# 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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Date: 12 August 2021

# 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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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].

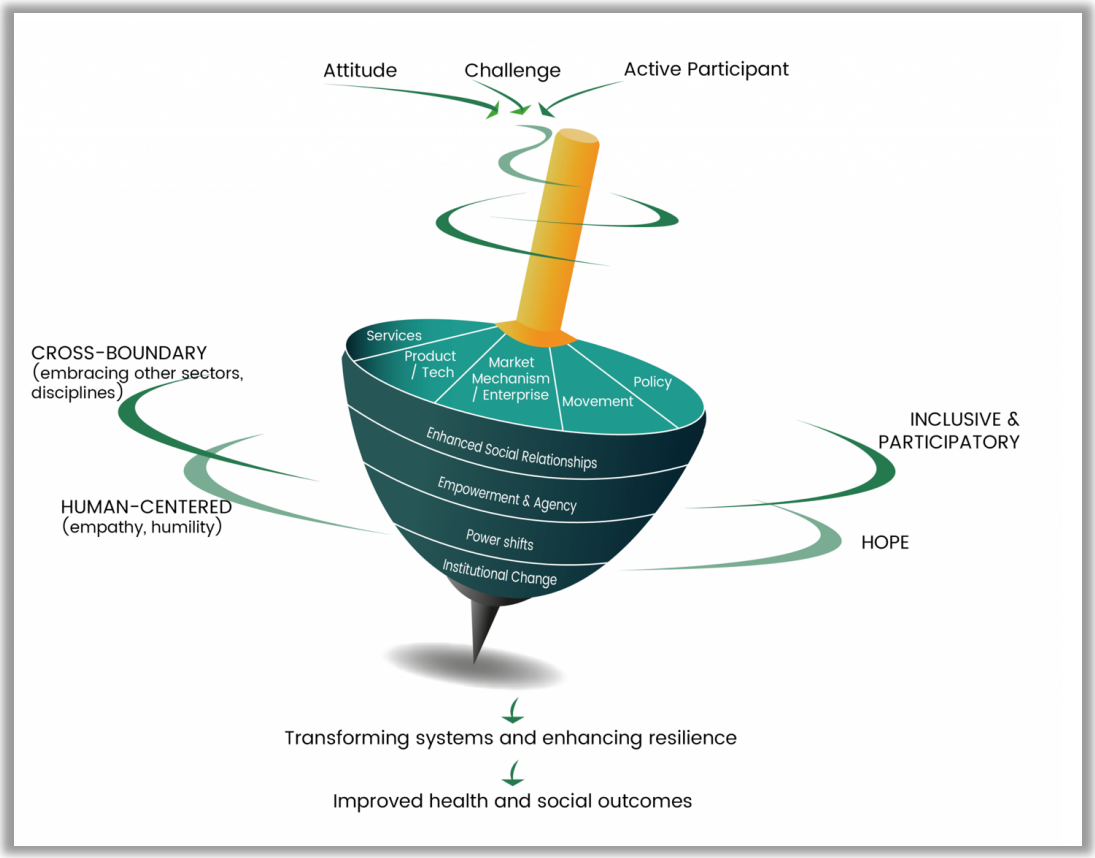


**Figure 1-1**: *Social innovation conceptual representation* [50]

## 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

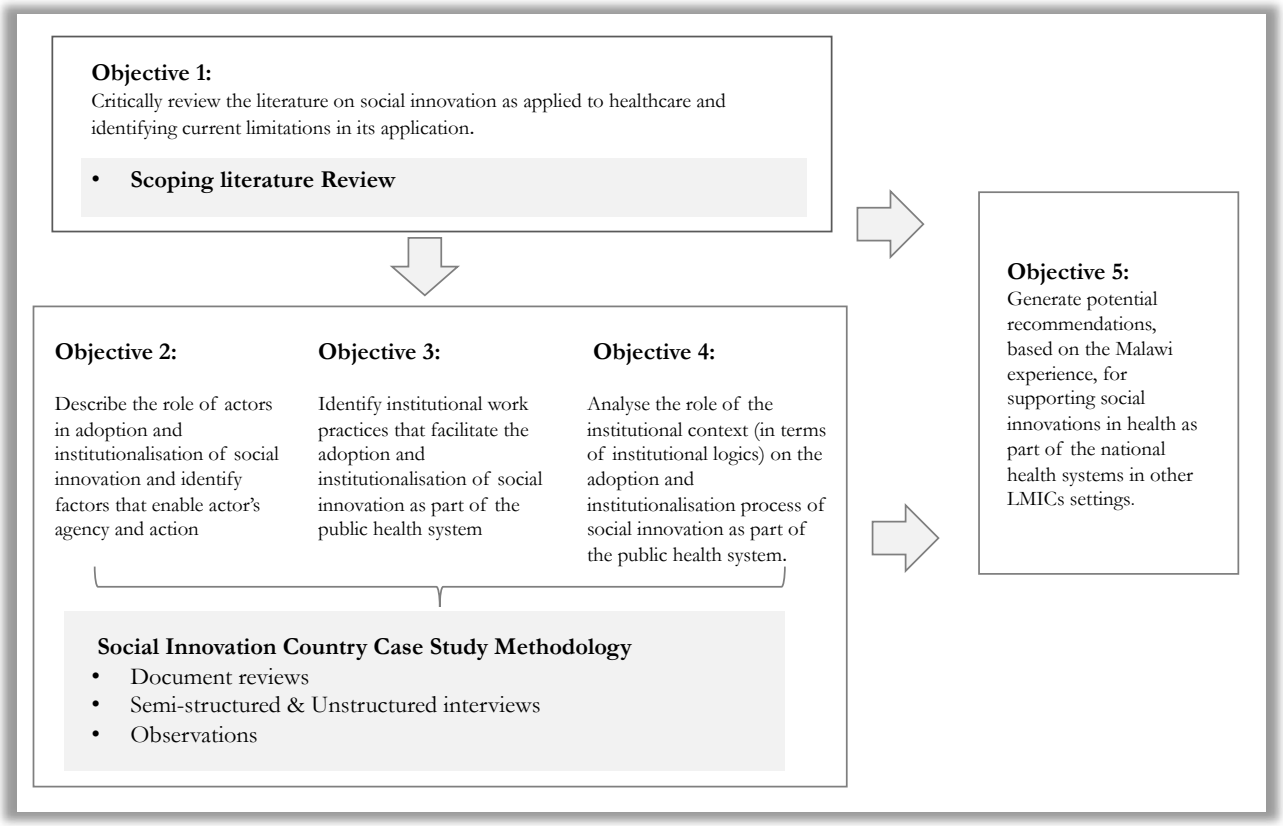


Figure 2-1: *Study research design*

