free numbers that are 24 hours. If they can use Chipatala Cha Pa Foni linking whatever issues or questions to HIV too. The officers who are under Chipatala Cha Pa Foni, we have advised them to a structure which is already there. There are the central hospitals, the health centres as well as district hospitals, they have got 24-hour centres, no matter the challenges they usually have somebody is there 24 hours. They have their toll-free numbers for the trauma that is there as well. If we can maybe link it to this. So the main issue from the members was linking the trauma initiative to Chipatala Cha Pa Foni. Is it Chipatala Cha Pa Foni under the trauma programme or is the trauma programme under Chipatala Cha Pa Foni? But to me, it is like a brother and a sister, and they should work together to see how best they can link one to the other so there is effective implementation. So, if vertical and horizontal integration of human resources happen, then I feel the problem of human resources can easily be resolved. Human resource integration at the vertical and horizontal levels.* Interviewee 038 (Government)

> Quote 2: *"I will chip in. The Malawi government has a set up on the issue of the budgets. When it is not the year when we are doing elections, as this year, we know in May there will be an election, and the financial year for Malawi starts on 1st July, it ends on 30 June. So, by the time we would be starting on 1st July this year it is expected we will not have a parliament to endorse the budget. Well, the other four years, there has been already parliament to approve the financial year. So, the Deputy Country Director is saying is, what is the process? So, this time the Ministry of Finance called all the Ministries and all the Departments to make their budgets, including the area of Clinical Services which is housing CCPF. And we did that, and we submitted according to the deadline they gave, through the Directorate of Planning, and submitted it to the Minister of Finance. Once they have seen it, they give us, what they call, the ceiling, so that we finalise it based on the ceiling. But before that, it is what my colleague is saying, we have to defend it. In the*

calendar, before the ceiling, we have to justify why this one is the first of its kind for the government to embrace. It is like a new kid on the block. We expect to defend. While the other budgets, we don't anymore defend them. Whatever we have put, we just wait for the budget ceiling. Once the ceiling has been given, we prioritise the first priority, the other activities for which the budget may not be enough. We just put those activities if there may be any partners to support us or a re-allocation. So, here, this year it will not go to the parliament. It is the mandate of the Ministry of Finance or the team there, equally us, the Ministry through the Permanent Secretary, and the Minister, we are the ones once we have approved it to the Minister of Finance, it will be taken as the budget for 2019 to 2020 financial year…But for the treasury this time around, it is up to us, the technical, from the ground. So, we feel that this is a blessing in disguise, and it would not have many challenges. Once the PS and Minister of Health say to the Minister of Finance, this is very important, we want to proceed. While the parliamentarians, we need to educate them, to tell them, but here they already know, it is already approved to access these resources." Interviewee 038 (Government)

Quote 3: *"Yes, of course, the opportunity now is in the medical emergency services. Two, there are so many, I think initiatives, there are partners like YONECO (an NGO), they are doing similar type of things but it's on the gender-based violence and the like. So, I think, what's key is to change probably, even its focus. Because you don't need medical personnel to manage a call centre. You can get any person with experience to manage any call centre or train them…yes…and link the service…let's say with the emergency medical service and essentially this is just a program just for promoting and referring people where to go, so the key will be sort of getting those lower cadres that you can easily manage.* Interviewee 049 (Government)

From the findings presented above, the innovation process entailed in institutionalisation thus appears rather as one of 'everyday innovation' (as compared to radical innovation that would lead to complete institutional disruption)[427]. This process is comprised of many smaller creative embedding strategies and ideas proposed through the participation and shared leadership of a wide range of diverse actors spanning vertical hierarchies and horizontal boundaries.

8.2.2 Practices for Constructing and Maintaining Relationships

The ongoing relationship between the implementing NGO and government counterparts played an important part in the process of institutionalisation. The meso-level of the study conceptual framework (Chapter 4) accommodates organisational level practices, informed by Positive Organisational Scholarship. Three relational practices were identified through analysis of empirical data that supported the construction

and maintenance of relationships: respectful engagement [428], mutuality [429, 430], and appreciative attention [431-433].

The respectful engagement was identified from observational and interview data, as practised in particular by institutional entrepreneurs representing the NGO, in their dealings with government actors. This practice contributed significantly to the quality of the relationship generated with the government, and thus supported the willingness of multiple government actors to engage in the institutionalisation process. As expressed by this government interviewee: *"I don't know how I can call it…the willingness on our colleagues from Village*Reach*. I think for me, right from the time we started with [country director], they were always sharing information. And I remember even there were times when they would want to do it not in the correct way and I would guide them and say no, this is the proper way. So, they were appreciative in saying thank you so much for guiding us to do the proper thing. So, this is how we were able to inform our other colleagues at the ministry so that it became embraced."* Interviewee 010

Respectful behaviours in an organisational context are defined by how people esteem the worth of another individual, the dignity and care for others' positive self-regard [434]. As illustrated in the quote above, the NGO institutional entrepreneurs showed respect to government actors by requesting their advice and input throughout the process, which was perceived as humility, and acting upon this advice received, reinforced to government actors that he or she was held in high esteem.

Perspective-taking [435] by the NGO actors was another practice that signalled respect to government actors. Government actors perceived there to be empathic understanding of their daily reality and the competing demands on their time. The NGO actors showed an openness towards being asked questions and provided answers.

> *But fortunately [country director], and the other one [monitoring officer], they are such good people. When the director introduced me to Chipatala Cha Pa Foni, we have been working very closely. My office is relatively busy, but they do understand me [laugh]. They're understanding is something else that I don't take for granted. Some of the things may be like they are dragging but they always come in to help that those things move on. And they can talk better about how we are trusting each other but I think I like the openness. Ja. When I ask questions, I always get answers. So that builds the trust and the understanding that this office is also busy."* Interviewee 015 (Government)

These practices enabled more actors to share in the responsibility of the innovation and fostered a sense of belonging. Both practices also contributed to building confidence of the actors involved in the initiative. This made them more comfortable to take risks in advocating for and supporting CCPF within their own departments or organisations, in various ministerial forums and especially at the senior management level. It was noted by government actors interviewed at the central and the district level, that this practice of

respectful engagement was unique and rather contrary to that which they often experience when dealing with organisations external to the health system, especially foreign organisations or agencies wanting to implement initiatives in Malawi. Few offer early opportunities for input in shaping programmes to government actors. Government actors, even those at the central level (highest level of government), often perceive the behaviour of external organisations to be top-down and imposed. This, in turn, limits the quality of the partnership created and the sense of ownership the government feels towards non-Malawian innovations or programmes. This factor will be further discussed in Chapter 9.9.2.

> *"We don't like the ideas to be imposed. First of all, it should be that the both of us should understand and accept."* Interviewee 014 (Government)

A characteristic of the relationship between the NGO and government included mutuality. This can be understood as relational reciprocity in which both the NGO and the government actors accepted mutual influence, equality, responsiveness and dependence towards each other and their shared purpose of institutionalising CCPF. From observational and interview data, this was particularly well represented in the relationship between the government lead and the NGO institutional entrepreneur seconded to support this lead. This mutuality was a key contributor in fostering and heightening the positive emotions (see 8.2.3 below) required for day-to-day implementation, despite the challenges presented.

> *"So, we are a team. Already we have a small team here, me and [technical advisor] and my director is always giving me the support I need. I like her when she challenges me to say, 'you can do this, so that is motivating already.*" Interviewee 014 (Government) (2018)

> *"Village Reach is giving to the clinical services by possibly bringing [technical advisor] to work with us here, is something that is also another thing because sometimes you tend to forget some very…very important things and as she says…she cushions…pestering issues…like right now, she was reminding…when I saw her…I was like, my goodness, [name] is coming again!!!...she has come here 3 times today to remind me…to remind me about your meeting, to remind me about the…letter!!!...but I have been torn into so many pieces today. So those reminders themselves are big support!!...and Lucky sometimes…not sometimes…you see…there other things that you need a pair of hands, so [technical advisor] provides those extra pair of hands to do other things. She is always willing to do something extra from what she could have been doing maybe in Village Reach. So, the support that I would need to me is that just making sure that the team is strong, and we have put our own systems that are going to torch on Chipatala cha pa Foni as part of the wat we do daily."* Interviewee 014 (Government) (2019)

The sense of mutuality between the NGO and government, also served as a resource in the institutionalisation process, as it generated a sense a shared identity in CCPF, as actors felt they were in this process together, and together the goal at hand was perceived as being more attainable.

Finally, at each steering committee meeting, the practice of appreciative attention, which entails recognising the generative aspects in the work and the people engaging in the work, was displayed in several ways: meetings were all started by a meeting participant offering to say a prayer (in the local Chichewa language or English). The prayer comprised of offering gratitude to God for the day, the opportunity to be engaged and a request for wisdom to know how to proceed. Following, the meeting host, either the government lead or a representative, would welcome each of the attendees (often by name) and give gratitude for the time they have set aside to attend the meeting. Gratitude would further be expressed to each of the cross-sectoral partners represented, as well as the various technical government departments for their contribution to CCPF. Special attention would be given to highlight the specific value and role of the collaboration created. The government lead would recast the vision for CCPF, and emphasise the novelty associated with the initiative. In this way, he set it apart as something special and unique to be involved in. During each of the meetings, positive news updates were shared before challenges were highlighted – frequently, this would entail the increasing number of Malawians using the service, the service receiving external recognition through an award or an invitation received to present at an international forum. These acts of affirmative attention created a generally positive affect among participants and in so doing, likely became a contributor to their future creative behaviour, as noted by these different interviewees:

> *"The MOH is looking forward to taking it up. If a district has 8 health facilities, we want them to consider CCPF to be the 9th because Chipatala Cha Pa Foni is part and parcel of all the health facilities in Malawi and we just have to make it that way. And in that way, it will require us to advocate, there will be some challenges but with all these ideas that I hear, I am very confident. When we were charged by the Ministry of Health, as the Clinical Services Department to facilitate or promote CCPF, we were confident because we had people behind us. You know, when you have people behind you, even if you have all these challenges and we don't expect to be disappointed because of you people. So, your presence here gives us courage. So, with those few remarks, I just want to say thank you very much and I look forward to all the discussions. Your input is very valuable here."* Government Chair 1, Meeting 29.06.2018

> [1 year later] "*The collaboration partnership is really key, and it needs to be prioritised. It is important to communicate to the community that this is something unique, the first of its kind.*" Government Chair 1, Meeting 26.02.2019

[1 year later] *"The mandate we have been given is to make a project into a programme. We are blessed by the senior management, which was endorsed by the same office, it has been successful as a project but now has to be taken as a programme.*" Government Chair 2, Meeting 26.03.2019

A significant moment of positive affirmation, recalled by several interviewees as well as personally observed, occurred during the June 2018 meeting. An elderly Group Village Headman attended the meeting and shared a narrative of his experience with CCPF. Hearing a first-hand account of the impact and his expression of appreciation for the initiative strengthened the belief of government actors in the initiative. Other ways of sharing positive narrative accounts of CCPF were also utilised in subsequent meetings, as commented on below when beneficiaries were not able to attend – these included short video testimonies or written accounts prepared by the NGO.

"But I learned from one of our steering committee meetings there are some champions of Chipatala Cha Pa Foni. Some people in the village have been using Chipatala Cha Pa Foni. It was very amazing to see that this person with his phone, Chipatala Cha Pa Foni. was able to give health messages to almost an entire village and the entire village was able to ask about anything, that is related to health, through this on his cell phone." Interviewee 018 (Government)

"So, when the Ministry saw that initiative was bearing fruit after some of the women, who had assisted through that system gave testimonies, the Ministry saw that this innovation could also help in alleviating some of the problems that people face, perhaps due to a lack of information but also due to the distant places they might be before they can seek assistance at the hospitals." Interviewee 039 (Government)

"The two beneficiaries who attended the meeting had the opportunity to share their feedback before lunch. Their feedback was in Chichewa, so I didn't understand it but from the reaction by MOH counterparts, there were lots of smiles and agreements. It is a smart strategy to bring beneficiaries to the meeting. It makes for a very compelling case to have beneficiaries speak directly to MOH officials and for them to hear a first-hand case of the experience of CCPF." Observational Note 29 June 2019.

8.2.3 Positive Emotions at a group level: Hope and Pride

As described in Chapter 7, the 9 actors operating as institutional entrepreneurs displayed several positive emotions (theory in Chapter 4). These were passion, strong motivation towards social good, gratitude, hope and having an asset-oriented attitude. Positive emotions were also identified in the steering committee

members. These were noted in interview data but also informal observational data from meetings as well as informal encounters with these actors. The two most represented positive emotions in the steering committee members were hope and pride.

Various challenges were experienced during the institutionalisation process (as summarised in Table 6-1). As a result, by March 2019, during the second data collection visit, it became clear that it would be hard for the government to fully complete the institutionalisation process by the set date of 30 June 2019. On the third and final visit in August 2019, this was indeed the reality confronting all the actors. The challenges faced included: first, the difficulties of the MoHP absorbing 29 additional nurses as part of the government establishment (i.e., having the necessary funding to create new positions), especially with the resource constraints faced by the Malawian government and the 2019 financial year budget cuts. Second, the CCPF project budget was 75% higher than that of the total annual Clinical Services Department budget. Although funding support from a bilateral development agency, a long-time partner of CCPF, made it possible to support the project for an additional 3-months, it was entirely unclear how the full-operational budget required for this initiative could be secured in the long term. Third, government actors challenged the leadership of the appointed government lead. They felt that the lead was intended to make the initiative a programme at the central level, and this was in opposition to the Malawian decentralised health system. In their opinion, the district level should rather be tasked with day-to-day implementation, and in so doing, be involved. (See Chapter 9 for further analysis).

Each one of these challenges would present a valid reason for not continuing with the institutionalisation process and becoming resigned to the fact that they would be insurmountable within the timeline set for the process to be completed. The institutional entrepreneurs were not naïve about these types of challenges. They were able to engage in critical thinking, clearly identifying obstacles and expressing their own doubts. They were also able to reflect upon decisions made over time that may have had negative and unintended consequences on the process. Yet, as illustrated in the data below, what remained surprising was the resolute belief by all the institutional entrepreneurs that despite all the challenges faced, institutionalisation would eventually be possible. This future, possibility-oriented and visionary view in the face of significant challenges confers with the positive emotion of hope, described by literature from positive psychology and linked to the micro and meso level of the conceptual framework (Chapter 4). Although classified as a positive emotion, hope is unusual. Unlike other positive emotions, it doesn't arise in settings where circumstances are perceived as safe but rather becomes alive in dire circumstances, circumstances in which people would fear the worst but continue to yearn for better [246].

"I think when we get to have a strategy meeting and he says for instance: "[name], I am not worried about money. I know this thing has to run and it will run. Money will be made available, that is the least of my concerns". At one point I was concerned that the budget that was passed represents, maybe 10% or somewhat of what it takes to run CCPF. But if he is quite confident to say that is not his problem, that is not his worry, then why should it give me a headache (laugh). If he is quite confident and I am now talking to someone who is taking it on, then there must be something he is banking on so I really shouldn't have a headache about this. So, when you have those discussions with Dr [name], you go into the room nervous but as you are leaving the room, you go, mmh, I think I need to rethink it all and see and get to the level of confidence that he is. Yeah." 002 Interviewee (NGO)

Interviewer: *"On a scale of 0 to 10, how far do you think with zero, not at all and 10 is being completely institutionalised, where is CCPF along that line?"*
Respondent: *"I think, 95%, yes. Maybe 95% would be too generous. The major thing is the hotline, all the things have been done, except the human resource. The human resource has not been fully recruited. Once the government recruits the human resources for Chipatala Cha Pa Foni, that would be 100%. The only thing that is remaining is the recruitment of the human resource. But with the human resource being crucial it cannot be 1%."* 015 Interviewee (Government)

"Yah, to me it is a mark for Malawi. It is something people said couldn't work, it was a waste of time, a waste of resources but there it has come. So, to me, it is possible, once you have enough information, recommendations, or findings that this can make a difference in society. Believe in yourself, believe in what you're doing. If the authority around you is convinced of what you are doing, I think that is enough arsenal to give." Interviewee 038 (Government)

"I would say that the potential is there. I don't see any reason why CCPF should fail to be part of the system because it is all about the decision. It is all about the decision, the people to be open-minded and make the necessary decisions. That's all." Interviewee 049 (Government)

The hope expressed by the 9 institutional entrepreneurs and the steering committee members appeared to match up to Snyder's understanding of hope as being "the sum of the mental willpower and waypower that you have for your goals" [259] (Chapter 4). As per the quotes above, all had mental willpower - the perception that they can initiate actions to achieve the goal - as well as waypower - the ability to find alternate routes towards achieving their goal if obstacles present. These qualities identified in the data also differentiate hope from optimism. Optimistic individuals hold fast to the belief of a positive outcome but lack the critical thinking about how to arrive there. However, the CCPF actors, especially the 9 institutional entrepreneurs, can rather be described as high-hope individuals [249, 259].

As mentioned previously, the broader group of steering committee members were a rotating group of people, and government representatives were often assigned to attend. Thus, it is plausible that this group didn't only attract high-hope individuals by self-selection. Yet, even in the broader group, a sense of hope and hopefulness was observed, as exemplified by this frontline nurse who attended the meeting and whose job security depended on an institutionalisation process being successful:
"Yes! We have invested a lot and it will be bad to just give up now. We still have hope that it, though it will not go as we wanted, as we anticipated, we still have hope that it will go through." Interviewee 003

Hope as willpower and waypower were further expressed through members continuing to recognise possibilities amidst growing awareness of impending challenges with institutionalisation, as well as their ability to deliberate and propose practical action steps. Steering committee members, as expressed below by a district-level government representative, were able to truthfully identify challenges and clearly express doubts yet maintain an enduring belief in the possibility of successful institutionalisation.

> ***Interviewer:*** *"So how do you feel about the whole process? You are hopeful or what is your personal feeling around?"*
> ***Respondent:*** *"I think it will crash the way it is going now. I think it will crash and we will start again to pick it up from the bottom. And two things might happen, Village*Reach *might be frustrated that it crashed, they might come back until the end of the year maybe. That's what am thinking, or it will be frustrated but it will still push the government to pick it up. Those are the two scenarios I am looking at because I believe come July, we will not have a human resource ready, come July we will not have financial resources, come July we will not have good monitoring and evaluation that will be done there. So if handover indeed happens in July, then it will crash and they will start picking it up from the ground. But for me, I think it's a wonderful innovation and there is a lot of things that can be done. I just hope the government will give it all the support that is needed, I know some people are very interested and have ideas to take it to another level. I think we should expect that we will have challenges, the challenges will be there, but the good thing is to believe that if we fall, we will pick it up."* Interviewee 045 (Government – District)

A second positive emotion that was widespread at the group level was pride. There was a strong sense of pride among the members of the steering committee in their involvement as contributing to the overall success of the CCPF initiative. They viewed the initiative as a means to positively impact their country as a whole and felt that, especially as Malawians (national pride), they will then be able to take credit for implementing an initiative that few other African countries have been able to do. As a reminder to the reader again, all the actors engaged in the institutionalisation efforts of CCPF did so on a voluntary and non-renumerated basis, contributing over and above their daily work tasks and functions. Pride can be seen as an

intangible resource, reward and incentive in the perseverance of ongoing efforts by actors without any monetary compensation [436].