### 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.

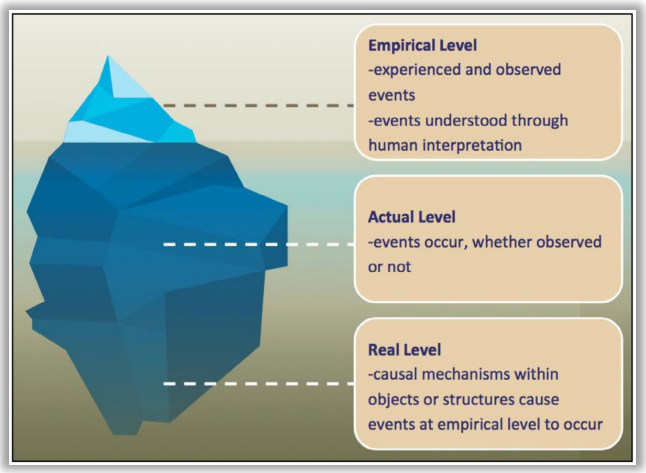


**Figure 2-2:** *An iceberg metaphor of CR ontology [69]*

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.<br>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.<br>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.

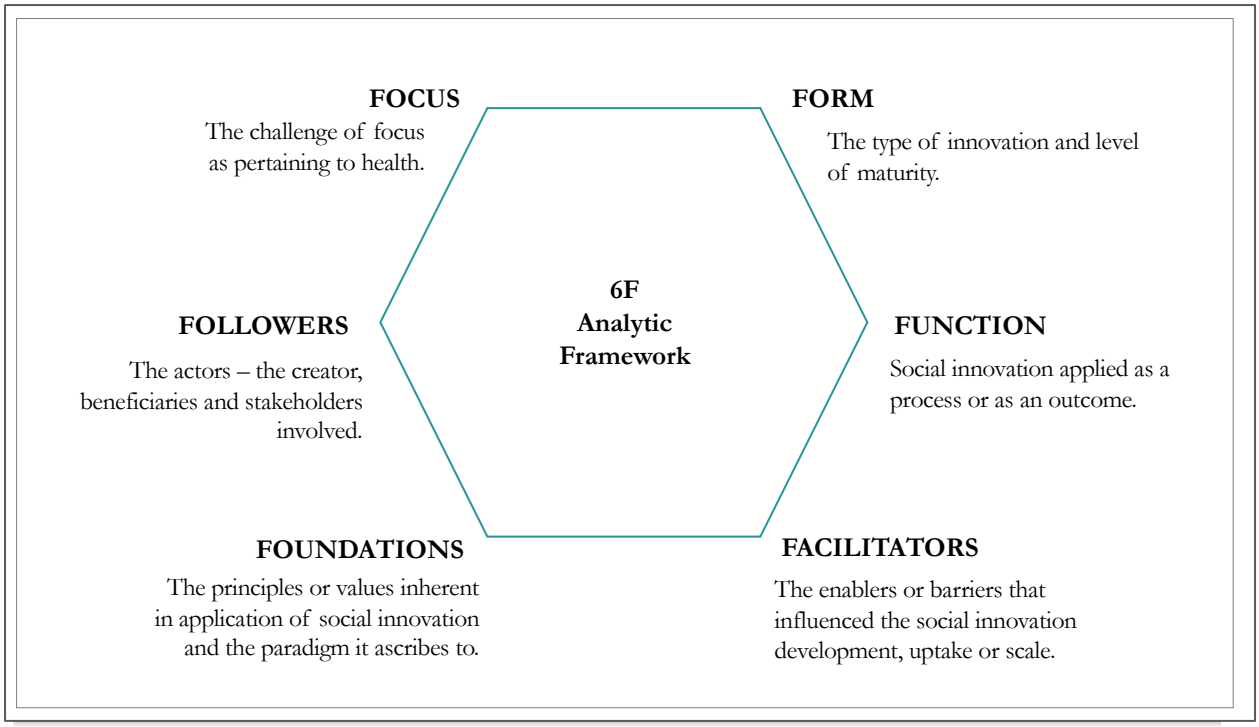


**Figure 2-3:** The *6F Analytical Framework*

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<br>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<br>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) |

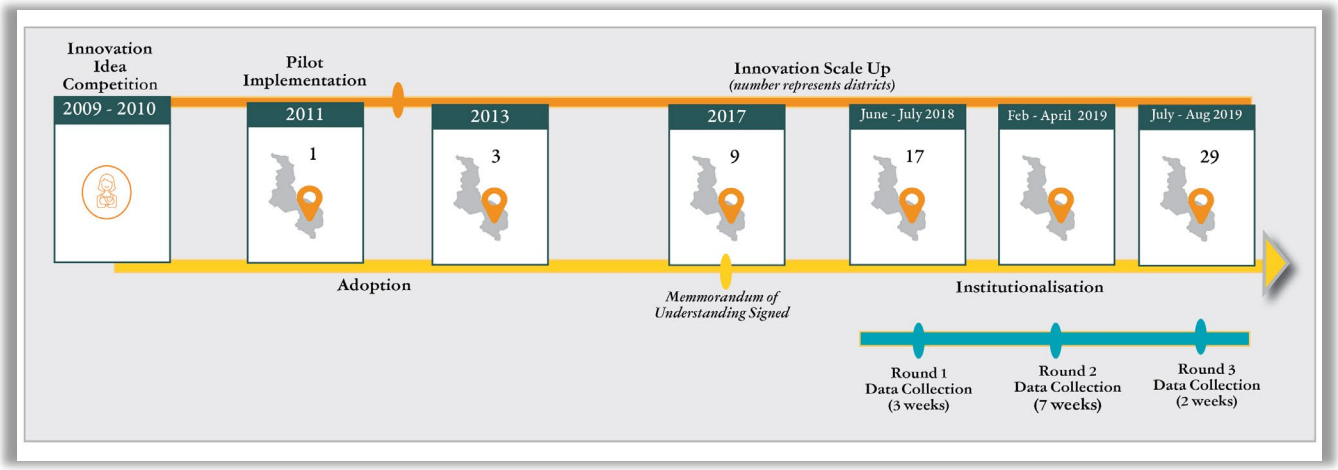


**Figure 2-4:** *Innovation key milestones and data collection process.*

### 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.

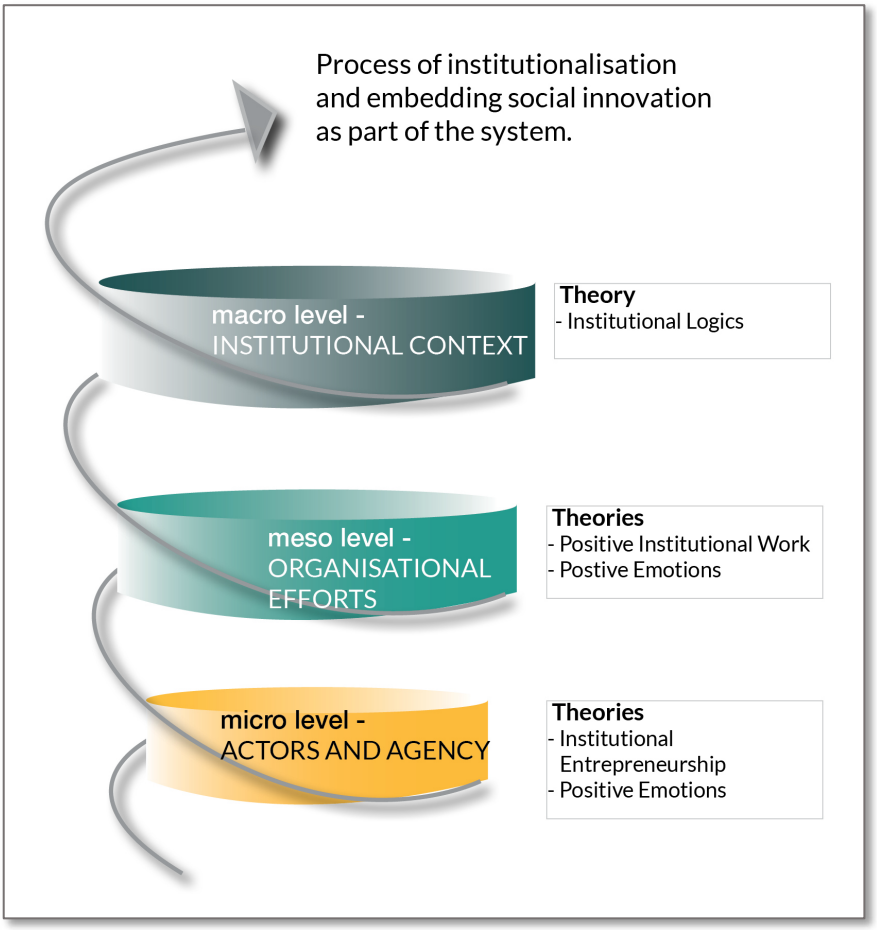


**Figure 2-5:** *Modified study framework*

## 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.<br>• 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.<br>• 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<br><br>[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<br><br>[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.