> *"Just to say, here in sub-Sahara, our countries have more or less similar problems, so I am convinced something that has worked in Malawi should be able to work in our neighbouring countries. And like that when we make the changes, when we make the impact in our health indicators, Africa is a nation who will be able to improve the indicators and even contribute…because I know it is African and Asia which are making the global indicators not that much good. So, we look forward to a time when these innovations can be shared. It is a global village and brings that impact."* Interviewee 010 (Government)

> *"To contribute something towards the development of my country. That is the most important thing, because when you see people that are using something which you contributed, you feel good, especially in the health profession. You feel good. People are better because of my contribution. People are healthy because of my contribution. My country is developing because of what I did that day at Mnponela. So, it was really very good. For me, I would be very happy if the initiative is continuing the way how other things are going on in Malawi because by doing so, lots of people can benefit from the service."* Interviewee 051 (District)

> *"I think seeing this project come from it just being on paper of an agreement and it's 'ok, we want to set up this particular SMS message and oh my gosh and can we do that and then we send that SMS blast and then we get feedback, 'oh my gosh! we got 20-something thousand phone calls from this.' And then the testimonies, meeting the people that this initiative, this project has impacted is just so heart-warming and so fulfilling for me. I mean, come on! We can see the impact manifest from this woman who was able to be assisted from just a phone call. So yeah, it is really, really awesome. I love this, this is why I love my job, I can just see how, ok, we have signed this and then, so that happened, you know?"* Interviewee 026 (Private)

> *"Yah, to me it is a mark for Malawi. It is something people said couldn't work, it was a waste of time, a waste of resources but there it has come. So, to me, it is possible, once you have enough information, recommendation, or findings that this can make a difference in society believe yourself, believe you're doing. If the authority around you is convinced of what you are doing, I think that is enough arsenal to give."* Interview. 038 (Government)

8.3 Conclusion

This chapter highlights how institutionalisation can be regarded as a process of innovation in and of itself. It is not a form of radical innovation like the initial process of creating the CCPF which sought to bring about institutional disruption. Rather, innovation in institutionalisation seeks to push boundaries while maintaining

the institutional integrity of the broader system. This form of innovation has an 'everyday quality, in that it was comprised of actors suggesting and trying multiple ideas, acts, strategies and reconfigurations to creatively find a way to embed the CCPF initiative.

This chapter further illustrates the interplay between this notion of institutional work as 'everyday innovation' occurring in support of institutionalisation. Creative embedding practices, relational construction relational practices and positive emotions were enabled by the steering committee group structure. This innovation in institutionalisation was thus not a process that depends solely on the capacity and skill of talented individuals.

The findings presented in this chapter show how the relational shared and facilitated space created through the meeting structure of the steering committee served as the ground to cultivate creativity, as well as the space to hold and increase positive emotions such as hope and pride. As CCPF necessitated the participation of a diverse array of actors to achieve the institutionalisation process, this also supported the adoption of a more shared and distributed leadership approach.

However, not all meeting spaces in health systems operate as relational contexts capable of generating these outputs (hope and creativity). Three positive organisational practices were identified which could be plausible contributors to achieving the outputs observed. The relationship between the group members was marked by an investment in the practices fostering respect, mutuality, and appreciation among members of the group. These practices recognised the intrinsic value of each person, beyond their functional role or designation. These practices were key to building the relational strength and connection between the NGO and the MoHP, between the small group of institutional entrepreneurs and between the members of the Steering Committee. The relationships cultivated were described both by government and NGO actors as being unique and rather different from the usual relationships found among 'partners' in the health system (See Chapter 9 for further discussion of this point). It is worth acknowledging that these practices, especially when initiated by Malawian's part of the project, reflected the cultural values of personhood as described in Chapter 4.

Beyond the strong relational connection, the influencing role of the 9 institutional entrepreneurs was important. These 9 individuals could be characterised as high-hope individuals. Within the context of the broader group, they appeared to inject a baseline level of hope and operate like catalytic agents to raise the group's hope levels. Hope can be regarded as a resource in and of itself, generated within the relational context of a group and can be shared among people in the group.

Thus, the process of social innovation institutionalisation holds value in and of itself as it gave 'space' for the inclusive interaction and establishment of relationships among actors (across boundaries, hierarchies, and sectors) who may not otherwise have had reason to engage relationally. A different dynamic from the usual hierarchy of a bureaucratic health system was thus observed and power was shared more horizontally, as opposed to across vertical lines. Through the quality of the relationships generated (relationships of respect, mutuality, and appreciation) as well as leveraging the high-hope levels intrinsic in institutional entrepreneurs, it was possible to raise the collective hope levels of the group. This high level of hope provided the broader group with the internal resources to unceasingly continue in creating solutions to support the institutionalisation innovation process, despite the reality of the challenges and obstacles faced.

9 CHAPTER 9 - CONTEXTUAL INFLUENCES IN SOCIAL INNOVATION ADOPTION AND INSTITUTIONALISATION: CHALLENGES AND CONTRADICTIONS IN INSTITUTIONAL LOGICS

9.1 Introduction

This last results chapter explores the macro-level of the proposed social innovation framework that was introduced in Chapter 4 and aims to understand the influence of the institutional context on the institutionalisation process. As noted, this level of the framework is informed by theory on institutional logics, to identify the material, symbolic and historic patterns and principles that shape the actions of actors [213, 230]. It is also informed by literature on the political culture and nationalism, the notion of Malawian moral personhood and African management culture, as reviewed in Chapter 5.

This chapter also goes beyond a focus on only the social innovation case study but describes a broader understanding of the context within which this case study was situated, including the experiences of other non-Malawian innovations and initiatives implemented in the country. These experiences drew attention to the underlying mechanisms that further the interpretation of the processes of adoption and institutionalism.

This chapter was thus derived by an inductive analysis of interviews conducted with a range of actors: people involved in other innovative initiatives, people directly involved with the CCPF social innovation as well as people, not directly involved (within the Ministry of Health and from other health implementing agencies in Malawi). The former group of actors had a personal history with these processes related to new and innovative initiatives (in which they have been involved within their respective technical areas). By drawing upon their past experiences, they were able to provide a critical reflection upon the institutionalisation process under consideration. The study also sought out conflicting or contentious opinions of actors, such that a full and comprehensive understanding can be gained. The findings described in this chapter were further substantiated by personal observations and cross-checking these observations with Malawian research colleagues and literature.

Considering the macro-level of the study framework, the purpose of this chapter is to:

- Analyse contextual software factors, from the past innovation experiences, which contribute to the case under investigation.
- Analyse the institutional logics and especially contradictions in logics, as relevant to the social innovation case under investigation.

9.2 Contextual software factors influencing institutionalisation: The role of institutional logics

9.2.1 Contradictions in logics associated with ownership and acceptance: National-identity logic versus non-Malawian development logic

The importance of country-ownership is rhetoric frequently used in the health policy and systems literature [437]. The theoretical lens of institutional logics, as per the macro-level of the framework, assisted in bringing a richer understanding of how the theme of 'ownership' and 'acceptance' is interpreted by different actor groups and why it played an important role in the success of institutionalisation. These themes emerged inductively from the first round of analysis. This theme was continually explored in subsequent rounds of data collection to deepen the understanding of its impact on social innovation.

Two different institutional logics were identified from interview data, as occurring in Malawi, regarding new initiatives being implemented in the country: a national-identity logic and a development logic. The contradictions in logics were able to explain the themes of ownership and acceptance. Contradictions in these logics were found to be influenced by the political history of the country, national identity, and prior development experiences.

As described in Chapter 5, Malawi has a long colonial history and, during the time of this research, there was a renewed political and social momentum to see the realisation of Malawi as a self-reliant nation, independent from outsider influence. '*The Malawi we want is possible and will happen!*'[337] Personal observations and experiences gained from social encounters within the country, and from reading local newspapers, highlighted the renewed national pride held by Malawians in their identity and in locally-developed initiatives being for Malawians by Malawians.

The Malawian health system is not yet self-reliant. Like many other sectors in the country, health is dependent on and influenced by 'colonial influences in the form of international development assistance' [312]. More than 62% of the total health expenditure (2017) comes from external development partners [312]. Thus, despite the desire of Malawians to be fully independent, the country remains beholden to external influence and directives guiding the country's development in health and across other sectors. According to Adhikari et al [329]: "*There seem to be discrepancies between the usually rather idealistic donor expectations and the everyday practical realities of the how the Malawian social system functions. External development partners try to influence the country's health system with their ideas of what constitutes international development, and through offering their support in the running of projects.*

They are usually short-term and results-oriented. There is very little long-term donor commitment". A report by the German Development Institute, based on an in-country survey on attitudes towards donors, found a large proportion of participants indicating an indifference and at times even an aversion towards donor activity in Malawi [438]. Unfortunately, the matter has been complicated by public sector financial mismanagement, such as the Cashgate scandal. This has led to distrust in the relationship between foreign donors and the government, with resources often channelled away from the government system and through various NGOs operating in the country, with heightened monitoring (See Chapter 5).

Study respondents from district health management and community leadership structures interviewed shared their feelings and opinions regarding donor-funded projects and the implementation of these projects. They highlighted an overwhelming sentiment of feeling side-lined in these initiatives. It further creates a perception of disrespect when they, as Malawian nationals, are not involved from an early stage during the conceptualisation and implementation of new initiatives in the country. The resulting consequence of well-meaning donor-funded projects implemented by non-nationals is implementation failure. The lack of Malawian national involvement further results in a lack of projects achieving national ownership and thus having limited sustainability.

> *"So, the other issues are ownership and involvement of…. essentially who is involved at the designing stage. So, if the implementers…. long-time implementers are not involved, eventually scalability…even at the policy level becomes a problem. Mostly they will start as a project may be by an organisation, then its agreed, it could be a good idea but maybe it may not be in tandem with the system after the program goes…the idea fails like that."* Interviewee 049 (Government)

> *"I have forgotten the name. But, in terms of their implementation strategy, they implement by themselves. They came and introduced the project, we have this project, and then we went on to do the necessary. They did not involve the facility team members. And those projects, honestly, have not been successful. Because why they lack ownership. After the projects have shifted out, nobody knew what they were doing and then they failed to sustain the project. So, I think that is one of the problems that make projects fail if they don't involve the owners of the facility. They just go and say if it is a community project, they go say to the community part implementing the project. Or if it is not by the community, but in terms of sustainability they fail to sustain the project because there is no one to carry over when they have phased out."* Interviewee 036 (Government - District)

Beyond the more commonly cited factors of need and cost influencing institutionalisation of new initiatives in the context of Malawi, two additional factors mentioned most frequently included cultural acceptability and symbolic representation. These two factors were key process factors – the 'how' by which ownership can be achieved.

In terms of cultural acceptability, the Ministry of Health, beyond being delivery of health care, very much considers themselves to also be owners and custodians of Malawi's cultural heritage and values. Respect for these values contributes to initiatives being taken up as part of national identity.

> *"The first thing that I will allow her or him is that… respecting our culture, respecting our culture in the sense that, you know, sometimes, there are some other visitors that might bring in things like, the kind of addressing…, the way you know, how you should be addressing some people…., but I would recommend, I would recommend somebody who is an intruder, but he respects the rights of my people in my area, he also makes sure that, when he is around, he should not pass on some things that may not help my community, and again, he should make sure that the health of the community is still intact, is not tampered with…"* Interviewee 029 (Community – Traditional Leader)

Senior government respondents, actors with 20+ years of government experience, elaborated that those new initiatives coming into the country which was not aligned with Malawian identity as expressed by culture and values, irrespective of their potential health impacts, would not only be unacceptable but was also expressed that action would be taken to ensure those innovations do not take root (be institutionalised) in the country. An example of an innovation that was in opposition to country values based on failing to respect traditional and religious principles was cited:

> *"I remember there were certain organisations who I may not say, they wanted to use the cell phone to take pictures of the cervix. That one was not accepted in our safe motherhood committee because they think you are going to violate their privacy but also how sure are you that this health worker is going to just use those pictures for the purpose it is intended. There are going to be viral, they can be sent…so that once was not acceptable."* Interviewee 009 (Government)

Inherent in a logic of national identity, Malawians are the values of collectivism, respect and cultural alignment. Often implementers operating from a development logic, which is more individualist and transactional, may lack awareness of competing logics of operation within a specific country context such as Malawi. This will be further explored in the section below.

i. Role of logics in the ownership of Chipatala Cha Pa Foni

The logics of national identity and development, as identified above, were further explored as it pertains to the ownership and institutionalisation of CCPF. There were discrepancies between the perceptions of actors, based on the logic they ascribed to, regarding the ownership of the CCPF social innovation as part of the public health system.

District-level and community-level actors were specifically sensitive to the tension that arose at the grassroots level in terms of who would own and be responsible for CCPF in the long run. A development logic was associated with the achievement of results and demonstrable impact. For these district-level actors, ownership entailed a trade-off between having CCPF being a well-run NGO initiative achieving its intended outcomes but with time-limited duration versus a sustained nationally owned initiative. This is seen in the quote by a district-level government actor below:

> *"My opinion is that it would be best run by an NGO because I know that government in terms of the resources is limited. It is already having enormous tasks that it is not able to do due to resource constraints. It is difficult for it to prioritise certain areas not because it wants to neglect them but because of the resource. Once an NGO is operating in a particular area, it stays focused and then it is likely to bring more impact."* Interviewee 036 (Government - District)

In contrast, it was found through interviews and observations, that CCPF as a nationally owned initiative comes with its connotations and beliefs held by actors. National ownership was associated with government implementation, which was perceived to be weaker than that of externally funded entities. Multiple Malawian actors, even those working within government, expressed concern and scepticism as to the government's capacity to effectively manage the day-to-day implementation of initiatives and the real risk of initiatives to '*die a natural death*' in the hands of the government. Where externally funded organisations had more funding at their disposal, the government's resources (financially and technically) remain limited. A laxer and more hands-off management approach of government, as compared to externally funded implementers, were also cited as factors that could result in long-term implementation failure.

> *"Me I can say, if the project [CCPF] can remain with the NGO, it performs better than what it would perform in the government hands. That is my suggestion. Yes. Unless we change in terms of how we run things in terms of government."* Interviewee 035 (Government -District)

> *"My main concern is not the funding but the seriousness, the way [the NGO] was taking it seriously that project. Taking it at heart, that seriousness, wherever it will be housed in the ministry of health, it's my appeal….even if you don't have money…we need somebody who is vigilant, somebody who….they should really….but if you…will have the laissez-faire way how we take these programs, I tell you it will die a natural death and it will be not doing justice to the monies from our partners who have invested here including Airtel Malawi, it will not be justice to all of us we embraced it from a start. So, my biggest worry is about the seriousness of the officers who are going to be responsible, so as a new program."* Interviewee 030 (Government - District)

Yet, despite the concerns with the government's capacity to achieve results, the overwhelming belief and attitude of the government and community actors across all levels of the health system, even the sceptics,

agreed that if CCPF is to be institutionalised as a Malawian initiative, it must be nationally owned, and national ownership meant government leadership of the initiative. A national-identity logic was associated with universality, durability, and sustainability.

As expressed by this community representative, once nationally owned, CCPF will be something that is not only for a selected district or group as is the case with externally funded initiatives, but rather it will be an initiative that is for all Malawian people: *"Yes…., and you know what, (…) when you have everything that belongs to the government, it's for everybody. That was not sustainable, this time around it is very sustainable because it is in the hands of the government, now the best thing is that you know, in the coming time, you know, years, it needs to have its board, that is going to be getting some, you know, some salaries, or monies directly from the treasury, it has come to stay."* Interviewee 029 (Community)

A national-identity logic also held connotations of durability and sustainability. Externally funded and externally implemented initiatives were associated with being time-bound, quick to change and lacking longevity over time. The government, on the other hand, was regarded as being an entity that will remain constant even irrespective of changes to development agendas or funding changes. The government, despite respondents agreeing on the challenges government faced in terms of delivery, was perceived as an entity that can be trusted, as it is Malawian.

> *"If it's an NGO going there (to implement), they feel like there is a benefit in that thing, but then if that NGO goes, that thing is not sustained, (…) it goes with the NGO. They then wait until another NGO comes in. When it's with the Ministry of Health, they will feel, that's the government and when you ask them, 'Who is the government?' They will say that we are the government, so, that's a better way than…."* Interviewee 033 (Government - District)

> *"What we are seeing is that, if something has been taken by the government, it means that the government is stable, it is their time and again, government, an organisation happens that, when it comes, it goes, so, if something is with the government, it means that it has been established, so, if it has been established it also means that we will not be anxious, that in the past, we used to be anxious that, if [NGO] leaves, where will it end.*" Interviewee 030 (Community)

> "*It is better for the government for the sake of sustainability. You know there is this issue of donor fatigue. For the sake of it, the government should take the project as its own."* Interviewee 034 (Government - District)

Government ownership of CCPF, as other initiatives, was closely linked to the national value of independence, as respondents saw themselves reflected in government '*"They will say that we are the government, so that's a better way'* Interview 029 (Community).

As mentioned in 9.2.1 above, due to the colonial history of the country, trust in the Malawian identity supersedes trust in the 'outsider'. Thus, ownership is as much a reflection of trust and pride in the Malawian identity as it is of practical actions towards institutional embedding.

Lastly, CCPF was considered to be culturally acceptable as its method of providing health information was through qualified nurses ensuring privacy, confidentiality, and sensitivity to cultural issues (especially around women in a patriarchal society). The cultural alignment of the initiative to traditional Malawian values was a factor that supported the initiative receiving acceptance from Malawian traditional authorities (Chapter 5 & 6). Cultural alignment supported the ownership of the initiative by the government.

ii. Tensions due to contradictions in logics in CCPF institutionalisation

The two different logic lines identified help to explain the tension that was experienced during the institutionalisation process.

As per the findings in Chapter 7, symbolic institutional work plays an important role in the institutionalisation of an initiative. Symbolic ownership precedes and influences the likelihood that concrete actions towards ownership can be successful. Malawian respondents used family as a metaphor for explaining ownership. As per the quote below, CCPF as a new initiative was equated to being a child, with the government being its parents, and the parents want to look after their child, as it is their child. However, they require the assistance of others to do so well.

> *So, you know the government, it is just like a mother and a father who has got a lot of kids. For example, when I consider the Malawi government, it is like a family which has got 10 kids. So, for a father who has fewer (resources), assume and say, he needs assistance with one or two children. The father says, yes that is great! And if there is an agreement, that I will assist you maybe for 5-years and after that, I will hand over your children. The father will say, ok, I don't have any option, I have to agree because they are my children. But he knows, deep down in his heart, even though this one is going to give me my son or my daughter, I don't think my family can afford to care for the child in the way how this person was assisting the son or the daughter.* Interviewee 051 (District)

When operating under a national identity logic, ownership is thus achieved by the perception created, i.e., one of government showing leadership as parents, even if it is not yet fully able to care for all the needs their child may have.