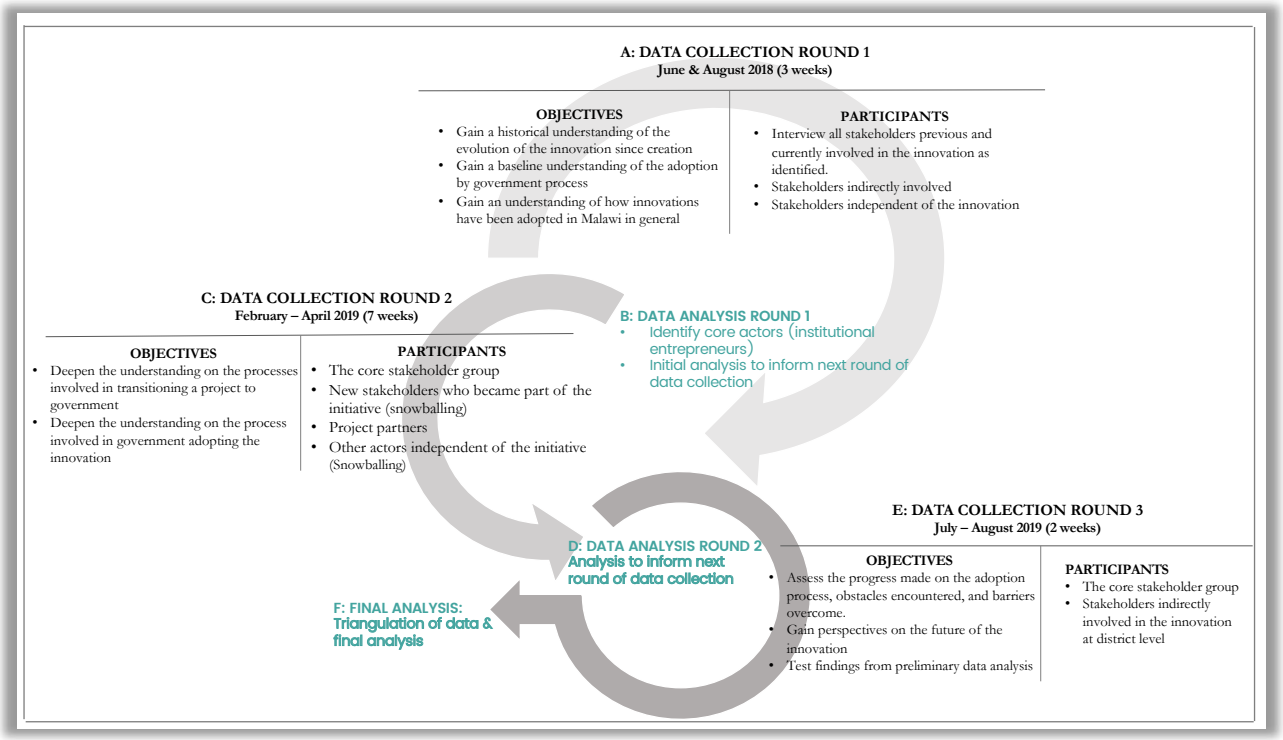


**Figure 2-6:** *Data collection process overview*

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: Participant List** – 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].

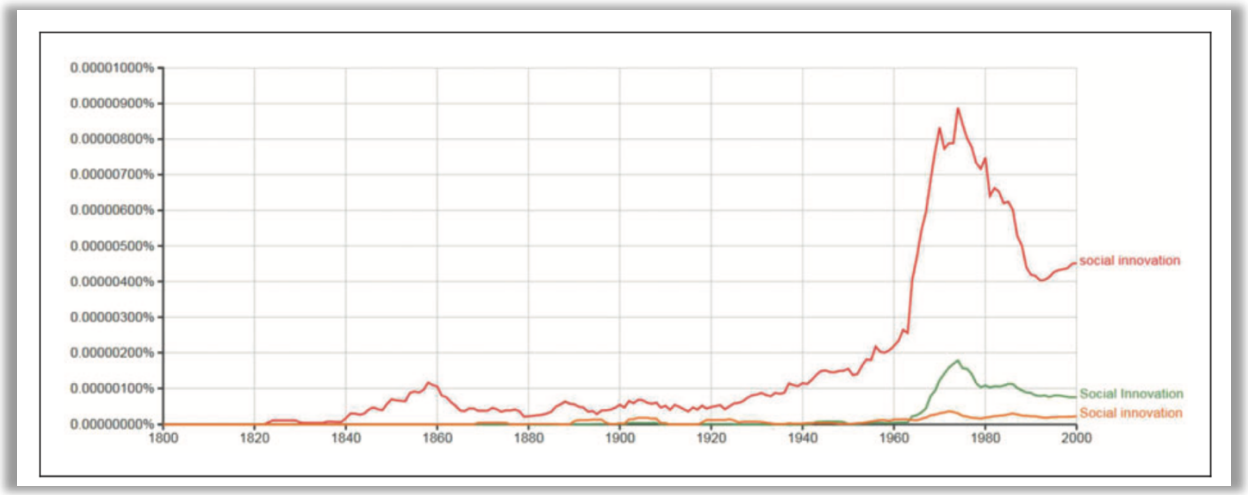


**Figure 3-1:** *Use of 'social innovation' over time*

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.

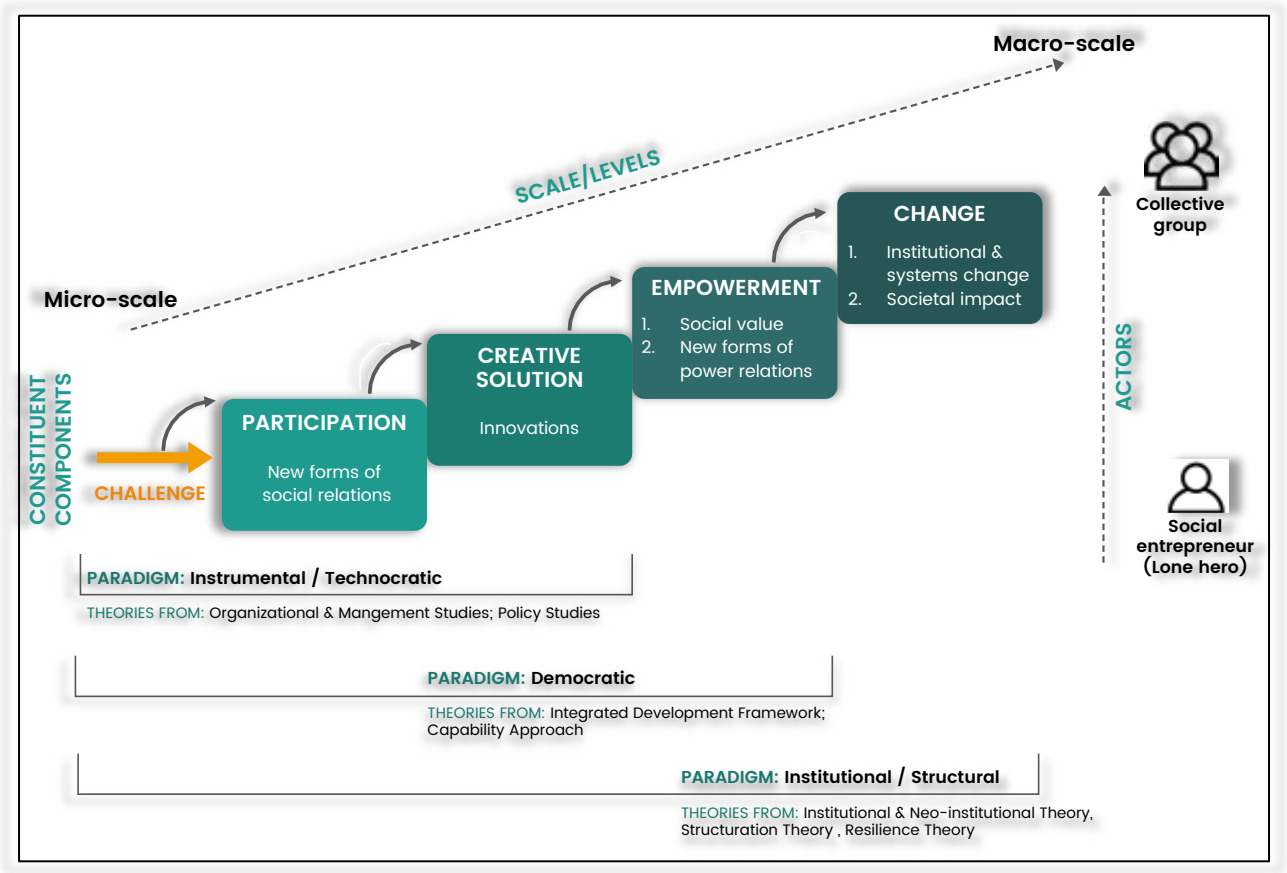


**Figure 3-2:** *Components, Paradigms, Theories, Scales and Actors of Social Innovation*

| 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<br><br>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<br><br>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).<br><br>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)<br><br>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.