Through the frame of development logic (results and outcomes-oriented), the NGO approached ownership as something transactional to be achieved through clearly defined actions that will result in measurable results. However, actions that would be considered pro-active, efficient and even supportive in one operating logic (the development logic), led to symbolic acts of misrepresentation of ownership, as perceived by the opposing operating logic (Malawian national identity logic). This contradiction in the two lines of logic at play was highlighted in interview data and how the limited symbolic representation of government ownership during the institutionalisation process resulted in confusion, scepticism, and distrust among some actors (from within and external to government) as to who the true owner is. These actors stated that, even two years after the MoU was signed, the innovation still created the perception as being a 'project' external to the health system, driven by outsiders (NGO-led) and lacking the symbolic value and identity required for ownership and institutionalisation as a government 'program'. Projects were held to the donor logic of initiatives achieving results, but limited in their lifespan, unlikely to be sustained and only for a selected region or group. Programs, on the other hand, were considered to be government-owned and led initiatives.

There were several examples cited by Malawian actors that were interpreted as limited Malawian ownership of CCPF. The first example of this was the actions of the NGO to lead the drive towards having the government absorb all 29 hotline nurses. For the NGO, once this was achieved, then the initiative would be considered to be institutionalised. The NGO regularly emphasised this during meetings and even took initiative to call a steering committee meeting where this aspect can be discussed. A second example, the district health management teams (DHMTs) needed to be made aware of the initiative, and thus the NGO sent several of its team members to introduce the initiative to the DHMTs. From a development and project management logic, the actions taken by the NGO to lead the institutionalisation process would be considered appropriate steps. However, it did result in some conflicting sentiments from Malawian government actors at the central and district-level who felt that these actions failed to give the symbolic representation of CCPF being a government-owned initiative. According to the government actors, the NGO should 'handover' and then move into the shadows, such that government can take and be perceived to be taking the lead. Other interpretations of 'handing over' was explained by actors as an experience of top-down imposition – being forced to take something on before one is ready.

"It came from somewhere out there and implemented by the outsiders which are very difficult for us to say can we embrace it because it's now, they are doing handovers. I see it as they are still on the drawing board. If you say hand over, you just hand over and you are in the background, let the owner of the handover start embracing it. Not the actual doing but the talking. You start with them (government) doing the talking. But they (the NGO) are still at this time calling meetings. With the Chipatala cha pa Foni showcasing, they (NGO) went to the College of Medicine, so it is getting complicated because at one time I said, 'Are they really stopping, or they don't want to stop?'. At one point they (NGO) wanted to go and train the lectures at College of Medicine and then we (government) were like what's happening? When you do the handover, you do it completely and you stay in the background. They (NGO) even called another one (steering committee meeting). Then I am saying, what are these meetings for? Because if this thing is already embedded in the ministry of health, we should not be hearing of it once a quarter if it is already incorporated. It should not be a special thing." Interviewee 046 (Government)

"Okay for me firstly the way I was taught for every activity that is being done by a partner, still the lead person should be someone from the government. Mmh, we are not sure until now, we are not sure under which sector does it fall. It is completely being done by [the NGO] and we have two months to go now. And the plan is that when it's time to hand over, there will be a 2-week period where they will be shooing that person who I think is not enough." Interview 045 (Government – District)

Thus, despite all the recommended project management actions taken to advance institutionalisation, the failure to pay closer attention to how these actions came about and what they may symbolise, was a limitation of the ownership, and thus a hindrance in the institutionalisation of the initiative. Despite the positive associations of donor-led implementation and even the negative associations of government implementation, the likelihood of success of institutionalisation is still more strongly associated with maintaining/working towards government ownership, as a representation of Malawian identity.

9.2.2 Contradictions in logics associated with personhood: Malawian collectivist versus Western individualist logic.

The second type of logic contradiction that was identified in the data as influencing the institutionalisation process was the presence of a Malawian collectivist vs. Western individualist logic. The influence of this contradiction in logics was first inductively identified from broader data gathered the implementation approaches associated with non-Malawian and Malawian initiatives. Subsequently, data specific to the CCPF initiative was deductively analysed to assess whether and how these logics would influence the institutionalisation process.

Respondents described the implementation approaches adopted by non-Malawian initiatives as a key reason for why the institutionalisation of these initiatives would often be resisted by the government. The prevailing sentiment of government actors interviewed, irrespective of the level at which implementation occurred, was that projects led by Westerners often followed a top-down implementation approach. The negative consequences of these implementation approaches which fail to engage all participants in a meaningful manner, beyond tokenistic consultation, are well described [439-441]. Although this literature mainly describes the top-down implementation in the context of policy makers imposing directives on frontline staff, the same sentiment is often experienced by Malawians (central and district level government actors) when Western implementers operate in the country.

> *"We don't like the ideas to be imposed. First of all, it should be that the both of us should understand and accept".* Interviewee 014 (Government)

The tension experienced by Malawians, due to Western implementation approaches can be explained by a contradiction in the logics of personhood held by each group. As described in Chapter 5, a Western logic of personhood is based on an essentialist, individualist and intellectualised way of being a person. In this logic, the individual expert takes centre stage and where achieving success and outcomes are idealised. Malawian logic subscribed to a notion of 'moral personhood' and being a moral person cannot be achieved outside of the relationship with another. Togetherness, co-membership and co-belonging are not merely for the purpose of achieving outcomes, rather it is inherent in being and becoming a good and moral human being. As per the moral theory of Ubuntu, *"I am because we are"* represents a deeply embedded and far-reaching institutional logic, in which collectivism, relationships and compatriotism trumps individualist rule-bound and rigid bureaucracy inherited by African countries from periods of colonial rule [377, 399, 442]. The Malawian logic regards progress as collective expertise gained through engaging all members of the respective social group, as described in Chapter 5.

> *"It is one of the values of the Ministry of Health, you cannot do anything alone. It is the Ministry of health, while sometimes there is that there is no perfect machinery, but it is not uncommon for the Ministry of Health to do this. This is one of the values to work together, to collaborate. That is why the Ministry of health have so many partners and so many partners can work with the Ministry of Health because collaboration is very valued in the Ministry. It could be part of Malawi culture, but I comfortably comment on the Ministry of Health. But in Malawi, I know there is this spirit of Ubuntu. When you go into the community there you are not alone. You cannot do anything alone especially when it is when somebody is in trouble, people always come to support. So, this is the culture in Malawi but in the Ministry of Health, it is one of the values.* Interviewee 015 (Government)

Many government respondents and other Malawian respondents highlighted what their expectations are of collectivism. It would entail the engagement of Malawian actors – at central-level and district-level actors as well as communities – starting at the idea stage, even before any implementation occurs. This engagement needs to be open and transparent, with all information disclosed. Engagement also needs to give opportunity space for input to be given and adjustments to be made to projects and not merely be used as an approach to inform actors.

> *"However, most of the NGOs coming to the district, they come with their own project already made somewhere, so it's always difficult because it's always donor-driven, that is, and if a donor wants an NGO to tackle a specific area, it doesn't matter that we are lacking more in a different area."* Interviewee 011 – (Government - District)

> *"The other issues are, I think this is a clear demonstration of how most of the projects that donors tend to bring occur. They tend to bring projects without, for example, I am not sure whether the application for the grants was made together with the government but what I have noticed is that an institution will write a proposal, agree with a donor, work out the costs without government, and they will implement, and all those costs are not disclosed to the government. The moment they disclose it, it is too late or there are huge costs that government cannot take up.*" Interviewee 049 (Government)

> "*We just impose some of the activities on the communities, we tell them, we are in the offices we set our objectives and our strategies and then we just take them to the communities. By the time the project is phasing out it is the same time that we are finding out that the activity on the ground is also going. Ja. There are a number of them in Dedza and even here in Zomba and in Mangochi. A number of projects have failed. But with this approach of the community identifying their own problems I hope it will work…The other issue is that you might be found, you get a donor, they are funding a certain project and the project is failing but when the donor is coming, say he wants to see some if things improved in an area, you will see that most people they go there in the community and then they do rehearse to give a picture that things are working in the community but it is not like that. Where things are failing, we should accept that things are failing and then we should change strategies but most of the time they do rehearse, to convince the partner that things are working. And mostly, most of the time, when they go to the communities, they work with only a few individuals. They do not present to the whole community. That is the other challenge. Ja*" Interviewee 034 (Government – District)

> *"So, getting the buy-in from that structure is critical before you actually bring in the programme. And then actually introducing the tool or the approach but really getting thought of how to implement from the district health team. Then you get the buy-in. Most of the time it is us telling them what we are bringing, and this is what it is going to do. It is ok to do that but it is also good to listen in terms of listening but yah sure this thing is great, but if you do x, y, or z, or whether it is humouring them in a way because we have our rigid way of thinking as well, as in 'this is the way it's*

supposed to be done, whether it is actually humouring them to try it and fail and then correct the mistake together I think is when you get the buy-in. Otherwise, it becomes an HP+ project, a Save project, a USAID project, and it is never our project." Interviewee 054 (Donor-funded Malawian health Implementer)

According to Malawians, collectivism ensures that implementation is successful and that it can be sustained with an increased likelihood of institutionalisation. Through examples of past projects shared by Malawian interviewees, they had a clear process for a collectivist engagement at each project stage. Table 9-1 below highlights the preferred process by which new initiatives should be introduced and implemented in the country, as described by the majority of senior government respondents.

TABLE 9-1: Preferred Process of new initiative introduction and implementation (Source: interview data)

Components of the Process	Process Details	Channels or Structures to be honoured
Problem Identification	- Addressing a problem that has been outlined in annual district health implementation plans, health sector service review or health sector strategic plan. - Sitting down in discussion with relevant structures to identify a key need they have	Central level: - Technical Working Groups - Relevant Technical Department - Planning Department District-level: - District Health Management Team Community-level: - Area & Village Development Committees
Project Ideas / Design	- Discuss, brainstorm, and refine ideas with relevant structures based on input received	
Project Implementation	- Define roles and responsibilities - Define timelines (especially if to transition to government) - Develop a joint implementation plan and roadmap - Conduct relevant skills training for relevant government departments. - Include relevant structures in the implementation (avoid creating a parallel structure) - Conduct a pilot with evaluation evidence gathered. - Present findings of the pilot back to relevant structures	Central level approvals - Senior health management committee. - Sign a Memorandum of Understanding between relevant parties and government District level approvals - District Council (to include Traditional Authorities)

As seen in table 9-1 above, through the lens of the decentralised Malawian health system, a dual set of structures are to be consulted and engaged with to provide input in projects, even before implementation is to commence. Multiple respondents agreed that the likelihood of successful institutionalisation success depends on whether all the relevant structures at the central and district level were being engaged with.

"Many are the times, because most of the partner, some of the partner they can just go to the central level and discuss with the central level and then they just come here. When such a scenario arises, it is a bit difficult for us to say no because they have already discussed it there. So, what they discuss with the central government or with the central level, and they come here to the district, and they said we already discussed, for example, we have already discussed with the Ministry. We have already discussed with the directors, so the directors said we should come here and do A, B, C, D. Once that arises, there is nothing we can do because they have already discussed." Interviewee 051 (Government - District).

"But at the same time if you come in like a partner comes in and implements the projects themselves without eh ministry or without eh department working with them. The people there, the people whom they are working with, they always think, okay, we are doing this because the partner is seeing us. And when the partners' leaves, they know there's nobody to supervise them, they don't own it. It's like the partner who was going there now and then was the owner so when he goes everything goes. Interviewee 024 (Government)

As listed in Table 9-1, multiple structures, and actors, at various levels of the health system in Malawi need to be engaged. The logistical implications of Table 9-1 are that this process requires engaging with actors at different forums that take place at different time intervals and different geographic locations. This approach requires time – this is one of the greatest resources in support of institutionalisation.

Temporality, or time as a resource, is a construct that is regarded very differently in African/Malawian logic as compared to Western logic. In the West, the saying often goes 'time is money, emphasising efficiency and effectiveness. However, in African culture, similar to many other indigenous cultures [443], time is not a linear construct representing a clear beginning and end, with something to be achieved between these points. Rather as Cilliers [444] points: "In Africa, time is not so much duration as it affects the fate of the individual, as it is the rhythm of the breathing of the social group. Perhaps the image of a spiral depicts best what Africans understand as time – a spiral that includes both linear and cyclical dimensions, as it reflects the rhythms of life." Time or temporality could thus be seen as the underlying 'mechanism' of a logic that is either individualist or one which creates space for sharing and communality. As Cilliers [444] further explains, the African notion of 'now' is different from the Western understanding of the 'present', as in the 'now' is the quality of the experience shared with other actors.

Time is thus inherent to the concept of Ubuntu, upon which African and a Malawian management logic is built (see Chapter 5). This time-subservient collectivist process stands in tension with the western logic of

efficiency, and thus Western implementers often selectively choose structures to engage with, to support their logic of efficiency.

i. Tensions due to contradictions in logics in CCPF institutionalisation

Taking a closer look at the CCPF initiative, contradictions in logics surfaced. The contradiction between an African and Western logic, influenced the extent of engagement with other actors (e.g. district level actors) and the appropriation time during the institutionalisation process. The section below describes an initial collectivist logic applied to the implementation of CCPF and then how a shift of logic occurred in 2017, to a western individualist logic, and thus a change in the CCPF implementation approach. This change in the predominant logic held in implementation and institutionalisation resulted in tensions that placed institutionalisation success at risk. The change to a more Western logic, led to a more centralised institutionalisation process versus a more process in line with the structures as per a decentralised health system (as listed above in Table 9-1).

Chapters 6 and 7 described how the CCPF social innovation started as a community and district-level embedded initiative, closely aligned with all the relevant structures (as per Table 9-1) within the context of a decentralised health system. Of note, at this time (2012-2017), the project was led by a Malawian national. Informal interviews and informal discussions with him, he explained how he made efforts to engage all structures and people who were affected by this initiative (traditional and community leaders, frontline workers, district health managers). He also prioritised working through these structures versus implementing them in parallel to them. Not only were community and district level structures engaged, but also central level technical departments in addition to donors and other partners. This collectivist engagement approach from 2012-2017, fostered a sense of shared ownership of the CCPF social innovation among all involved. Other respondents, who were involved in this stage, including field implementers, frontline workers and community leaders, also reflected on their involvement and how CCPF was perceived as 'their' initiative. This demonstrates the Ubuntu and collectivist implementation approach inherent in this logic.

Once the adoption was formally achieved in 2017, a much greater focus was placed on the central level of the MoHP, especially as the initiative moved its physical location onto the premises of the central MoHP in Lilongwe. However, in seeking to achieve ownership through embedding all technical departments and external partners at the central level (through the Steering Committee structure), district and community health structures were not engaged to the same extent. The Malawian project lead (2012 – 2017) further reflected how the new non-Malawian project lead (2017 onwards) diverged from this initial approach to more

exclusively focusing on central level government structures and donor partners. From data triangulated, this appears that it may be due to four reasons: first, the initiative reached a more national scale with implementation across multiple districts, thus making it more complicated and time-consuming to involve all relevant district-level actors; second, until this time, the NGO had been responsible for financially supporting and fundraising for the initiative and the longer the institutionalisation process continues, the more funding it would need to solicit; third, the non-Malawian lead's appointment contract with the NGO held a clause about achieving successful institutionalisation and fourth, a lack of fully understanding the symbolic and cultural meaning derived from a collectivist implementation approach.

In the context of a decentralised health system like Malawi, the central government level is intended to guide implementation, while the district level is meant to be the implementers. Engagement at the district level in the institutionalisation process, was only started towards the end of 2018 – 2019. This engagement was not to the same extent as when the initiative was first introduced in the pilot district. In new districts where the initiative was introduced, there was only one brief meeting with district health management team. By focusing the institutionalisation process at the central level and not to the same extent at the district level, in the context of a decentralised health system, government actors (at district and central-level) questioned the ownership of CCPF as truly a government-led initiative. It appeared as an initiative implemented in parallel with district-level structures rather than in partnership with the district level.

> *"So, we are using them as an office, but we are also trying to engage already existing structures in the district, so it goes back to what I was saying to say, ok because the office feels involved, the people feel they are involved and then they are more eager to say ok, I think we are in this together. Putting effort is much, much easier than thinking that you are operating in a parallel manner. We are doing our thing, and Chipatala Cha Pa Foni is doing its own thing, but that sort of engagement then removes the parallelism and puts you on the same track."* Interviewee 053 (Government - District)

It is further worth noting the role of temporality (time) within these processes. The adoption process was achieved more slowly for 5-years, in contrast to institutionalisation which was intended to be achieved over 2-years. In the MoU signed between the MoHP and the implementing NGO in April 2017, the intention was stated to have institutionalisation completed by 30 June 2019. Actors across different levels expressed their concerns with the 2-year institutionalisation timeline and proposed a phased approach over a longer time frame (5-years). This would allow for the resource burden to be shifted gradually from the NGO to the government and not all at the same time e.g., staff gradually added onto the government payroll, a few at a time, as and when government budget becomes available.

> *"So, the previous experience was important for us. The other thing which was also important was, this is the government, we shouldn't say we are transitioning on this date. We shouldn't dictate things. We should wait on them. If we don't have money to run beyond the dates, we should just be honest with ourselves. Ok, we will just stop a little bit here and wait for you, but this is how Chipatala Cha Pa Foni works and it is important that just give them the value on their system. So, maybe and they also, they as I mentioned, they would know what department would be relevant. Not just now, but even for the future, you know. For me, this is prevention, and it is education. So, Health Education and Community Health, those were the very best departments who we were supposed to align with."* Interviewee 007 (NGO)

The signing of the MoU occurred within a similar period of transition in leadership within the NGO. As mentioned above, the adoption process was stewarded by a Malawian national (project officer) working for the NGO, his role was taken over by a non-Malawian national. This resulted in a change in implementation logics – from an African-centred logic to a Western-centred logic, which appeared to have been based on recommendations made by the NGO headquarters in the United States. To achieve this deadline, interviewees corroborated that it appeared the new project lead aimed to do so in the most efficient manner, thus focusing their efforts on the central-government level to meet their own contractual employment obligation. No explanation was found in the data as to why this period was selected as a deadline by which institutionalisation is to be completed but could likely be due to the financial resources the NGO would have to solicit to continue support for this project.

> *"What [NGO] is doing is to put up their management systems. So, the government must put in management systems, we have to develop protocols on how to run Chipatala Cha Pa Foni, we have to come up with guidelines and policies that are related to running Chipatala Cha Pa Foni. This is an innovation, and those things need to be done now before we take over.* Interviewee 015 (Government)

As noted in Chapter 5, Malawi is a decentralised health system. However, due to the nature of this being a mobile-health innovation, beneficiaries could be reached directly via their mobile phones and by promoting the initiative to them via mass text media promotional messages. Where the district level usually acts as a gateway to the community, the initiative was able to reach a national scale by circumventing the district level structures. However, although the growth of the initiative could be achieved by directly reaching beneficiaries, it posed challenges in terms of whole-system institutionalisation. District health offices were only made aware of the initiative (not involved in it) in October 2018, 8-months before full health system institutionalisation was to be completed. At the time of completing the data collection, shortly after the set date for institutionalisation to be completed (30 June 2019), it was evident that it was not yet possible for the Ministry of Health to manage the day-to-day operations of CCPF independently: the 28-nursing staff did not yet

receive positions as part of the government establishment; skills transfer - especially for the management of the technology infrastructure - was incomplete; no permanent positioning for the initiative was found within the government structure and no government operations manager was appointed from within government to lead the day-to-day operations. Donor partners thus were solicited to provide additional funding for a further 3-months as a stop-gap solution.