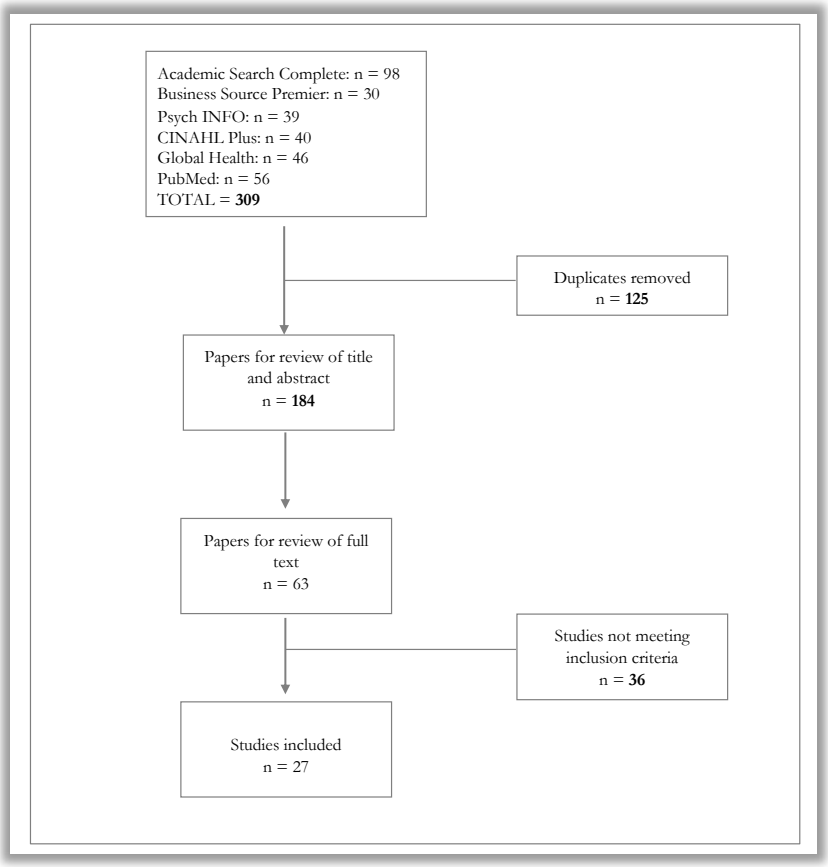


**Figure 3-2:** *Literature search and review process*

### 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)<br>Castro-Arroyave et al (2020b)<br>Srinivas et al. (2020) | | |
| | **Non-Communicable Disease** | Mason et al. (2015) | McCarthy et al. (2013)<br>Rugge et al (2013)<br>Grindell et al (2017)<br>Windrum et al (2018) | McCarthy et al. (2013)<br>Henry et al. (2017)<br>Valentine et al (2017)<br>Windrum et al (2018) | Dube et al (2014) |
| | **Maternal, women & child health** | Mason et al. (2015)<br>Cheema et al. (2019)<br>Awor et al. (2020) | Castro-Arroyave et al (2020a) | McCarthy et al. (2013)<br>Dufour et al (2014)<br>Farmer et al (2018) | |
| | **Ageing population** | | Gigha et al (2020) | McCarthy et al. (2013)<br>Kim et al (2019) | Currie et al (2014).<br>De Rosa et al (2017(<br>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)<br>Ballard et al (2017)<br>Vijay et al (2018)<br>Mariavittoria et al (2019) | Wass et al (2015)<br>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:<br>− Self-directed, empowered and autonomous nursing teams providing a range of comprehensive services in a relationally oriented way that would achieve patient independence.<br>− One-cost fee for service with limited managerial staff to keep administrative overhead to a minimum.<br>− A digital intranet to connect all nurses and perform scheduling, billing, documentation and outcome monitoring. | ↑ health worker motivation.<br>↑ patient outcomes & satisfaction.<br>↓ 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:<br>- 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.<br>- Teachers act as main custodian of school children health. | ↑ community ownership over health in line with collectivist cultural values.<br>↓ in indirect costs of accessing care via in person doctor consultation.<br>↑ affordability of care.<br>↑ 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<br>- A joint venture between a network of physicians and healthcare management company to extend health services.<br>- Model supported by two sickness funds and a network 150 partners including allied health services, sports clubs, and self-support groups.<br>- Outcome-oriented financial approach: profit only made if cost margins of population goes down i.e., outcomes improve.<br>- Provider training in supporting patient self-management and shared decision making.<br>Patient accountability through a patient advisory board, satisfaction surveys and patient ombudsman. | ↑ patient outcomes.<br><br>↓ 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:<br>- A hub-and spoke model linking community organisations to clinics.<br>- Non-medical professionals, community volunteers, deliver palliative services.<br>- Services delivered directly in people's home. | ↑ access to of care.<br><br>↑ affordability of care.<br><br>↑ 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:<br>- Training diabetes educators (different health professionals) and specialist physicians' postgraduate course<br>- Engaging professional associations to set standardised processes for diabetes care and ensuring compliances<br>Including the services as core to the Social Health Insurance fund | ↑ patient knowledge & self-management.<br><br>↑ healthy lifestyle behaviour in diabetics. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Srinivas, ML et al. (2020) [167] | Learner Treatment Kit<br><br>Self-collection for HPV Screening | Malawi<br><br>Peru | Save the Children & Malawi Ministry of Health<br><br>University research team | Community | School age children in 58 schools<br><br>643 low-income women | Addressing underdiagnosis of malaria in school children due to cost & access to care:<br>- Providing a product supply box of malaria diagnostics, treatment and other first aid supplies to schools.<br>- Training of teachers to administer diagnosis and treatment.<br><br>Addressing cervical HPV screening availability limitations in low-income areas through:<br>- Leveraging CHWs to provide self-screening kits to women and take kits for diagnostic procedures at health centre.<br>- Self-testing HPV done by women. | ↑ access to of care.<br>↓ 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:<br>- Linking schools to local organic food suppliers for local production and procurement.<br>- Food education for children through linking them to local farmers and combined teacher-pupil cooking classes.<br>- Shared engagement in meals by teachers and pupils (eating together). | ↑ knowledge of children on food production and nutrition.<br>↑ social capital between school and local community.<br>↑ 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:<br>- Pairing up intergenerational teams of school children with teachers or older adults through shared walking challenges.<br>- A digital pedometer linking to an online platform to measure progress. | ↑ physical activity.<br>↑ 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:<br>- 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).<br>- Time credits are exchanged for services such as shopping, dog walking, childcare etc. | ↑ community solidarity & agency.<br>↑ individual physical & mental wellbeing.<br>↑ access to necessary social services.<br>↓ 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:<br>- Training local women as community resource persons.<br>- Providing a product kit – a bag with contraceptive, household and hygiene products.<br>- Establishing a micro-franchise chain to ensure regular product provision. | ↑ increase access to contraceptives.<br>↑ female financial independence & empowerment. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Entrepreneurial models** | Cicellin, M et al. (2019) [176] | Low-cost clinic models | Italy | Centro Medico Santagostino;<br><br>Nuova Citta;<br><br>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.<br>These social business models, made possible through:<br>- Recruit and engage medical staff at reduced renumeration but with long term financial incentives.<br>- Different pricing models and a select number of high-value services<br>- Operating at economies of scale.<br>- Cross-subsidization between wealthy and low-income groups or between services generating different profit margins. | ↑ affordability of care.<br>↑ 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.