Several actors interviewed, suggested an alternate institutionalisation structure for CCPF, one closer to the model adopted in the pilot district and more embedded in district-level health structures. District-level, as well as central-level actors, was stated as being responsible for implementation and it should not be the role of the central government to attempt to do so (as which was being pursued). Each district has its own assigned health budget and capacities which could be leveraged to support the project. Rather than having one central call centre, suggestions were made to have several smaller ones located at the zonal level, of which districts are amalgamated into one of four zones.

> *"Yes, the issue of disjoint at the central level - decentralisation - because the central level is the ministry of health which has a policy technical direction while the implementers, majority are under the ministry of local government and rural development…the DHOs….so to leverage these two, Chipatala cha pa Foni as you have seen or heard it has been centrally managed….we have not involved the decentralization structures properly, so this district orientation is very key because now the challenges which now village reach was facing will now be our own challenges as Malawi government and implementation has always been a challenge for government programs."* Interviewee 038 (Government)

Respondents further suggested that district-level health budgets could be used to hire 1 – 2 additional nurses each. These nurses could leverage the supervisory support of existing local health centre staff and could be closely linked to the district referral structures for follow-up and monitoring. One of the ideas which were tried in 2019 was to have the hotline nurses apply for positions with the Lilongwe district, but the number of nurses was too great for the Lilongwe district to absorb. Leveraging these existing structures and decentralising institutionalisation were suggested as ways to ensure the long-term sustainability of CCPF and enhance the capacity of the government to manage the initiative without the NGO's support.

> *"At the district level, [the NGO] needs to provide one of their key staff who is conversant with how CCPF works to be working with government so that they are doing on-job mentorship as well as providing technical support on how they are implementing the project. But if [the NGO] only goes on top, and they provide the key people then, I think in Malawi, that doesn't work."* Interviewee 032 (Health Implementer – non-CCPF affiliated)

> *"At the same time, we have a very good referral system where we could refer those people who have any issues. If not decentralised and if centrally positioned, those people when they get a call, they have to link to the district health office on the problem which the person is coming from, which area is he. They should localise it, they should refer the patient to us and at the same time they should refer us to the patient or the client so that we can link the Chipatala Cha Pa Foni and the services we provide."* Interviewee 034 (Government – District)

Anxious concern was a common emotion expressed by government actors. Their anxiety and concern were founded upon not having had sufficient time to gain the skills required to manage social innovation independently. One government actor expressed his anxiety by comparing the handover of innovation to the government without the right skills, to that of asking an untrained pilot to fly an airplane. He felt this would result in yet another tragic failure: '*ok go and drive this Boeing Max…they will have this tragedy'*. Another district health official used an agricultural metaphor to compare this social innovation to a seedling, which, if given adequate support and the optimal environmental conditions and time, would be able to grow and flourish. Without these, the seedling would die. Respondents proposed the following preferred approach: first, a longer and more phased transition, in which the NGO will withdraw support gradually in response to the government's developing sufficient capacity; second, technical capacity building support should be provided from the beginning to ensure government actors have all the necessary skills to maintain the day-to-day operations of the initiative; third, the government will be evaluated by the NGO to determine their level of capacity and whether this is adequate before they withdraw; fourth, the policies and procedures will be cascaded down to district level, ensuring district health officials are aware, willing and accepting of the initiative and fifth, concessions will be made for arising contextual situations that result in delays e.g. the disruption caused due to the contested national elections that resulted in government budgets not being allocated. All these steps would ensure that the required capacitated collectivism is in place to sustain this social innovation within the context of an African health system.

> *"Yes, to me, I think how you can transit this thing is the way how we do the handover process of our seedlings. When we are about to take our seedlings from the nursery into the main field, we accept the watering almost daily and then later we try to water maybe once a day, and then maybe to skip another day we are trying to make those seedlings harden. So that when you remove them from the nursery into the main field they should withstand the harsh environment in the field, considering most of the seedlings you transfer into the main field during the sunny season. So likewise, as we are transiting from you to us, as you are handing over from you to us, you should not please pass abruptly but you should continue assisting us maybe for another year. But the assistance should be slightly decreasing little, little, little by little until you see that during that period we should be meeting and evaluating how we are progressing. Not just 3-months because I think from June, now it is 31st of July we are only remaining with 2-months. Now 2-months, as you see how things are going on in the government, the government now is just at a standstill, the*

things that are going on, so 2 months may elapse without coming up with a tangible thing and we say, now we are handing over. All the government system has just stood still the way how the political situation is going on. So, I don't think 3-months is enough. Why can't you give us about a year?" Interviewee 051 (Government - District)

"My take would be that it is good for the government to take over, but they should be handed over slowly whilst the government is being built capacity because if they hand it fully to government, I am afraid it is not going to be implemented fully but if it is handled in phase. They hand over slowly, they build capacity, they address the challenges so that they take them in stages so that they see where the challenges are and they provide the technical support where government need and, in the end, they will be able to say, ok, you are able now to implement because we have said these are the challenges we needed to do. And if those changes are handled right, they must ensure that policies are also going down to the district so that they should embed the CCPF in them. The community mobilisation will ensure that when they are handing over in stages, they will be able to also monitor the districts, what challenges the districts have so that they should advise. So now it is an advisory role, you are managing handover in stages at the national level but at the district level you are monitoring and providing technical support at the national level so that they provide direction to the district level so that their project should be adopted the at the district level." Interviewee 032 (Project Partner)

"No, I'm telling you what will happen [it will fail], because it is the handover bit. People are afraid of carrying over something that they don't know." Interviewee 046 (Government)

9.3 Conclusion

This chapter came about by paying attention to the conflicts and tensions that arose during the institutionalisation process from 2018 – 2019. Although these findings do require further and more in-depth investigation over a larger sample of projects implemented in Malawi, it merely aims to provide some initial explanatory understandings that can be tested in further studies.

Health policy and systems research (HPSR) has ascribed implementation approaches, whether top-down or bottom-up, as a factor influencing the outcomes of programs and interventions. However, it has not provided an explanation as to why these different approaches may be chosen by implementers or perceived as such by implementees. This chapter highlights the influence of institutional logics, operating as a software factor, on implementation and institutionalisation. The logics identified in this chapter highlight the supra-organisational patterns at play, patterns that go beyond the strategy of an individual or an organisation, but which operate in an unspoken and unquestioned way of being and doing. These logics had a particular impact upon whether symbolic and actual national ownership of the CCPF social innovation initiative was achieved.

As found in this chapter, the history of a nation, especially in the regard to colonial influences and independence, influences the broader institutional logics. The legacy left on African nations, by other nations who ruled and governed them for periods, is still very relevant in the national-identity logic held by Malawian actors. Implementation approaches by non-national actors, whether intentional or as most often is, unintentional could awaken embodied historic trauma [445] at a sub-conscious level, which results in actors either feeling unacknowledged or disrespected, and subsequently rejecting new initiatives. The concept of national ownership and pride in national identity needs to be conveyed by non-national implementers in both tangible and symbolic ways. Micro-actions conveying symbolic (perceived) ownership, is an important pre-cursor on the pathway of achieving actual concrete national and government ownership. A national identity logic is also associated with universality, durability, sustainability, and respect for cultural values. These values take precedent, even at the cost of sub-optimal implementation and in contrast to a time-bound results-oriented donor logic.

Cross-sectoral collaborations between non-state and state institutions further benefit from an awareness of different logics, and especially the influence of these logics within the context of a decentralised health system. And more specifically, being aware of how symbolic acts and time as a resource are appropriated differently in each. As described by interviewees, in Malawian logic, time is not the master of the social group, but rather the servant. Collectivism trumps efficiency. Timelines thus need to be approached with a greater degree of flexibility, not as an end in itself but subject to when all members of the social group (especially the district health system) have adequately been engaged and capacitated. In this way, the focus is not on the individual to own or manage an initiative but on the broader collective whole.

A western logic, which is also the same as a development-logic in this case, is based upon expediency, efficiency and achieving results. Although it has a high likelihood of delivering the intended outcomes for beneficiaries, it may not most suitable to achieve the institutionalisation of an initiative. In contrast, the Malawian logic values achieving whole-system involvement and key actors 'moving together. Sustained achievement of beneficiary outcomes as a value of national identity is held in greater regard, even at the sacrifice of efficiency. Various Malawian proverbs capture the essence of this: '*Mutu umodzi suzenza denga'* meaning, one person can't carry the roof by themselves; '*Chala chimodzi sichiswa nsabwe*' meaning, one finger does not crush a louse' and *Kuyenda awiri simantha koma kudziwa,* meaning working/walking in pairs is not a sign of fear but wisdom.

The nature of the institutional logic is an important influence on the institutionalisation process and thus also on the long-term sustainability of new initiatives, such as social innovation. Failure to pay attention to the specific logics at play can result in institutionalisation fractures and implementation failure which, despite the goodwill, efforts and other resources invested, could leave government actors feeling short-changed in their chance to achieve success.

10 DISCUSSION AND RECOMMENDATIONS

10.1 Introduction: The purpose of this study

Chapter 1 highlighted the need for localised innovative solutions to support the attainment of Universal Health Coverage (UHC) [8, 9] and that broad-based social participation of all health systems actors (citizens, communities, and non-state organisations) working in close collaboration with the government is imperative [30, 446, 447]. Social innovation, as a means to achieve particular outputs, and as a process, has been applied in many low- and middle-income countries (LMICs) to address system failures hindering the delivery of healthcare in LMICs (see Chapter 3) [3, 61]. Despite the burgeoning scholarly and policy interest in this field, peer-reviewed evidence on social innovation in health remains limited [61]. The literature describes social innovation as conducive to achieving large scale systems transformation, yet the question remains whether social innovation has true promise for strengthening health systems in LMICs to improve access to essential care. Or rather, is social innovation merely a distraction from tried and tested programmatic efforts, and a means to drive political agendas or a naïve development shortcut [132, 448]?

The focus of this doctoral research study was to fill the gaps in the current evidence base by bringing a deeper understanding of the application of social innovation in health systems in an LMIC context, as studied through an institutional theory lens. The original contribution of this thesis lies in that it is focused on LMIC health systems, exploring social innovation through an institutional lens and focusing on a local innovative solution contributing to UHC.

Scholars have further highlighted how social innovation's system-transforming potential is dependent on being institutionally embedded or institutionalised [1, 197]. Thus, despite social innovations in health being increasingly recommended and attempted in LMICs, their potential to support health system strengthening is dependent on whether they can be embedded and integrated into the public health system and delivered at a national scale.

The overarching aim of this research study was to assess whether public health systems in LMICs, specifically in the case of the Malawian public health system, would be able to adopt and institutionalise a particular social innovation; and if so, what software factors are conducive to the achievement of this goal. Software factors can include management processes and other organisational practices but also relational, value-related and

affective factors [13, 16]. Building on both health policy and systems research (HPSR) and social innovation research as transdisciplinary fields, this study adopted an interdisciplinary approach. It drew on literature and theory from a range of fields including public health, sociology, psychology and organisational and management studies to meet the five objectives set out in Chapter 1 [63].

10.2 Main findings

This section provides an overview of the main findings discussed in Chapters 3 – 9. First, it highlights the study findings reflecting the current understanding and investigation of social innovation in healthcare, as well as the limitations, informed by Chapters 3 and 4. Second, it presents a synthesis of the key findings that emerged from the application of the social innovation study framework to the 'Chipatala Cha Pa Foni' innovation in Malawi in Chapters 6 – 9. The concluding section identifies recommendations about social innovation in the context of health policy and systems research (HPSR) and practice.

10.2.1 Current understanding and limitations of social innovation in health care

A semi-systematic narrative scoping review was conducted including all published peer-review literature on the concept of 'social innovation' as applied to the domain of healthcare from the past 10-years (Chapter 3 and published in the Journal of Infectious Diseases of Poverty in March 2021 [61]). The first finding from this review is the challenge associated with different methodological reporting standards from among the different disciplinary articles included in this review – demonstrated in the small number of articles that fit the inclusion criteria. Often social innovation research methods were not reported and if reported, the reporting was done with limited information, thus making it difficult to assess the quality of the evidence. The case study methodology was the most common. It was found that the socially, politically, and geographically embedded nature of social innovation poses a challenge for comparison studies. There was also a clear gap identified for studies to be conducted by LMIC researchers and in resource constrained LMIC settings, as most studies to date, originating from high-income countries, and thus the application of the findings to LMIC settings is further limited.

Second, this review focused on social innovation's application to health found that the conceptualisation used were often narrow. Social innovation was conceptualised mainly through a technocratic paradigm, with social innovation as a product or service aiming to achieve greater effectiveness or efficiency in healthcare or as a process focusing on increasing beneficiary participation. The technocratic social innovation paradigm is in

line with a reductionist view of health systems as machines as well as with neoliberal political agendas [11, 14, 132]. The value of social innovation in achieving these utilitarian outputs remains important. However, its application through a technocratic paradigm does not provide evidence of whether social innovation also supports progress towards people-centred health systems (health systems that recognise the role, relationships and values of health system actors [192]). Neither does the technocratic paradigm on social innovation indicate whether enhanced participation, facilitated by external experts, leads to greater levels of empowerment, agency and ownership of health and healthcare.

Thirdly, the review demonstrated the intersectoral, boundary spanning and holistic nature of social innovation initiatives in healthcare. This aligns well with the Sustainable Development Goal approach, which requires a shift to more cross-disciplinary multi-stakeholder integrated action. A few studies highlighted how social innovation projects which had longevity (10+ years) promoted sustained systems and institutional transformation. Although only these studies examined social innovation through the institutional paradigm, the findings were rich in identifying factors that enabled successful and sustained change. These studies provided helpful direction to practitioners wanting to replicate the lessons in their own settings. If social innovation's potential to achieve sustainable systems transformation for the achievement of the SDG's is to be realised, the application and study of social innovation through an institution paradigm is required.

Building upon the gaps and limitations identified above, Chapter 4 extended the depth of this inquiry of social innovation through institutional paradigm, by drawing on social innovation literature and theory from different disciplines. This chapter identified several academic and pragmatic contributions social innovation theory could make such as: overcoming limitations in commonly applied innovation theories in public sector contexts; approaching the health system more holistically, as comprised of multiple interconnected levels of action and influence; and testing a new conceptual framework for its broader application to HPSR. Each contribution will be further discussed below.

First, studying social innovation through means of institutional theory can address the limitations of other more commonly used diffusion or scaling theories applied to public sector innovation. A limitation of existing theories is its approach to innovation adoption and scale as a process of standardisation and control as opposed to a continuously evolving process requiring multiple iterations and adaptations. These theories are also limited in their overemphasis on resource and hardware issues in upscaling innovation and thus failing to account for the software or institutional forces as explanatory factors of the adoption and institutionalisation process.

Second, the institutional theory was identified as better suited to the study of social innovation within a health system context. A conceptual social innovation framework proposed by Van Wijk's et al [43] was able to more holistically accommodate the study of social innovation from a complex health systems perspective by accounting for the multiple and interconnected levels of action and influence. This conceptual framework incorporates different institutional theories (institutional entrepreneurship, institutional work, and institutional logics) as applied to the micro-, meso- and macro-level respectively. The framework is more sensitive to the identification of software non-instrumental factors influencing the institutionalisation process, as compared to other health policy (Kingdon's policy streams) and social innovation (Hollings resilience cycle) frameworks (See Chapter 2). Although these latter frameworks supported understanding the evolving process of adoption and institutionalisation over time, they did not provide a structured way to assess affective and process-related software factors. Findings from this study presented in Chapters 7 -9 revealed that software factors had a key influencing role in the institutionalisation process, not just at a micro-level but also at a meso-group level and a supra-organisational context level.

Third, this study modified the micro-and meso-level of van Wijk's framework by incorporating theory from Positive Organisational Scholarship (POS) and positive psychology, and, in so doing, extended its potential application in HPSR beyond social innovation (Chapter 4). Both POS and positive psychology consider the positive or life-giving processes within organisational life. This theoretical orientation serves to provide the researcher with a lens through which to approach research, starting from the premise that good and virtuous qualities and practices exist and can be identified; similar to the glass-half-full analogy. This is in contrast to the deficit-based orientation, often implicitly adopted in health policy and systems research, focusing predominantly on the identification of challenges or failures; and promoting change to overcome these. The addition of this theoretical orientation to the framework strengthened its capacity to not only identify types of institutional work that can support social innovation but more specifically identify positive practices (Chapter 8) and positive emotions (Chapter 7 & 8).

Notably, this is not the first time POS is merged with institutional theory. Nilsson [271] also applied it in his research within social purpose organisations. However, the inclusion of positive emotions and specifically that of hope is a new contribution (see more below). In the field of HPSR, this study offers the first application of this positively oriented, institutionally underpinned, framework in an LMIC health system setting, applied to a social innovation case study. The positive nature of these practices and emotions allowed them to be classified in this study as a form of non-material resources present in organisations. In so doing, this broadens the relevance of the framework as positive practices and positive emotions could likely be factors present also present in non-social innovative initiatives. This framework would merit further testing

and application more generally in HPSR, beyond the just investigation of social innovation, but in studying more generally the institutionalisation of programmes and policies.

10.2.2 Software factors influencing the adoption and institutionalisation of social innovation

The social innovation case study under investigation was 'Chipatala Cha Pa Foni's (CCPF – translated as *Health Centre by Phone*) adoption and institutionalisation as part of the national Ministry of Health and Population (MoHP) in Malawi'. The idea for this initiative came from the grassroots as it was proposed by a young Malawian, and it was implemented by a non-Malawian NGO. CCPF can be deemed a social innovation initiative due to the shifts it required in the institutional dimensions of the health system. As a social innovation initiative, it called for transformation in the traditional role of nurses as bedside care providers to remote health advisors; and a re-distribution and 'democratisation' access to health information from professionals to citizens. As a social innovation process, it created a broader space for participation of people who have traditionally fallen outside the professionalised health boundaries and hierarchies and fostered a collective shared identity and meaning (see Chapter 6).

In the next section, the five main software factors discussed in Chapters 7 – 9 are described. Figure 10-1 below proposes a synthesis and prioritisation of the emerging critical software factors emerging from the research. Although the multi-level conceptual framework aided greatly in identifying these factors and encompassing practices, some of them were not exclusive to a specific framework level. Rather, they emerged as factors of relevance, expressed in a variety of ways, whether at the micro individual level (Chapter 7); the meso/ organisational level (Chapter 8); or the macro / supra-organisational level (Chapter 9). Each of the five factors will be described in more detail below.