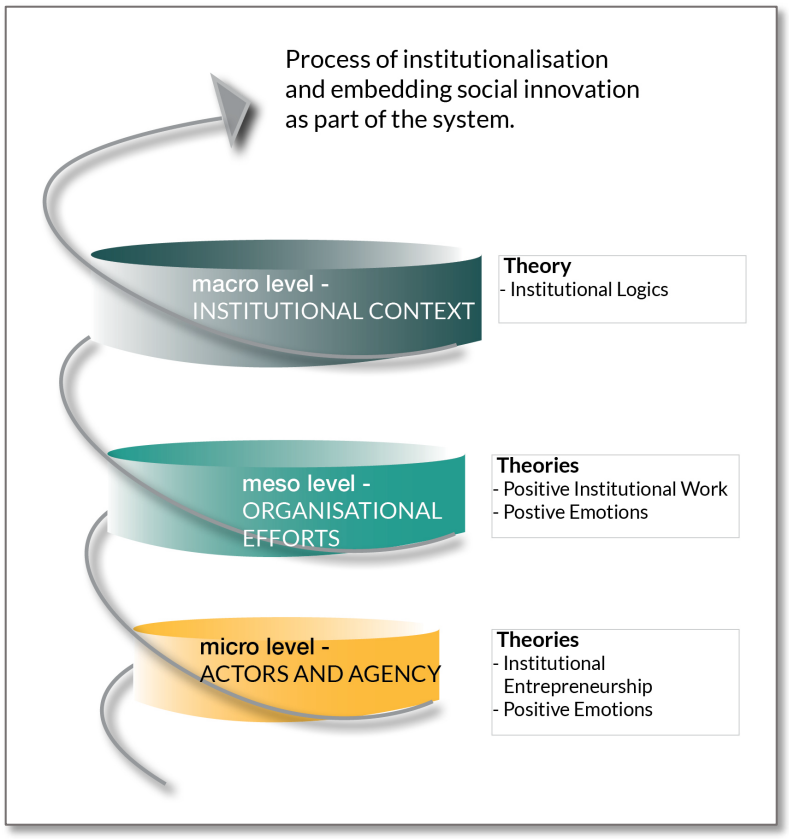


**Figure 4-1 (2-5):** *Modified study framework [43]*

### 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**<br>**Population % with flush toilet** [306] | 17.1% (6.7% of rural population)<br>3.3% |
| **Population % with electricity at home** [306] | 10.7%<br>(3.2% of rural population) |
| **Population % with mobile phone in household**<br>**Population % using internet on their phone** [306] | 47.5% (39.6% of rural population)<br>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<br>Health Sector Strategic Plan II (2017-2022)<br>National Community Health Strategy (2017 – 2022) |
| **Public: Private Provision** | 60 % health services provided by government<br>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)<br>26 District Hospitals (outpatient, inpatient & surgery)<br>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<br>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].

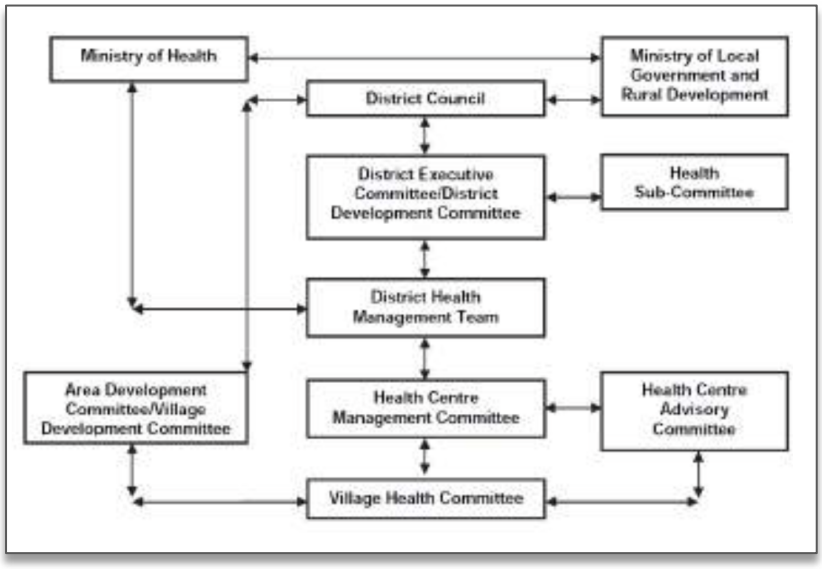


**Figure 5-1:** *Governmental structure of the healthcare system in Malawi* [351]

| 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<br>• Coordination and planning across programs and stakeholders<br>• Setting standards and monitoring adherence to guidelines and policies<br>• Monitoring and evaluating health systems<br>• National projects and central hospitals<br>• Internal and external communication on matters related to the health sector.<br>• Capital investment and expenditure (including contracting, drug procurement and distribution)<br>• 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<br>• Service delivery & public health (including water quality, sanitation, and hygiene)<br>• Recurrent expenditure and procurement for district hospitals and clinics (except drugs)<br>• Monitoring standards<br>• Contracting CHAM health facilities through Service Level Agreements<br><br>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<br><br>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<br>• Inspection of facility conditions and drug stock<br>• Formulating recommendations on facility equipment<br>• Complaint management<br>• Provide feedback & report issues to DHMT<br><br>Members: 10 community members |
| Traditional Authority (Senior Chief) | Community Development | MoLGD | Area Development Committee (ADC) | • Represents all VDCs in a Traditional Authority (TA) area.<br>• 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<br>• 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.<br><br>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<br>• Prepare project proposals to submit to ADC<br>• Community mobilisation and action |
| Group village headman | Community Health | | Community Health Action Groups (CHAG) | • The health-arm of VDC, representing different VHCs<br>• Collective voice on community health issues<br>• Provides support to VHCs to ensure effective functioning<br><br>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<br>• Work with Health Surveillance Assistants (HSAs) to deliver preventative and promotive health services<br>• Develop Community Health Action Plan<br>• Recruits' volunteers<br><br>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

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

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

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

# 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, 413, 414]. 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, 415]?

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.