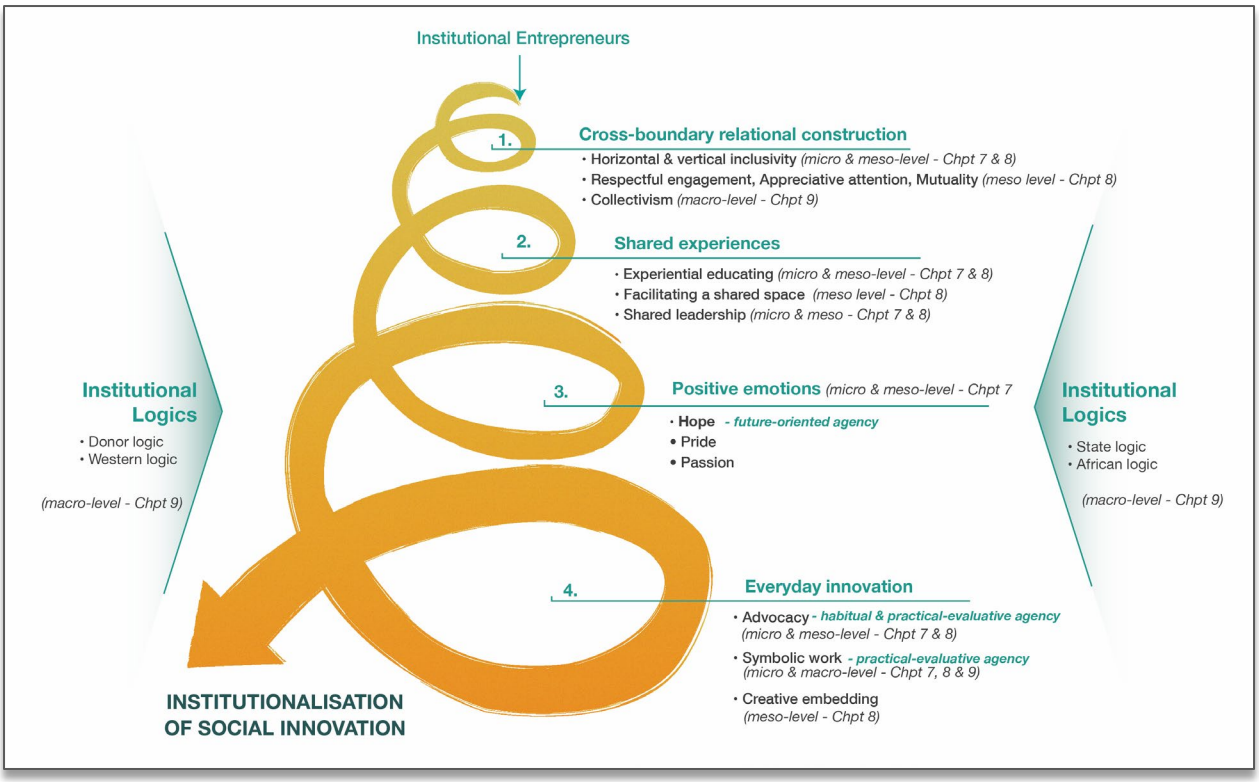


Figure 10-1: *Synthesis of software factors in the adoption and institutionalisation process of social innovation, over time.*

i. Cross-boundary relational construction

Chapters 7-9 revealed the importance of institutional work as cross-boundary relational construction, in breadth and depth. Based on the findings that emerged from each of the three chapters, relational practices were an important enabler of the institutionalisation process. These relational practices include vertical and horizontal inclusivity, positive relational practices and collectivism.

This study found adoption and institutionalisation to each be a distinct process, requiring institutional work, as alluded to in Chapter 4. Adoption entailed, as described by Rogers [203], a process where the Ministry of Health and Population (MoHP) first know about innovation until a conscious decision was taken to permit the innovation to be implemented in one district in southern Malawi by the international NGO; whereas institutionalisation entails the innovation gaining a sense of legitimacy and embeddedness in within the minds of individual government actors and the organisational routines [217, 218, 220]). In the literature, most studies have focused on the process of adoption or scaling of public sector innovations and to a far lesser extent on understanding the process by which institutionalisation unfolds and the factors influencing it. As described as a limitation in Chapter 4, studies, including those in the context of LMIC health systems, place an overt focus on understanding the drivers of innovation that support the social innovation gaining

acceptance and is initiated and implemented to achieve a larger geographic reach [449-454]; but there is less of an understanding of what it takes for an innovation to be embedded as part of the cultural-cognitive scripts such that a new institutional regime (a perspective from which meaning is derived) can arise [198].

As examined in Chapter 7, the adoption process of the social innovation initiative as part of the public health system started right at the beginning of the initiative's lifecycle (2011), when the citizen innovator first presented his idea as part of the nationwide innovation competition. This competition had the endorsement of the Ministry of Health and Population (MoHP). The adoption process was predominantly focused on the micro-level, engaging key individuals strategically, gaining their buy-in and working in close collaboration as a multi-sectoral small group of institutional entrepreneurs and displaying all three dimensions of agency (habitual, practical-evaluative and future-oriented) [238]. The institutional entrepreneurs who made up the small group were all relationally orientated individuals who held collaborative engagement as a shared value. Relational construction among small group members was thus key in supporting the adoption process and was also extended outwards to allow for involvement and work to occur in close partnership with the community and district frontline providers in the pilot implementation district [32, 417]. This approach both represented vertical and horizontal inclusivity, as well as a degree of shared leadership (see Section ii below).

The institutionalisation process, as described in Chapter 8, started once formal contractual adoption of the initiative was achieved (2017 onwards), and this shifted the focus to the meso- or organisational level. Findings revealed that the institutionalisation process functioned as a second innovation process, in which members operating at group-level proposed minor creative strategies (everyday innovation) to try and embed the initiative. Contrary to the first phase of innovation (that of the ideation of the social innovation) which brought institutional disruption (Chapter 6); this second phase of innovation was focused on embedding the innovation in creative ways while maintaining the integrity of the overall system (see section iv below – Everyday Innovation Efforts). This phase was strongly supported yet again by the breadth of relationships constructed during Steering Committee Meetings, across sectors (horizontally) and hierarchies (vertically) with all actors, departments and organisations involved (except for district health management actors).

While the breadth of the relational building was important, it was also the depth or quality of relational construction which supported both the adoption and institutionalisation efforts. Depth in relational construction was achieved based on two factors: positive relational practices and collectivism inherent in a Malawian African institutional logic.

Positive relational practices were found (Chapter 8) to support the construction and maintenance of relationships during the institutionalisation process. These practices included: respectful engagement,

mutuality, and appreciative attention. The practice of respectful engagement [428] and respectful behaviours in an organisational context is defined by how people value the worth of another individual, the dignity and care they have for each other and positive self-regard [434]. Mutuality is understood as relational reciprocity that 'involves reciprocal transactions and exchange, mutual influence and responsiveness and a sense of common purpose' [429]. These relationships embody Buber's [455] notion of 'I-Thou' which is in contrast to the 'I-It' relationships found in the workplace, in which the other is related to as something to fulfil an objective, and not as whole persons [456]. 'Appreciative' as used in the tradition of appreciative inquiry [431], refers to seeing or noticing the generative dimensions in organisational life – 'things that give life (health, vitality and excellence to living systems [432]. Nilsson [433] describes the practice of appreciative attention in which organisational members both give value both to individual gifts and vulnerabilities. These three practices conferred with what is characterised in Positive Organisational Scholarship and positive psychology (as described in meso-level of the study framework in Chapter 4) as essential in generating high-quality connections. High-quality connections are relationships with a higher degree of emotional carrying capacity, which have the ability to withstand strain and degree of openness to new ideas and influences [457]. In brief, the generation of high-quality connections between the actors involved in this social innovation could be another explanation for why these actors continued in the institutionalisation process without ceasing, despite the challenges faced. The quality of these relationships functioned as a resource in support of this process.

Another key theme from the findings is the value of collectivism displayed in the actions of the Malawian institutional entrepreneurs involved in the process. This value of collectivism practised and lived out by these actors, transcended beyond that of being an individual personal value or a good strategic management practice; rather it could be explained by the Malawian logic of personhood described in Chapter 5 and found in Chapter 9 [377, 399, 458]. This supra-institutional force played an important role, influencing both the adoption and institutionalisation processes irrespective of the stage or actions involved. Malawian institutional entrepreneurs held a shared commitment, to invite, welcome, and include everyone affected to some degree by the innovation and to pursue collaborative inquiry as an unspoken and implicit strategy, with neither of these aspects ignored for the sake of time or efficiency.

In conclusion, findings from this study show that relational construction, and its accompanying institutional practices, could be prioritised as a starting point in the process of adopting and institutionalising a social innovation as part of a public health system in LMICs. The cross-boundary (cross-sectoral and cross-hierarchical) relational construction inherent in social innovation, is in line with the approach upheld by the Sustainable Development Goals.

ii. Shared experiences

Chapter 7 and 8 identified the embodied and experiential nature of institutional work similarly to what was found by Nilsson [271]. Three practices found in this research, speak to shared experiences being a software factor influencing the adoption and institutionalisation of social innovation: experiential educating, facilitating a shared space and shared leadership.

First, the institutional work conducted extended beyond merely 'educating' work through sharing information and building skills, and it included an experiential dimension. The experiential educating encounter (government respondents visiting the hotline and also answering incoming calls) provided to and shared by representatives of the MoHP, was identified as a key turning point in the adoption process. It highlighted the importance of providing more than technical data (evidence from impact evaluation studies conducted), and in addition to that, the need to create opportunities for personalised experiences by which actors can have a first-hand encounter engaging with the initiative and sharing in the experience with the frontline providers delivering the initiative. In the case of the social innovation initiative examined in this study, this took place through government representatives and other project partners visiting the hotline and by them directly hearing from the initiative beneficiaries. No personal experience can be devoid of emotion, and thus these positive experiences contributed further to generating positive emotions (see section iii below). This experiential educating work catalysed agency in each of the three dimensions within these actors in pursuit of further 'everyday innovation' efforts in support of the institutionalisation process.

Second, a facilitated shared space ritualised social interaction involved in the social innovation initiative. The practice of 'facilitating a shared space', links closely to Furnari's [418] concept of 'interstitial spaces of micro interactions' in which a catalyst (a facilitator, host, organiser) through his or her continuity of presence and providing structure and encouragement, supports creating a shared meaning an identity between actors. These shared interstitial spaces, through their nature of being temporal, episodic, and inclusive of a variety of diverse actors united by their common interest, facilitate collective experimentation. The steering committee structure was one such shared space, which facilitated a wide range of individuals and partners to think collectively and simultaneously about the institutionalisation process, outside of the constraints of their scripted institutional patterns of thinking. It was an opportunity for engaging in brainstorming around institutionalisation challenges and forging new alliances and collaborations to tackle different tasks. The practice of 'facilitating a shared space' also brought new resources and ideas to the surface, especially in terms of the strategic technical experience of actors who have been working within and across the government system for many years and financial resources from non-governmental partners. Members became encouraged and motivated to share

their resources when they witnessed their colleagues step forward to do so. These resources (technical and financial) were often the ones that were needed but lacking within the existing resource-constrained system.

Third, as was found in the section above, both the adoption and institutionalisation processes were approached through shared leadership, with the onus for achieving its outcome not resting on a single individual or organisation. Shared leadership was a practice that contrasts the traditional form of vertical leadership within health systems. The institutionalisation of social innovation initiatives such as CCPF was appropriate for shared leadership as it is an interdependent complex process, requiring a great deal of creativity [422]. As described by Pearce [422], the goal of shared leadership is for peers of mutual influence and power to lead each other towards achieving a collective goal. Shared leadership thus also embodies a sense of mutuality (as described above). The practice of shared leadership contributed to achieving broad-based ownership of the social innovation initiative and allowed new institutional entrepreneurs to emerge from the wings to provide strategic support to the institutionalisation process.

iii. Positive Emotions: Hope

"Hope is the refusal to accept the reading of reality which is the majority opinion, and one does that only at great political and existential risk. On the other hand, hope is subversive, for it limits the grandiose pretension of the present, daring to announce that the present to which we have all made commitments is now called into question." Walter Brueggemann [459]

This study, despite not focusing on the hardware or 'instrumental' factors (such as finances, human resources, technology etc), does not discount these factors. Rather, this study demonstrates the presence of human-based resources as another critical factor within the Malawi health systems. These human-based resources have often been underacknowledged or dormant. The role of trust [12], as a human-based resource, has been recognised in health systems but greater acknowledgement is required of other human-based resources such as hope, commitment, creativity, courage, and positive virtues [247].

In Chapters 7 and 8, the influence of positive emotions in the adoption and institutionalisation process was a notable finding. Emotions identified included passion, pride, and hope, of which hope played the most significant role. Hope did not only align with the notion of future-oriented agency (see Chapter 4), but it operated as the fuel for action by actors and sustenance for resilience. This was particularly evident during times when it seemed unlikely that the institutionalisation process will succeed, and as Fredrickson stated, 'hope creates the urge to draw on one's own capabilities and inventiveness to turn things around' [246]. This

'turning around' was present in many group-level meetings. These meetings often started with a list of challenges impeding institutionalisation (see Table 6-1), but by the time the meeting ended, multiple collective co-created solutions addressing those challenges were proposed. Carlsen [252] links hope to creativity by regarding hope as 'the engine for all human creativity and cultural development'. This was observed in the relentless commitment to identifying creative strategies displayed by the members of the steering committee. Hope enhanced the capacity of government and other actors to embrace the risk associated with new social innovations (such as CCPF), and in a way that moved them to personal action.

The hope generated at the group level was dependent on three conditions: first, a baseline injection of hope by institutional entrepreneurs into the group setting; second, by relational construction (section I above); and third, by shared experiences giving way for collective engagement (section ii above).

In this study, of 54 actors interviewed, only nine met the criteria of institutional entrepreneurs. Of the nine, four institutional entrepreneurs played a key role in government adoption of the initiative being achieved, and five institutional entrepreneurs facilitated the institutionalisation process. Each of these nine institutional entrepreneurs could all be considered high-hope individuals [259, 260]. They provided the initial impetus of hope required to unlock dormant hope in a broader group of individuals. This is confirmed by Ludema [251] who describes hoping as not as a solitary act, but rather an inclusive act in that it is 'inextricably linked and essentially interdependent'. As people tap into the life-giving relationships, they gain a sense of being carried and supported by others, and in so doing they become more generative and contribute in turn to the generativity of others.

But merely 'gathering' per se would not be enough for hope to move from an individual to a group-level resource. The relationship (and the quality of relationship) between institutional entrepreneurs and other members of the steering committee was key. It is as Buber [455] describes, the 'You-I' relational context is where hope is born, nurtured and sustained. It is also in relational dialogue that previously unrecognised opportunities are recognised and possibilities are discovered [251, 460]. Relational construction and shared experiences (as described above) thus seemed to operate as the fertile ground to cultivate hope.

In conclusion, the hope inherent in the actors engaged with thee in the social innovation process and thus generated by the social innovation process can be regarded as a human-based resource that (see more below in section 10.2.3) enhances creativity, resilience and personal satisfaction. This case study was unique in the level of sustained hope that was present throughout the unfolding social innovation process (creation, implementation, adoption and institutionalisation); and thus, in turn, hope also contributed to the

sustainability of the initiative, especially while waiting for material resources to surface. This study postulates a relationship between the social innovation process, hope and the sustainability of initiatives.

iv. Everyday innovation efforts for institutionalisation – tangible and intangible

Hope heightened the future-oriented agency at the group and organisational level. Once this dimension of the agency was heightened, it became easier to unlock other forms of agency (such as habitual and practical-evaluative forms of agency) in support of the innovation required for the institutionalisation process i.e., actors became activated for creative action based on new possibilities they were able to conceive. This creative action, as described in Chapter 8, could qualify as everyday innovation, and this functioned as a fourth software factor. Everyday innovation was supported by several types of institutional work and practices: advocacy, symbolic work, and creative embedding.

Advocacy work in support of social innovation required a different strategy depending on the process being pursued, whether adoption or institutionalisation. As described in Chapter 7, advocacy work conducted in support of the social innovation initiative's adoption as part of the health system was targeted and strategic, focused only on gaining the support of some key individuals in regulatory and political domains. This was not done as a public exercise but rather through a quiet behind the scenes approach that sought not to awaken any unnecessary opposition or resistance until contractual adoption was achieved. Once the adoption was achieved, advocacy work in support of institutionalisation changed tact; it was more pronounced with more public-facing opportunities sought to promote the social innovation initiative. This was done through the production and showcasing of videos, events hosted by the minister and health event days organised by the government. The focus of the advocacy work during the institutionalisation phase was to gain widespread symbolic legitimacy of the social innovation initiative as being fully owned by the government. Yet, advocacy work didn't come without risk. Conducting it prematurely, too wide or not wide enough, all influence the likelihood of social innovation's institutionalisation success.

Chapters 7, 8 and 9 highlighted the importance of symbolic work in the adoption and institutionalisation of social innovation. Across both processes, symbolic efforts, at times, carried an even greater significance than actual efforts, and supported enhancing the future-oriented dimension of agency in actors even further i.e., it gave actors a perceived sense of what is possible, even before it any actions took place. The main message conveyed through symbolic efforts was that of government ownership. As found in Chapter 9, historic contingencies i.e., the historic legacy of a country, had an important impact on the institutional logics. In striving to overcome a colonial legacy and achieve a strong Malawian national identity, ownership was an

important component of state logic. Whether it entailed establishing a hotline in the capital city on the government premises or it was allowing government actors to be the front face leading meetings and outreach efforts; the importance of these efforts to convey Malawian government ownership of the social innovation initiative was key as actors engaging in everyday innovation needed to realise institutionalisation success.

Last, the creative embedding of institutional work was a final contributor to everyday innovation. 'Embedding' as institutional work has been described by Lawrence and Suddaby as 'actively infusing the normative foundations of an institution into the participants' and organisational day to day routines' [49]. Yet, this study extends this notion of embedding to that of creative embedding: the recognition of possibilities [461] and a problem-solving ability [462] in support of achieving embedding. A caveat is that creative embedding work cannot be separated from other types of institutional work already discussed above such as relational construction and shared experiences. Effect and emotions, both positive and negative, [463] and social processes, including interpersonal relationships [420], also play an important influencing role in the creativity actors had available as a resource to draw upon in support of the institutionalisation process [420].

v. Contradictions in logics around ownership

The implementation and institutionalisation approach selected for new initiatives in LMICs, especially those implemented by non-nationals, will influence national ownership, and thus the likelihood of policy and programs in achieving sustained outcomes. Health policy and systems scholars have documented the negative consequences of top-down implementation approaches that do not give lower-cadre health system implementers sufficient and timely opportunity to participate in the implementation process [439, 440]. Beyond only considering implementation approaches whether top-down or bottom-up, this study points to the consideration of institutional logics, as a critical factor influencing implementation and institutionalisation.

The literature reviewed in Chapter 5 provided a foundational understanding of the contextual factors which play an influential role in the adoption and institutionalisation of social innovation: a) the country political history and culture; (b) the role of traditional leadership in society; (c) the structure and delivery of healthcare and citizen participation in health, and (d) the influences of personhood, management culture and religion**.**. As noted above, the socially, politically, and geographically embedded nature of social innovation makes it almost self-evident that the country's context will play an influencing role in the institutionalisation process.

Leading on from Chapter 5, Chapter 9 identified a multiplicity of logics that were in operation during the adoption and institutionalisation process, namely a national identity logic, a Malawian collectivist logic, a

development logic which in this case was also synonymous with a Western individualist logic. In the adoption process, a national identity and collectivist logic took precedence were in the institutionalisation, a Western individualist logic had a more prominent role to play. A national identity and Malawian collectivist logic, versus a development or Western individualist logic, contradicted each other on the theme of ownership (see section ii above). More specifically, ownership was affected by the value placed on collectivism and time within each logic. The logic contradictions in operation led to there being a trade-off in time expediency and efficiency to complete the institutionalisation process, at the cost of incomplete engagement of all actors involved especially, district-level health actors. Further, the likelihood of successful institutionalisation was risked by a lack of attention given to symbolic ownership, that would position Malawian government actors as the face of the initiative at the central and district-levels of the health system. The institutionalisation of a social innovation initiative required an extended timeline, one that will allow for broad and repeated collectivist engagement of all actors in the decentralised health system, especially district-level actors. It also requires a greater awareness of symbolic gestures to promote national identity. Engaging with all actors and building government capacity for the day-to-day management of initiatives right from the beginning and not wait until after contractual adoption is an important strategy to achieve institutionalisation.

10.2.3 Recommendations for Knowledge and Action

This thesis does not seek to provide prescriptions, as this would not be in the line with the values of social innovation. This thesis also recognises the unique nature and contextual embeddedness of social innovation. Thus, considering these two points, this section seeks to provide programme implementers, country decision-makers or aspirant social innovators with directions and principles that will stimulate thought and hopefully inform future actions. Drawing on the case study findings, four recommendations are identified and considered in further detail below and a starting point for future work and investigations in social innovation in health systems.

i. Leverage social innovation as an approach towards meaningful responsive governance in support of UHC

The importance of both UHC and re-imagined governance structures have received increasing emphasis in the wake of the Covid-19 pandemic [446, 464]. The process of social innovation can offer one such re-imagined opportunity, as the social innovation process operates as 'new ways of governing' [39], inviting citizen and cross-sectoral participation and extending collective decision making. In Malawi, the social innovation process can be leveraged to overcome current governance challenges [465], especially those

between government and non-state actors. Social innovation, if done well, goes beyond tokenistic engagement and can be considered an entry point to promote ways of working preferred by Malawian actors where new initiatives are introduced with the involvement of non-national actors (see Table 9-1). This process of collectivist engagement represents the Malawian value of what it means to be a moral person, in line with principles inherent ubuntu. All relevant actors across different levels of the health system are to inclusively and respectfully engaged, from problem identification, ideation to implementation and institutionalisation. In addition, the social innovation process also provides another mechanism, beyond the existing community governance structures (Area Development Committees, Village Development Committees, Technical Working Groups), to enhance citizen participation, shared leadership and health system responsiveness.

In the historic colonial context of Malawi, as in many other African countries, social innovation can be used as an opportunity to shift the emphasis on locally initiated solutions, which are in line with and bolster national identity. This in itself could support overcoming the persistent challenges prior studies have ascribed to policy implementation failure that led to either unintended consequences or a lack of sustainability of initiatives; with limited actor participation and poor government ownership being a key limitation [437, 451, 466]. For resource-constrained LMIC health systems, the support and broad-based participation stimulated by social innovation can also enable governments to engage in innovative and higher-risk projects. Governments can leverage social innovation to bring new resources to bear in support of system strengthening efforts such as technical skills, implementation capacity, financial resources, and human-based resources (see more below).

ii. Recognise and cultivate human-based resources as assets in health systems

The institutionalisation of new initiatives into a health system, considering the resource implications, remains a considerable challenge in settings. Health systems can adopt three actions regarding recognising and cultivating human-based resources:

First, as a starting point, health systems thus need to recognise and proactively identify individuals with high levels of human-based resources, in particular high-hope individuals. These individuals could be present both within the government sector, as well as those in the non-state sector and from civil society. In attempting to identify high-hope individuals, the following is to be considered: high-hope individuals may not be individuals of the highest health system position, status or educational qualifications; rather they are individuals who have the vision and who see possibility beyond the challenges faced. Selecting or giving opportunity for high-hope

individuals to emerge, i.e., by not discounting their future-oriented perceptions which may be contrary to the accepted status quo; can be a valuable asset to social innovation in the early stages. These individuals can also be used to influence a larger group, as they unlock and raise the hope-levels dormant within a larger group. The raising of collective hope levels (future-oriented agency) subsequently becomes a catalyst towards further action (habitual and practical evaluative agency) and relentless determination, as is required to institutionally embed an initiative. These individuals should be given opportunities for shared leadership, alongside health system actors who are already in leadership positions, in support of institutionalisation and health system strengthening efforts.

Second, the 'ground' within which both hope and agency can be nurtured and cultivated in health systems, is a shared relational context (relational construction, shared interactions and shared experiences). A shared relational context can either be created through a small group of actors, uniting relationally to regularly share and discuss, through using practices such as respectful engagement or mutuality; or through facilitating a space for larger group gathering. In a pressured health system context, finding time for gathering can be limited. However, when conducted well, even if not frequently, through utilising positive practices such as appreciative attention, these gatherings can be a raise the levels of hope and other human-based resources (e.g., creativity, trust and pride). Thus, more facilitated spaces for shared engagement need to be created within health systems and these spaces need to inclusively welcome actors from different sectors and hierarchies that are power equal (all voices being recognised as having an equally valuable contribution to give). Health system actors, especially government actors, should be awarded the time and opportunity to participate in these spaces that allow for equal and shared experiences.

Third, as in this case of Malawi, the social innovation process, through the shared leadership of high-hope individuals and the facilitated spaces for shared relational engagement, provided a more positive experience from what Malawi nationals usually experience regarding initiatives implemented by non-nationals. The social innovation institutionalisation process applied well and with sensitivity, could be an alternative and a way to overcome some of the past and present colonial-style implementation practices.

iii. Strengthen the social institution's relationships within health systems through the process of institutionalising social innovation

The institutional paradigm of social innovation can strengthen the human character of health systems as it is sensitive to software factors. First, further social innovation research adopting an institutional paradigm in health systems should be conducted in different contexts as it offers the opportunity to use social innovation

for health system strengthening. In addition, this research can benefit from applying more diverse methods, especially those that are more experimental.

Second, the social innovation institutionalisation process, beyond the outcomes it provides to beneficiaries, has value in itself has through: bringing new health system leaders to the forefront (institutional entrepreneurs); facilitating greater cross-boundary relational construction between government and non-state actors, raising human-based resource levels and building the capacity for collective creativity (see the positive practices detailed in Figure 10-1). Health systems could thus approach social innovation, not as a risk to systems integrity but as a way to strengthen systems integrity, as all the socio-cultural capacities generated have transferrable benefits by application in other existing or future health system initiatives. The socio-cultural systems change which occurs by actors collaborating on a tangible social innovation initiative can provide a subtle and rather subversive way by which the human and dimensions of health systems can be nurtured, beyond only enhancing programmatic care delivery and health outcomes. This study suggests a reduction in concern by decision-makers that social innovation institutionalisation will hinder and distract from ongoing agendas and efforts to build stronger health systems. Rather it provides direction to social innovation's complimentary contribution in institutional strengthening and supporting the achievement of people-centred health systems [192]

iv. Adopt a logic-attuned institutionalisation approach and positive practices

Actors seeking to implement and institutionalise a social innovation, first and foremost, need to have a greater awareness of their institutional logics from which they operate and by which they approach these processes. Second, attunement is needed by non-national implementers of the institutional logics in operation within the country or health system within which they are pursuing these processes. The logics will influence both how the implementation and institutionalisation process is managed, and more importantly, how it is also perceived. The symbolic meanings of implementation approaches, especially in a context with a multi-layered colonial legacy, should not be underestimated.

Collaborations and partnerships between social innovators and government will have a higher likelihood of success if each party can surface their operating logics and engage in open dialogue on how compromises can be found, as well as how clashes in contradictions can be avoided. However, beyond mere attunement of the logics at play and the contradictions that may exist, this calls for a change in how the implementation is approached by non-nationals. Non-national social innovation implementers, holding a contradictory logic to those in operation within the implementation country, need to visibly demonstrate respect for country logics.

These demonstrations can be symbolic. Selected positive practices, such as respectful engagement, perspective-taking, mutuality, and appreciative attention, can be used to further surface and demonstrate respect for country logics. These simple organisational practices, which are deeply human, hold equal importance to project management practices striving for rigorous implementation. A practical strategy would be adjusting the timelines and metrics of success, based on what is realistic and achievable for government actors.

Logic-attuned implementation can play an important role to ensure that country ownership is achieved, at a deep and genuine level. Logic-attuned implementation and positive practices are practical ways to avoid implementation experiences being perceived as 'imposed upon and support the global momentum towards decolonising health systems [467].

10.3 Limitations

The first part of this study, the narrative scoping review, has a limitation in that it was only conducted only in English peer-review literature. Articles in other non-English languages, especially Spanish and French, could have provided further insights on the concept as applied to health care in an LMIC setting. Furthermore, a small number of English abstracts screened and eligible, could not be retrieved via available university access to literature and databases.

The second part of this study, the case study investigation, was initially conceived to be conducted as a comparative case study between two social innovation initiatives in two low-income African settings: Malawi and Rwanda. Although willing partners were found in each country who wanted to participate in this study, the initiated ethical approval proved challenging and lengthy. Due to limited research resources and the time frame of a doctoral programme, it was thus decided to only focus on one country. The study thus focused on only one social innovation case. The limitation of generalisability from a single case was addressed by enhancing the use of theory in analysis, and thus deepening the analysis. In this way, sound analytic conclusions of relevance have been generated which can be considered in other settings.

Both the scoping review as well as of the case study was conducted by a single researcher, posing challenges for the validation of the findings. To address this limitation, emerging findings were continually discussed with Malawian researchers from the University of Malawi to check the interpretations of the data. Data findings were also discussed with the PhD supervisors involved in this study. In addition, triangulation of

data sources and methods were done. Findings from the initial two rounds of data collection were tested with respondents during the third and final rounds of data collection to ensure the accuracy of interpretation.

The initially theoretical framing of this study was drawn from social innovation theory and policy analysis. After the first round of data analysis, it was discovered that this theoretical framing and conceptual thinking did not suffice in explaining the findings emerging from the inductive analysis. The first round of analysis led to a selection of a social innovation conceptual framework drawing on the institutional theory which was only published then. Although greater depth could have been achieved in using this framework in all rounds, the multiple subsequent rounds of data collection, over a longer timeframe, were added depth and they also provided an opportunity to re-engage with actors from the initial rounds to ask new and more in-depth questions. This study remains broad in terms of its use of a variety of neo-institutional theories and did not fully achieve advancing theory development in any particular stream (e.g., advancing the theory on institutional entrepreneurship). There is thus an opportunity to continue this inquiry and spend longer periods in the field (studying a social innovation over years) and in different settings.

This study was initially focused on analysing both the hardware and software factors associated with the adoption and institutionalisation of social innovation. In the first round of data collection, it was found that the implementing NGO was already investing in the study of the hardware factors. The NGO documented the hardware factors as a toolkit package called - 'Journey to Scale with Government' [468]. In the first round of analysis, it was also discovered that the software factors were richer and more extensive than conceived during the study design. Thus, in subsequent rounds of data collection, the only focus was given to software factors. Focusing only on the software factors supported the greater depth found in this study.

This study was primarily focused on the adoption and institutionalisation process, and the practices involved in this process. Although actors were studied, power relationships were touched upon, but it was not the primary focus of this study. Social innovation does focus on power shifts among actors and exploring issues more specifically about hierarchy and associated power relations were beyond this study scope, but worth exploration as a future area of study.

Lastly, the adoption of a positive orientation or affirmative bias in this research, as per the theory of Positive Organisational Scholarship, could arguably be a limitation and a contention. This orientation was a conscious decision in the methodology of the study, affecting how the data were perceived and interpreted, with a purposeful focus on positive outcomes, characteristics and processes and the enablers of these positive phenomena. This orientation is based on a much deeper held value or belief about the intrinsic goodness of individuals and institutions [272]. This is in contrast to the postmodern rejection of any universal aspect of

human nature, that could lead to the critique of 'denying reality', 'ignoring the negative', 'reckless optimism' and 'failing to explore issues of power' [279-283] (see more in Chapter 4). Although acknowledging that this positive orientation may pose limitations to this research, it was still deemed as a beneficial counter to the traditional 'negative or deficit bias' of organisational scholarship and identification of ways to strengthen the health system. This study, however, did still seek to identify issues of contention and critical voices (see Chapter 2, Methods)

10.4 Areas for further research

This study was one of the first conducted in social innovation in the context of the government health system of a low- and middle-income country that was aiming to study the process of adoption and institutionalisation in greater depth. This study's findings revealed several opportunities for extending and deepening the inquiry:

- Further inquiry in social innovation within the field of health policy and systems research is required from an institutional perspective. Neo-institutionalism provides an opportunity to study social innovation using many different theoretical angles. Extending the period of qualitative inquiry, as well as having researchers be more embedded within the initiatives of study, is essential to capture the temporal aspects of embeddedness of social innovation.

- The study framework used for this study has not yet been applied to the field of health policy and systems research. It will benefit from further testing in studies on social innovation in health systems but also other public health programmes and policies.

- A next step for this research would be to test the findings on the critical software factors (Figure 10-1) in the context of another low- or middle-income country and to determine whether these are generalisable.

- The notion of human-based resources in health systems primarily, the role and influence of hope in health systems, merits further investigation. Health systems researchers have highlighted the importance of trust as a human-based resource but hope, although studied in organisational studies, remains unexplored in health systems literature. The value of other positive emotions, as described in the field of positive psychology, would also be a valuable exploration.

- The influence of institutional logics on implementation of health programmes and projects requires further exploration. This study provided initial insight into some of the logics that could be at play, but health systems scholarship could benefit from more investigation to identify the logics at play and also how contradictions in logics could result in unintended consequences.

- Given the interest in what determines success and accelerates progress to UHC, multi-disciplinary studies in health systems conducted with a positive or affirmative lens offer considerable potential and should be encouraged, especially drawing on fields such as Positive Organisational Scholarship. By adopting a positive or affirmative lens, programs, such as social innovations, which were previously unrecognised, can be brought to the public domain, including examples of where country governments, such as, in this case, Malawi, have been able to realise broader benefits as a result of the social innovation (in this case - institutionalising social innovation and greater actor participation) which have often been elusive in many other more developed countries despite global recommendation options to the continued shift from vertical to system-wide change processes.

10.5 Conclusion

" *I went to sleep dreaming of Malawi and all the things made possible when your dreams are powered by your heart*" William Kamkwamba [469]

The story from the young Malawian innovator and pioneer, William Kamkwamba, has attracted global interest. As a young boy living a rural Malawi, he was not able to complete his schooling due to his family's poor economic circumstances, which were caused by a severe drought that destroyed all their crops. Yet the spirit of hope in this 14-year-old boy could not be quenched as he sought to find a solution for his family. His creative use of old dynamo to build an electricity-producing wind turbine resulted in his family receiving the gift of light at home. William's invention changed the life not only of his family, but it had a marked impact on his whole community, as new business and education opportunities opened up.

This research study was an attempt to draw attention to the creative potential residing within humans – whether citizens or government officials – working within low and middle-income countries (LMICs). This human ingenuity, to turn persistent social challenges into new solutions with a system-changing potential, has been called social innovation, and institutional entrepreneurs play a key role in facilitating the social innovation process. While social innovation has the potential to enhance people's quality of life, social

innovation, in deeper and more profound ways, addresses the root causes of challenges, such as power inequities and limited participation.

Social innovation initiatives can arise from unlikely sources, even from a 14-year-old boy with limited education. Similarly, the idea of a national health hotline (Chipatala Cha Pa Foni -CCPF) proposed by a young Malawi software developer at a nationwide innovation competition has resulted in a measurable improvement in health for millions of Malawians. It has also provided a new approach for the Ministry of Health of Malawi by which Universal Health Coverage can be achieved – through making health information accessible and enhancing appropriate and timely care-seeking behaviour. The accompanying social innovation process necessitated the participation of a range of cross-sectoral and cross-hierarchical actors; all contributing knowledge, skills, and resources in support of the government embedding it as part and parcel of the national health system. This study shows the process by which the Ministry of Health, an international NGO and other partners went about to achieve this institutional embedding of a social innovation initiative.

This study identified the value of studying social innovation through an institutional theory lens, and by the application of a multi-level social innovation, the framework to support the identification of relevant software factors that influence and contribute to the social innovation adoption and institutionalisation process. Five software factors were identified: cross-boundary relational construction, shared experiences, positive emotions, everyday innovation, and institutional logics (Figure 10-1). LMIC health systems have a prevailing deficit orientation towards resources yet, by approaching this study from a positive or affirmative orientation, it further revealed how selected software factors operate as human-based resources to maintain and sustain social innovation initiatives. The role of actors, institutional entrepreneurs, and their display of agency in all three dimensions, are imperative to mobilising group-level action towards the achievement of a goal considered by many to be unattainable.

Beyond the value of social innovation as a practical solution for how health systems can achieve Universal Health Coverage; the process of social innovation may hold even greater potential. Social innovation as a process challenges the prevailing instrumental notion of health systems by moving the dial towards more responsive and participatory governance and national ownership of health interventions, while simultaneously unlocking new and dormant resources within the health system. Social innovation's potential to support the institutional strengthening of the technical but also human dimensions of health systems merits further inquiry.

11 POSTSCRIPT

The case of the adoption and institutionalisation of CCPF (a social innovation) within the context of the Malawian health system, was presented in this thesis during its lifecycle from 2018 – 2019. This represents a relatively short, although significant, time period within the full history of this social innovation initiative which commenced in 2011. During the 2018 – 2019 period, the main goal of all the actors involved in this initiative (the implementing NGO, the Ministry of Health of Malawi and partners) was to achieve a successful leadership transition that would enable the initiative to be fully and sustainably owned and maintained by the Ministry of Health of Malawi, such that it can accessed by Malawians across all 28 districts in the country. It is notoriously difficult for community or civil society-led social innovation initiatives to be adopted by government, due to institutional discrepancies that have to be overcome. Thus, this case study was selected for its relevance to the question– "*Can public health systems in low-income countries, such as Malawi, adopt and institutionalise social innovation?*"

The study period raised many questions, concerns and doubts as to whether this indeed will be possible for the Malawian public health system. Actors involved in this effort held a high positive motivation, goodwill and hope for its success, but this did not reduce their awareness of the risks of failure. The initial transition endpoint was contractually determined to be 30 June 2019. During the study period, this date came and went, and institutionalisation was not yet completed. However, in a post-study follow up, participants affirmed that institutionalisation indeed became possible by January 2020. Donor partners sustained the initiative until the time the government was able to finance the initiative. With the emergence of the Covid-19 pandemic, this social innovation became a key part of Malawi's national Covid-19 response. The implementing NGO continued to provide technical assistance to the Ministry of Health to co-ordinate donor support for the initiative as well as improving the CCPF software and service in line with emerging Covid-19 needs and questions. One participant noted that the pandemic served to fast track and solidify the institutionalisation efforts. The pandemic response also saw the second main private telecommunications company of Malawi getting involved to support CCPF by zero-rating the calls to the hotline for all their users. This has enabled all mobile phone users in Malawi to have access to the service. By December 2020, a new unit (governance structure) was established within the Ministry of Health, with its own dedicated lead, in which CCPF as well as emergency services were placed. CCPF now has its own dedicated funding and human resource allocation. The Ministry has continued to drive CCPF with the goal to turn it into a fully-fledged telemedicine hub. The implementing NGO, although no longer responsible for day-to-day implementation or management, continues to aid the Ministry in pursuit of this goal.