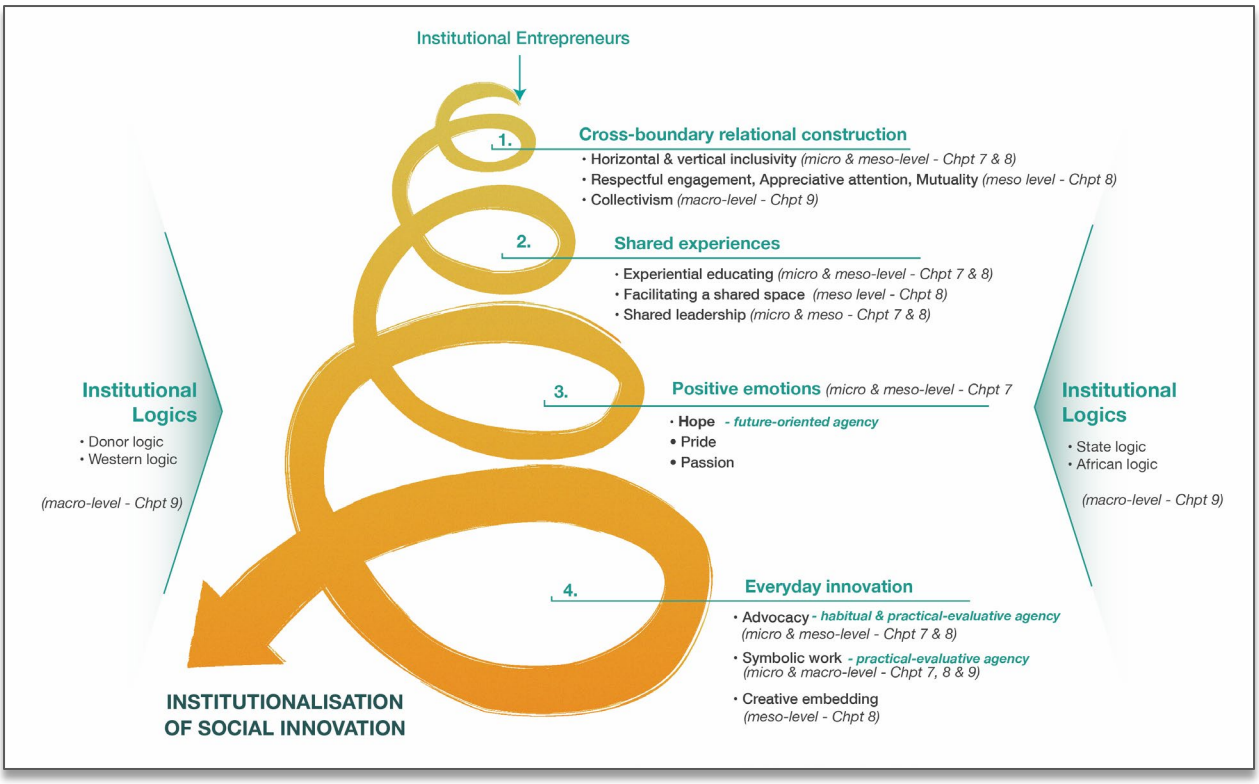


**Figure 10-1:** *Synthesis of software factors in the adoption and institutionalisation process of social innovation, over time.*

### 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 [416-421]; 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, 422]. 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 [423] 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 [424]. Mutuality is understood as relational reciprocity that 'involves reciprocal transactions and exchange, mutual influence and responsiveness and a sense of common purpose' [425]. These relationships embody Buber's [426] 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 [427]. 'Appreciative' as used in the tradition of appreciative inquiry [428], refers to seeing or noticing the generative dimensions in organisational life – 'things that give life (health, vitality and excellence to living systems [429]. Nilsson [430] 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 [431]. 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, 432]. 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 [433] 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 [434]. As described by Pearce [434], 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 [435]

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 [426] 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, 436]. 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 [437] and a problem-solving ability [438] 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, [439] and social processes, including interpersonal relationships [440], also play an important influencing role in the creativity actors had available as a resource to draw upon in support of the institutionalisation process [440].

### 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 [441, 442]. 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 [413, 443]. 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 [444], 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 [418, 445, 446]. 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 [447].

## 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' [448]. 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 [449]

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*

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### 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.

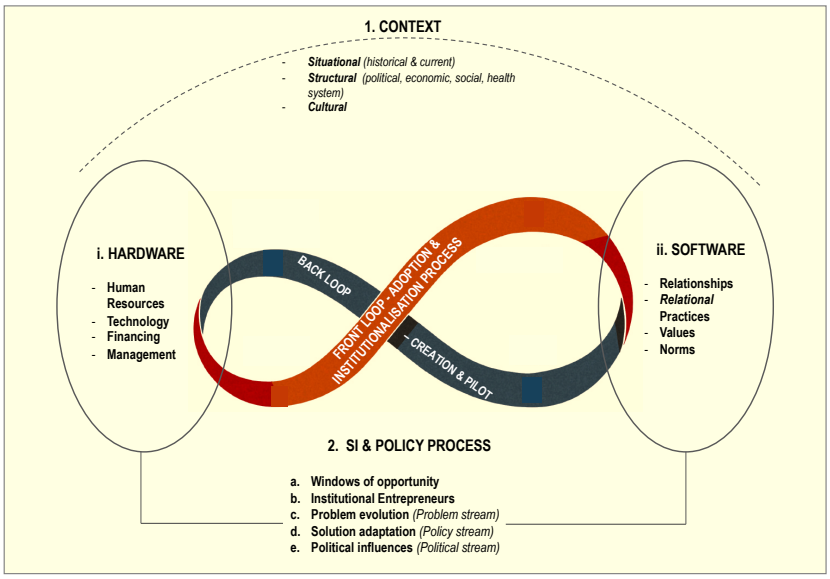
Kalata yofanana yopempha chilolezo izaperekedwa kwa otenga mbali

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 [450]

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 [451] describes how Kingdon is useful in understanding policy formulation, through the coupling of the policy and politics stream; and Ridde [452] 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' [453]. 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 [454]. 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?