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13 APPENDICES

13.1 Consent Form – English & Chichewa

INFORMED CONSENT - MALAWI

PRINCIPAL INVESTIGATOR: Dr Lindi van Niekerk
MALAWI COUNTRY STUDY TEAM: Dr Don Mathanga, Dr Vincent Jumbe
SUPERVISORS: Dr Dina Balabanova, Prof Lucy Gilson, Prof Susan Rifkin
ORGANISATION: University of Malawi, College of Medicine & London School of Hygiene and Tropical Medicine &
TITLE OF PROJECT: *Adoption and institutionalisation of social innovation in health in low-income countries*

PART I: INFORMATION ABOUT THE STUDY
INTRODUCTION
I am a researcher from the London School of Hygiene and Tropical Medicine / College of Medicine, University of Malawi. We are conducting a study to better understand how social innovations are developed and integrated as part of the public health system in Malawi.

I would like to invite you to share your experiences and views by participating in this study.

WHAT IS THIS STUDY ABOUT?
Social innovations are defined as new programmes, policies, procedures or processes that seek to address social problems. Social innovations are developed by individuals or organisations from different backgrounds, including citizens. In healthcare, social innovations intend to make services more effective and efficient for the people and also bring change the broader system that created the problem in the first place. Across Africa, several social innovations in health have been identified and studied. These innovations have shown promise to improve the health of communities and also strengthen the health system.
This study will seek to better understand two primary care social innovation cases – One Family Health in Rwanda and Chipatala Cha Pa Foni in Malawi. The interest of this study is to understand how each of these programmes were developed and integrated as part of this country's public health system. The findings from this study will contribute to knowledge on how to improve innovation services in Malawi and how from the lessons learned in Malawi and Rwanda, could guide other African countries who would like to engage in social innovation in health.

PROCEDURES & PARTICIPANT SELECTION
Different individuals are involved in developing, implementing and scaling up social innovations. For this study, I would like to interview each of these individuals to gain a deeper understanding. You have been identified as someone who has played a key part in social innovation in Malawi.

If you agree to participate, I would like to interview you and ask questions related to your experiences to do with social innovation in this country. The interview will take 30 – 60 minutes but will vary based on your level of involvement. I may request a follow-up interview at a later occasion to find out about any progress or changes since our last discussion.

The interview will be done at a time and place convenient for you. If it is not possible to meet in person, the interview can be done telephonically or via Skype. During the interview, I will write notes to capture the information you share with me. To ensure that I do not miss important details, I will ask your permission to audio record the interview.

To get a better understanding of the work you do, I may also ask you to accompany you while you are working and observe how you go about your daily tasks. To increase my understanding of your work, and if there is an opportunity, I would want to get involved and participate in the activities you perform.

DURATION
This research will take place over the course of 12-months, from June 2018 – July 2019.

RISKS AND DISCOMFORTS
I will be asking you to share your thoughts and opinions about the work you are engaged in. If you do not feel comfortable in answering a specific question, you will be under no obligation to do so. You do not have to give any reason for not answering a specific question. The information you share with me will not influence your role at your organisation or the services you receive. Please take your time and relax. There are no right or wrong answers.

BENEFITS
There are no direct benefits for participating in this study, although I truly value your ideas and experiences. The information gathered for this case study will be used towards attaining a PhD but will also be written up as journal articles that can be shared with other countries, to learn from your experiences. Before publication, articles will be shared with you to be sure that my interpretation is correct. There will be no financial compensation for your participation in this research.

VOLUNTARY PARTICIPATION
You have the right to decline participation in this study. You also have the right to withdraw from the study at any time, for any reason, if you so decide.

CONFIDENTIALITY
To help protect your confidentiality, interviews will occur in your preferred location (in a private room).
Your name will be removed from all collected study materials and it will not be disclosed in the writing up of the case study or any other research publications.
Your views will not be shared with your manager or employees of the organisation or with the Ministry of Health. Information gathered from you will be stored safely and securely (see below). You will give an opportunity at the end of the interview/discussion to review your remarks, and you can request to modify or remove portions of those, if you do not agree with notes taken. Your name will never be identified in any publication arising from this study.

DATA STORAGE
Information gathered from this researched will be identified with the aid of study identification number only. Your name will not be made known. Information collected from you (notes and audio recordings) will be kept separate from any of your personal contact information. Information files will be stored on a password protected computer and two password protected encrypted external hard drives in London. Duplicates will only be shared with the country research team. The data will not be shared with any other researchers outside the study team.

RIGHT TO REFUSE OR WITHDRAW
You do not have to take part in this research if you do not wish to do so. Choosing not to participate will not affect your job or job-related evaluations in any way. You may to stop participating at any time without there being any repercussions. If you choose to withdraw from this study, all information collected from you will be not be used and destroyed.

WHO TO CONTACT
If you have questions about the research in general or about your role in the study, please feel free to contact any of the following people:

- Dr Lindi van Niekerk – lindi.vanniekerk@lshtm.ac.uk /phone:+447449936292 / whatsapp: +27722362079
- Dr Don Mathanga - dmathang@mac.medcol.mw

If you have questions/concerns about your rights in this research project, you should contact the Malawian National Ethics Committee: Mr Mike Kachedwa on 0999 360 516 / 01 770 406 / Email: mckachedwa@ncst.mw

PART II: CERTIFICATE OF CONSENT

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I asked, have been answered to my satisfaction. I consent voluntarily to participate and understand that I have the right to withdraw from the study at any time without any penalty. I provide permission for the following:

An interview to be conducted with me: ☐ *Please tick the box if you give permission*

For the researcher to observe me doing my work: ☐ *Please tick the box if you give permission*

For my interview to be audio recorded: ☐ *Please tick the box if you give permission*

Print Name _____

Signature _____

Date _____ Day/month/year

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Thumb print of participant

Signature of witness _____

Date _____Day/month/year

KALATA YOPEMPHA CHILOLEZO - MALAWI

PRINCIPAL INVESTIGATOR: Dr Lindi van Niekerk

MALAWI COUNTRY STUDY TEAM: Dr Don Mathanga, Dr Vincent Jumbe

SUPERVISORS: Dr Dina Balabanova, Prof Lucy Gilson, Prof Susan Rifkin

ORGANISATION: University of Malawi, College of Medicine

& London School of Hygiene and Tropical Medicine

TITLE OF PROJECT: *Adoption and institutionalisation of social innovation in health in low-income countries*

GAWO I : CHIDZIWITSO CHOKHUDZANA NDI KAFUKUFUKU

MAU OYAMBA

Moni , dzina langa ndi _____ ndipo ndine mwawa wa sukulu amene ndi kuchita za udokotala wa PhD ku sukulu ya ukachenjede ya London School of Hygiene and Tropical Medicine / College of Medicine, University of Malawi. Ine ndi ofufuza woziimira pandekha amene ndapatsidwa mphamvu, yofufuza ntchito zoyambitsidwa za tsopano za umoyo (kusinthika kwa anthu onse) zayambitsidwa ndipo ndi zili gawo la dongosolo la za umoyo ku Malawi. Kafukufukuyu akuchitakanso ku Rwanda.

Ndikukuitanani inu kuti tigawane zimene mukudziwa ndi maganizo anu potenga nawo mbali pofunsidwa mafunso ndi kuyang'anitsitsa.

KODI KAFUKUFUKUYU AKUKHUDZA CHIYANI?

Kusinthika kwa anthu onse kukutanthauza ndondomeko za tsopano, mfundo, dongosolo kapena ndondomeko zofuna kuthana ndi mavuto a anthu onse. Kusinthika kwa anthu onse kungathe kupangidwa ndi munthu payenkha, mabungwe ndi pakuzungulira ndi kufotokozera mfundo zosiyanasiyana kuphatikiza nzika. Mu chisamaliro cha za umoyo, njira izi zatsopanozi cholinga chake ndi kukwaniritsa ntchito yothandiza anthu ndi kubweretsa kusintha kwa dongosolo limene linayambitsa vutoli pa chiyambi. Kuzungulira mu Africa, kusinthika kwa anthu onse mu za umoyo zakhala zikudziwika ndi kufufuzidwa. Kusinthikaku kwaonetsa ndi kulonjeza kupititsa patsogolo za umoyo m'madera ndi kulimbikitsa dongosolo la za umoyo.

Kafukufukuyu afufuza chisamaliro chofunikira cha kusinthika kwa anthu onse – Za umoyo wa banja limodzi ku Rwanda ndi Chipatala Cha Pa Foni Ku Malawi. Cholinga chathu ndi kumvetsa za kusinthika kuwiriku kumeneku kunayamba bwanji, kukhazikitsidwa ndi mmene mfundozi zinalandilidwira ndi kukhala gawo la dongosolo la za umoyo mu dziko muno. Zotsatira za kufufuzaku mukafukufukuyu zizathandiza kudziwa za mmene mungapititsire patsogolo ntchito za tsopano ku Malawi, komanso ndi momwe anaphunzirira ku Malawi ndi Rwanda, maiko ena mu Africa amene akufuna kukhudzidwa ndi za njira za tsopanozi angathandizidwire.

NDONDOMEKO NDI KUSANKHA OTENGA NAWO MBALI

Mu kafukufukuyu,anthu osiyanasiyana amene akukhudzidwa ndi kusinthika kwa anthu onse kapena ali mudongosolo lokulitsa kusinthakaku azafunsidwa mafunso. Izi zizakhudza woyambitsa ndi ogwira ntchito za kusinthikaku, atsogoleri a m'madera, ndi othandiza amene akukhudzidwa, oyimilira unduna wa za umoyo ndi anthu amene akugwira ntchito zakusintha mudziko muno.

Ngati mwavomera kutenga mbali. Ndikufuna kukufunsani inu mafunso okhudza zimene mukudziwa za kusinthika kwa anthu onse mu dziko lino. Kufunsa mafunsowa kuzatenga mphindi 30 – 60 koma kuzasiyana malingana ndi mmene mukukhudzidwira. Mafunso amene ndizafunse ndiokhudza mmene ntchitoyi inayambira, inayamba kwa nthawi yayitali bwanji ndi mmene ikukulitsidwa mu dziko lonse. Ndizapemphanso kufunsa mafunso olondoloza mtsogolo muno kufufuza za kupitirira kapena kusintha kuyambira pamene tinamaliza kukambirana.

Kufunsa mafunsowa kuzachitika pa nthawi ndi malo amene ali abwino kwa inu. Ngati ndikosatheka kukumana pamaso, kufunsa mafunsowa kungathe kuchitika pa lamya kapena kudzera pa Skype. Pa nthawi yofunsa mafunso ine ndizalemba zofuna kukumbukira pa mfundo zones mutigawire. Potsimikiza kuti zindiphonya zofunikira, ndikupempha chololezo kujambula kufunsidwa mafunsowa. Zojambulazi zizakhala za chinsinsi ndipo palibe kupatula okhawo amene ali mugulu la afufuza ali pa mndandanda pamwambapa azakhale ndi mwayi

Pofuna kumvetsetsa bwno za ntchito yanu ndizakupemphani kuti titsagane pamene inu mukugwira ntchito ndi kuyang'anira mmene mukugwirira ntchito zanu za masiku onse. Pamene zingatheke, ndizafuna ndi chitike nawo zimene zimene inu mukuchita

NTHAWI

Kafukufukuyu atenga miyezi khumi ndi iwiri (12) kuyambira mu June 2018 mpaka July 2019.

KUOPSA NDI KUSOWETSA MTENDERE

Ndidzakupemphani kuti mundigawireko maganizo ndi malingaliro anu okhudza za ntchito kapena chithandizo chimene mukulandira. Pamene musowa mtendere kuti muyankhe funso, simukuwumilizidwa kutero. Uthenga umene mutigawire siwuzakopa udindo wanu ku bungwe lino kapena chithandizo chimene mulandira. Chonde tengani nthawi yanu ndi kumasuka. Palibe yankho lolondola kapena labodza

CHOPINDULA

Palibe phindu lenileni kwa otenga nawo mbali mukafukufukuyi, ngakhale kuti ndimayamikira kwambiri malingaliro anu ndi zochitika zanu. Zomwe zimasonkhanitsidwa zimagwiritsidwa ntchito popeza PhD, koma zolembedwazo ngati nkhani zomwe zingathe kugawanidwa ndi mayiko ena a ku Africa, kuti aphunzire kuchokera pa zomwe munakumana nazo. Asanasindikize za kafukufukuyu, azagawanidwa kuti atsikimize kuti kutanthauzira kwanga kuli kolondola. Sipadzakhala malipiro a ndalama chifukwa cha kutenga nawo mbali mufukufukuyu

KUTENGA NAWO MBALI KODZIPEREKA

Simukuyenera kuvomera kukhala nawo mukafukufukuyu. Inu muli ndi ufulu kusiya kafukufukuyi nthawi ina iliyonse pa chifukwa china chilichonse chimene inu mwaganiza.

ZA CHINSINSI

Ndidzayesetsa kwambiri kusunga chinsinsi chanu. Pofuna kuteteza za chinsinsi chanu pamene mukufunsidwa mafunso izi zizachitika pa malo amene ine mukufuna. Dzina lanu silizatchulidwa kwa wina aliyese kupatulapo inu mukapereka chilolezo cho ulula mu zolemba zathu. Maganizo anu sazagawanidwa ndi okuyang'anirani kapena ogwira nawo ntchito mu bungwe kapena unduna wa za umoyo. Dzina lanu lizachotsedwa mu zolemba ndi zojambula zimene zizasungidwe mwachinsinsi ndipo sizizagawidwa kwa wina aliyense amene sali mugulu la ofufuza.

DATA STORAGE

Mfundo zotoleredwa mukafukufukuyu zizadziwika ndi nambala yodziwitsa ya kafukufuku zizasungidwa ndi kutetezedwa ndi dzina ndi mawu a chinsinsi mu kompyuta, kusiyanitsa za umwini zimene ndilinazo zainu. Mafailowa zasungidwa ndi ma pasiwedi awiri mu external hard drive ku malo ogwira ntchito ku London ndi mafailo ofanana azagawanidwa ku gulu la ofufuza mu dziko lino. Inu simuzadziwika mu zosindikiza za kafukufuku kapena mu mfundo za zogawanidwa ndi ofufuza ena.Mfundozi sizizagawanidwa ndi ofufuza ena kuti afufuze.

RIGHT TO REFUSE OR WITHDRAW

Simukuyenera kutenga nawo mbali ngati simukufuna kutero ndipo kusankha kutenga nawo mbali sikuzakhudza ntchito yanu kapena kuyesedwa pa ntchito munjira ina iliyonse. Mungathe kusiya kutenga nawo mbali mukufunsidwa mafunso nthawi ina iliyonse m'mene mukufuna ndipo ntchito zanu sizidzakhudzidwa. Muzapatsidwa mwayi kuthetsa kufunsidwa mafunso/kukambirana kuti mubwerenze demanga zanu ndipo mutha kupempha kuti musinthe kapena kuchotsa magawo amene simukuvomereza azimene zalembedwa.

KULUMIKIZANA NDI NDANI

Ngati muli ndi mafunso okhudza kafukufukuyu kapena udindo wanu mukafukufukuyu, chonde khalani omasuka ndi kulumikizana ndi anthu awa:

- Dr Lindi van Niekerk – lindi.vanniekerk@lshtm.ac.uk /phone:+447449936292 / whatsapp: +27722362079
- Dr Don Mathanga - dmathang@mac.medcol.mw

Ngati muli ndi mafunso /nkhwawa zokhudza ufulu wani mukafukufukuyu, inu mungathe kulumikizana ndi a: Mr Mike Kachedwa on 0999 360 516 / 01 770 406 / Email: mckachedwa@ncst.mw

GAWO II: CHITSIMIKIZO CHA KUPEREKA CHILOLEZO

Ndawerenga uthenga wakambidwa kale, kapena wawerengedwa kwa ine. Ndinali ndi mwayi ofunsa mafunso okhudzana ndi izi ndipo mafunso ena aliwonse amene ndinafunsa, ndayankhidwa ndipo ndine wokhutira. Ndapereka chilolezo modzipereka kutenga nawo mbali ndipo ndamvetsa kuti ndili ndi ufulu osiya kafukufukuyu nthawi ina iliyonse opanda chilango. Ndikupereka chilolezo kuti ndifunsidwe mafunso kujambulidwe

Sindikiza Dzina_____

Sayini _____

Tsiku la pa mwezi _____ Tsiku/mwezi/chaka

Ngati sadziwa kulemba ndi kuwerenga

Ndili ndi umboni olondola owerenga za kupempha chilolezo kwa ofuna kutenga nawo mbali, munthuyo anali ndi mwayi ofunsa mafunso. Ndikutsimikiza kuti munthuyu wapereka chilolezo mwaufulu.

Sindikiza dzina la mboni _____ Chidindo cha chala cha manthu cha otenga nawo mbali

Sayini ya mboni _____

Tsiku la pa mwezi _____Tsiku/Mwezi/Chaka

MUNTHU OTENGA CHILOLEZO

Ine, _____, ndawerenga molondola kalata ya uthenga wa chidziwitso kwa ofuna kutenga nawo mbali, mmene ine ndikudziwira ndikutsimikiza kuti otenga nawo mbali amvetsa zotsatira zi:

1. Kufunsa Mafunso

2. Kuonetsetsa pa ntchito yawo
3. Kunjambula pa kaseti kufunsa mafunso

Ndikutsimikiza kuti otenga nawo mbali anapatsidwa mwayi ofunsa mafunso okhudza kafukufukuyu, ndipo mafunso onse amene otenga nawo mbali anafunsa ayankhidwa molondola m'mene ine ndikudziwira. Ndikutsimikiza kuti munthuyu sanakakamizidwe kuti apereke chilolezo, ndipo chilolezochi chaperekedwa mwa ufulu ndi modzipereka.

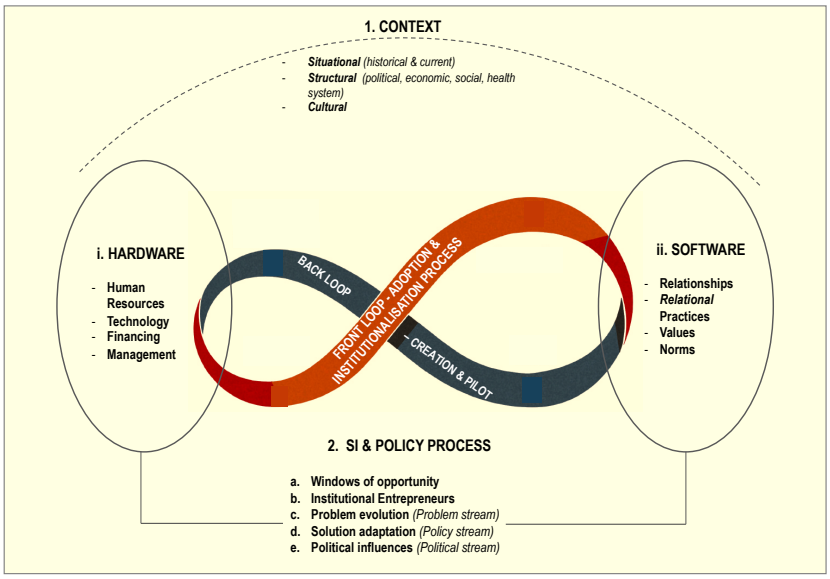
Kalata yofanana yopempha chilolezo izaperekedwa kwa otenga mbali

Sindikiza dzina la ofufuza/munthu otenga chilolezo_____

Sayini ya ofufuza /munthu otenga chilolezo_____

Tsiku la pa mwezi: _____ Tsiku/Mwezi/Chaka

13.2 Initial conceptual thinking



To better understand how a primary care social innovation can be adopted as part of the public health system in the context of a low-income country, a composite framework will be used drawing on existing frameworks in each of the respective fields (social innovation, health systems and policy analysis).

a. Social innovation evolution and the policy process

To understand both social innovation and systems change, I turn to the adaptive cycle. The adaptive cycle, first presented by Holling [90] in the field of ecology has become a way of explaining change within a specific system and how these changes could lead to greater resilience [52].

Social innovations are regarded as *systems transformations* and thus their own evolution over time from idea to maturation, cannot be separated from the influence, effect and implication they have upon the system within which they are introduced and implemented. Innovation calls forth change as it is inherently about doing something in a new or different way from the status quo. How a system responds to this demand for change will depend on its resilience capacity – to break down and to reform existing its structures and patterns to internalise / accommodate the change while at the same time maintain integrity and avoid total collapse.

The strength of the adaptive cycle as a framework lies in both being able to explain the social innovation evolution process and also the adaption process of the system as it adopts and institutionalises the social innovation. Researchers have also used the adaptive cycle as a way to understand the various policy levers governments can adopt in supporting social innovation at various stages [470]

Holling presents the adaptive cycle as an infinity loop, that is both continuous and simultaneous. It consists of a back loop, a phase of radical change, and a front loop, a phase of more incremental change. Within each of these loops, four sub-stages are further described. For the purpose of this research, the back loop and front loop will be considered as the two distinct stages of the social innovation evolution and policy process (the process of adopting and institutionalising it within the health system).

The back loop, consisting of the release and reorganisation sub-stages, is set off when a stimulus disrupts the current way of being or doing i.e. radical change. Critical problems may give rise to existing structures to break down and for resources to be released. These problems become opportunities for the development of new innovative solutions through combining available resources in new and different ways. Within the context of the system, the introduction of an innovation (non-routine change) can also disrupt the engrained institutional patterns, thus calling for a new way in which the system has to be organised. Stimulus opportunities, such as problems or innovations, opens up the space for new connections, resources and actors to enter.

The front loop, consisting of the exploitation and conservation sub-stages, is associated with slow, incremental and more deliberate change. In this stage, the social innovation grows, matures and scales. It is also the stage where the system can choose to adopt and institutionalise the innovation. This requires new structures (resources, rules, norms, skill sets) to be created such that it can become part of the status quo.

To gain understanding beyond the *'what'* that happens as the social innovation evolves, as explained by the adaptive cycle, and move towards the *'how'* the innovation becomes part of the health system, the policy analysis approach is useful. Policy is the way by which new planned non-routine change is introduced within systems. Innovations could be policies, and policies could be innovative but often new policy has to be created support the system restructuring required for adopting an innovation.

A framework that is able to provide a broad understanding of the policy process at various stages is the Multiple Stream Framework developed by John Kingdon [91]. The framework propose that policies emerge when key individuals (entrepreneurs) seize windows of opportunity that emerges when different streams are coupled. Kingdon's description of the role of actors, as '*policy entrepreneurs'*, are closely linked to social innovation literature's presentation of the role of actors, as '*institutional entrepreneurs'* – individuals who enable and support policy and systems change to come about [163, 240]. To understand the process, Kingdon

further proposes three streams of action: problem, policy and politics streams. The problem stream deals with issues that arose through indicators, events, or feedback, as public matters that warrant addressing; the policy stream entails ideas both promoted, explored and adopted as a potentially feasible solutions to the problem and the political stream consist of national events and factors that have influence on the policy process.

This social innovation adaptive cycle heuristic overlaps with the traditional stages of policy process. The back loop, as innovation goes from idea to pilot, is linked to agenda-setting as the idea is introduced to policy makers. For agenda-setting, according to Kingdon, coupling is required between the problem and policy stream.

The front loop, as the innovation matures, is linked to policy formulation, adoption and implementation, where policy makers have to determine how this innovation can become institutionalised as part and parcel of the system. Researchers have extended the use of Kingdon's framework to these stages of the policy processes. Berlan [471] describes how Kingdon is useful in understanding policy formulation, through the coupling of the policy and politics stream; and Ridde [472] illustrates how in policy implementation, coupling occurs between the problem and the policy stream.

b. Hardware and software of adoption and formulation

Based on the research question and the timeline in which the data collection was conducted, the main focus of this study is on the front loop in which the social innovation grows and matures, and where it is adopted and formulated as a policy to be implemented at national scale institutionalised as part of the health system. 'The formulation of policy is seen not as a stale and static process but, as the process of bringing it alive in practice' [473]. Thus, it is required to explore this particular time-point with even greater analytical depth, understanding both the '*how'* this process unfolds but also '*why'* this occurs ie. the factors that influence it.

I will explore at a more granular level of how this particular innovation/ policy becomes practically adopted within the health system, thus looking at both hardware and software factors, as presented by Sheikh et al [13], that influence this process. The hardware entails the concrete and tangible components of the innovation that has to be adopted as part of the existing health system structure – human resources, technology, finances, management. The software entails the more intangible and human components

influencing and affecting the process such as actors and their relationships, the relational practices employed and values and norms.

There will be a further analysis of retrospective data to understand the back loop – the creation of the innovation and how it arose as on as part of the health policy agenda. Based on data collected, there will be a narrow analysis on the prospective implications of the implementation of the innovation as a policy at a national scale, as part of the front loop.

<table>
<tr><td>1</td><td>2</td><td>3</td></tr>
<tr><td>Social innovation process</td><td>Policy Process</td><td>System</td></tr>
<tr><td rowspan="4">BACK LOOP</td><td>Windows of opportunity</td><td rowspan="4"></td></tr>
<tr><td>Problem stream</td></tr>
<tr><td>Policy stream</td></tr>
<tr><td>Politics stream</td></tr>
<tr><td rowspan="5">FRONT LOOP</td><td>Windows of opportunity</td><td rowspan="2"></td></tr>
<tr><td>Problem stream</td></tr>
<tr><td rowspan="2">Policy stream</td><td>Hardware</td></tr>
<tr><td>Software</td></tr>
<tr><td>Politics stream</td><td></td></tr>
<tr><td colspan="3">CONTEXT</td></tr>
</table>

c. Context

Health policy and systems research (HPSR)cannot be accurately interpreted without an awareness and understanding of the context within which the phenomena of interest is embedded and unfolding [474]. Systems, policies and innovations are artifices of human creation, thus shaped by a particular contextual reality [13].

Leichter [300] provides a framework by which a big domain such as context can be broken down into its smaller constitute parts. He presents context as comprised of situational factors (influencing events), structural factors (political, economic and social structures) and cultural factors (political and general culture). These factors are not only important in understanding the current reality, but also as a way of understanding the historical context, that shaped and still have influence and bearing on how actors operate within the current context. Historical and current contextual factors further shape the institutional structure by which the health system is organised and operationalised. An understanding of context will thus underpin each of the other.

13.3 Interview Guides (Round 1)

13.3.1 Schedule 1 – NGO (Creator / Implementer)

Personal

I'm curious, how did you come to do what you are doing now?

PROBES: professional background, current role, experience working in the country

Organisation

I would like to understand a bit more about VillageReach, and how it usually operates…

Where do new ideas come from?

When a new idea arises, what is the process?

What do you consider makes VR unique?

Looking back

What enabled CCPF to get started?

What **factors or opportunities were key to CCPFs success** in the initial stages of implementation?

[PROBES: engagement with MOH / engagement with community / funding/ partnerships]

Beyond the initial pilot, what **enabled CCPF to evolve and sustain until now?**

[PROBES: contextual challenges eg. low phone penetration, issues raised by the impact evalution etc]

How is CCPF **different today from what was initially conceived**? Who/ what informed these changes?

[areas of evolution/ change, role of actors, processes followed]

Since you have been involved, what has been the **key turning points (make or break moments)** for this innovation? [partners coming on board just at the right time]

What has been the **biggest challenges you have encountered in regard to CCPF implementation,** and how have you overcome these?

Could you clarify for me the different financial contributions that made this project possible?

Community engagement – how did this take place?

Government

Could you tell me more about how your engagement with the MOH began on CCPF? [probe: agenda setting]

What were the initial reactions and questions raised? [from whom?]

In your opinion, why were the MOH willing to engage in CCPF?

[motivations, enabling conditions, actors involved]

What was unique about your initial champions [who, their role, other characteristics]?

Could you tell me more about the steps / process /preparation that is being undertaken to make CCPF part of the national health system? [implementation plan / sustainability plan]

What has enabled this project to get to where it is now and what barriers had to be overcome?

From your experiences in working with the MOH, what are the biggest differences / tensions between the way VR operates and the MOH operates?

From other MOH's you have worked with, is the Malawi MOH different in any way?

If you were not aiming to scale this project in partnership with the MOH, how would you have approached it? Do you have any examples you could share with me of how you have done before?

Looking forward

In order to integrate CCPF as part of the public health system, what **adaptations or areas for further innovation do you foresee need to occur in the next year**?

What are the next **steps / processes need that need to happen** such that CCPF can achieve the 1 July 2019 full government integration deadline?

In your opinion, what are be the **3 – 4 crucial factors that will enable the MOH to successfully take over** CCPF? [Probe: concerns, doubts]

What are **potential barriers/ concerns** which you see that could prevent you from exiting by July 2019?

Beyond July 2019, what will affect the **sustainability of CCPF**?

[Probe: contextual / political / elections / things to maintain…]

Soft side

In the working context, have you noticed **any changes as a result** of this project? [in partners, in VR, in MOH?]

PROBE: intended / unintended shifts in people or structures or institutions

How have you been able **to foster tru**st in this project and between the partners? What has been integral to this happening? [esp with MOH]

What has been your biggest personal lessons from this journey?

[Revision 8 August 2018]

13.3.2 Schedule 2 – National-level decision makers (directly involved)

Personal

I'm curious, how did you come to do what you are doing now?

PROBES: professional background, current role, experience working in the country

Context & culture

I would like to understand a bit more about MOH, and how it usually operates in regard to innovation…

- Where do new ideas come from?
- When a new idea arises, what is the process?
- What are the challenges for government to engage in innovation
- What do you consider makes this MOH unique/ different in regard to innovation?

What motivates you in your work? [motivation, performance, why they do what they do…explore beliefs]

Besides you, who are the **champions of innovation** within the MOH and what makes them unique? [who are they, their role, their motivation]

If an idea comes from the outside:

- What is the usual process?
- What conditions need to be met / be aligned?
- What would make you resistant / reluctant to it

CCPF

When you first heard about/ was introduced to CCPF, what were the first thoughts in your mind? [positive, sceptic, doubtful..why?]

Would you regard this project as an 'innovation', if so, why?

PROBE: the way things are usually done

The idea for this project came from a young Malawian, do you think there is an opportunity to engage more Malawians in this way? **What processes/ structures will make this possible?**

You have played an important role in CCPF… **could you maybe explain to me how you have been involved, why you were involved in each specific stage/ step and how your role has changed over time?**

What have been **key turning points** in this project since you have been involved?

Agenda setting: What enabled this project **to get onto the agenda** of the MOH / your department? What supported this to happen? [area of pilot, role of TAs, role of community, role of evidence, funders / partners]?

Policy formulation: Why was the MOH/ your department willing to **adopt / sign a formal MOU**? What enabled this to happen?
PROBE: alignment with national health priorities, political agenda, culture, motivations, partners.

To scale CCPF up nation-wide, what **adaptations to the project have been necessary to date, and which do you foresee need to occur in the next year**?

In your department / within the broader MOH, what specific **changes has occurred or will be needed** to enable CCPF to be fully integrated by 1 July?

What has been the **biggest challenges you have encountered in regard to CCPF implementation,** and how have you overcome these? [Esp. within the government context]

In your working context, have you noticed **any changes as a result** of this project?
PROBE: intended / unintended shifts in people or structures or institutions

Once CCPF reaches national scale, and say 5-years from now, what are the changes you can envision in the community, in health services and in the health system as a result of this project?

Partnerships / culture

From your experiences in working with the VillageReach or other organisations pursuing innovation, what are the biggest **differences / ten**sions between they operate and way the MOH operates?

How have you been able to **foster trust** in this project between the partners? What has been integral to this happening? / **What has assisted this partnership to be successful?**

Future

In your opinion, what are be the **3 – 4 crucial ingredients that will enable the MOH to successfully take over CCPF?** [Probe: concerns, doubts]

Beyond July 2019, what will affect the **sustainability of CCPF?**
[Probe: contextual / political / elections / things to maintain…]

If another country government wants to follow your example of adopting innovations coming from outside the health system, what advice will you share with them based on your experience?

13.3.3 Schedule 3 – Informers

Personal

Could you tell me a bit about yourself?

PROBES: professional background, current role, how long living in this setting?

Context

What are some of the biggest health challenges / health service challenges you face in this area?

What has been your experience with projects implemented in this area:

- Who are the major implementers in this area?
- How do they usually approach implementation?
- Have there been failed projects? – Why would this be?
- When implementing projects in this area – what is most important to consider? [process]

Has the community here ever initiated projects themselves?

How is the community involved in the health (services) in this area? [explore official linkages/ structures]

CCPF implementation
In the beginning…

When and How did you first hear about CCPF?

[positive, sceptic, doubtful…why?] [Explore perspectives around technology]

What were the first thoughts in your mind when you heard about CCPF? What did you think about the idea?

What were the perception of people living here about CCPF? Did they have any concerns?

Could you tell me the story of how CCPF got started here?

[actors, processes, timeline, enabling factors, EXPLORE KEY TURNING POINTS]

Why did you become get involved in CCPF?

How were you involved in the implementation of CCPF?

Has your role changed over time?

How was or is the community involved in CCPF?

What have been some of the challenges CCPF has experienced in this area?

Has there been any changes in CCPF over time?

Do you have any advice for how the project could have been implemented better?

If not CCPF, is there another kind of project that the community would have preferred?

MOH transition

The Ministry of Health in Malawi will be taking over CCPF by 1 July 2018, as their own project. What do you think about this?

What concerns / fears do you have about this?

Do you think it is better for the government or Village Reach to own and run CCPF?

Why do you think CCPF received the support from the Ministry of Health initially? [agenda setting]

In terms of ensuring the MOH is able to run CCPF by themselves in July 2018, what do you think will help to assist this?

What advice/ lessons will you give to the Ministry of Health to help them take over CCPF successfully & expand this project across Malawi?

What opportunities are there for CCPF to collaborate / link more closely with the health facilities in this area?

Community perceptions

Have you noticed any other changes here, in this community, a result of this project?

PROBES: changes in behaviour, attitudes, actions – whether positive or negative]

Have people's mindsets changed over time? Could you tell me more about this?

Future

Do you have any suggestions for how CCPF can be improved or adapted going forward?

Is there anything else that is important for me to know / that you would like to share with me

13.3.4 Schedule 4 – Ministry of Health (District Level)

Personal

I'm curious, how did you come to do what you are doing now?

PROBES: professional background, current role, experience working in the country

Context

What are some of the biggest health challenges / health service challenges you face in this area?

Would you say there is anything that makes this specific district unique? [context, history, current political climate]

Culture around innovation

What motivates you in your work? [motivation, performance, why they do what they do…explore beliefs]

When you face problems here at the district MOH offices, how do you **usually come up with solutions?**

PROBE: agenda setting, actors, opportunities

Say, a community organisation wants to bring in an innovation into this area, what steps will be followed and what is important for them to know about this setting?

PROBE: type of actors they engage with, key factors, reactions, procedures, policies

In what situations would you be reluctant to engage with innovations coming from the outside?

Could you share with me an example of an innovation (other than this project) which the you have engaged with?

What makes it difficult for you to engage / support innovations here at the district office?

[lack of resources, lack of support, bureaucracy]

CCPF

How did you first hear about CCPF and what were the first thoughts in your mind? [positive, sceptic, doubtful..why?] [Explore perspectives around technology]

How has your mind changed about the project since you were first introduced to it? / What do you think about it now?

Would you regard this project as an 'innovation', if so, why?

PROBE: the way things are usually done

How have you been involved in CCPF?

How did CCPF **implementation** happen in your district? What were the **steps** that were taken? Who was engaged as part of this? [TAs, community members / was it different from other projects?]

Where there some things during implementation that you think could have been done **differently/ better**? [more engagement of people / challenges foreseen]

What has been some of the challenges with this project in this area?

Have you noticed any changes here a result of this project?
PROBES: changes in behaviour, attitudes, actions – whether positive or negative]

- How has this project changed health in your area?
- How has the local health centres responded to CCPF?
- How has people in your community responded to this project?

Why do you think this project has gained the support of the national Ministry of Health?

In order to integrate CCPF as part of the public health system, what **adaptations have been necessary to date and which do you foresee need to occur in the next year**?

If the government is to take this project over from VillageReach fully, what are be the 3 – 4 crucial ingredients that you think is important to consider? **Or advice you would give?**

If another district wants to also adopt CCPF, would you have any advice or lessons to share with them?

Is there anything else you feel is important for me to know?

13.3.5 Schedule 5 – Other Innovating Actors

Could you tell me about yourself and how you came to do what you are doing now?

I would like to understand more about how innovations are adopted by the public health system in Malawi

From your experience, how does the public health system usually respond to innovation?

When developing and implementing new innovations in this country with government as a partner, what would you regard as important factors to consider?

Have you ever been involved or know of innovative projects which failed?
PROBE: a specific experience

Could you share with me an example from your work where an innovation has been successfully adopted?

For the successful case, could you elaborate on:

Could you tell me more about **how your engagement with the MOH began** on this innovation? [probe: agenda setting]

What were the **initial reactions and questions** raised?

In your opinion, **why did the MOH engage / pursue** this? What was their motivation?

Who were your **initial champions and what role** did they play? [Characteristics of the champion]

Could you tell me more about the **steps / process** that is being undertaken to make this project part of the national health system? [implementation plan, sustainability plan]

What has **enabled** this project to get to where it is now? **[barriers to overcome]**

What were the **biggest challenges** you faced to date?

From other MOH's you have worked with, is the **Malawi MOH different** in any way? / What is **important for people to know** when wanting to embark with the MOH here?

What **contextual factors** are unique to Malawi that will affect the adoption/ institutionalisation of an innovation?

If you were not aiming to scale this project in partnership with the MOH, how would you have approached it? Do you have any examples you could share with me of how you have done before?

In your opinion, what are **the three crucial things that will need to happen for your project to fully integrated** into the Malawian health system?

How have you been able to foster **trust between your organisation and the MOH?**

Once integrated, what **affect the sustainability** of projects like yours?
[Probe: contextual / political / elections / things to maintain…]

What has been **your biggest personal lessons** from this journey?