SOCIAL INNOVATION AND SOCIAL CAPITAL IN HEALTH, AND ITS IMPLICATIONS ON THIRD SECTOR INVOLVEMENT IN THE PUBLIC SPHERE: REFLECTIONS FOR SELECTED COUNTRIES IN POST-SOVIET EURASIA

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Abstract

This paper reviews the study by Gallardo (2014) on social innovation (SI) in the health sector in selected Philippine provinces. Gallardo's study found government to have developed a space, so different parties including the third sector come together. Also, it appears that the formation of social capital (SC) is apparent and both SI and SC are facilitated by enabling/mediating mechanisms. This study employs key interviews and secondary data reviews, and asks: What is the role of the third sector in the development of SI in health and in the formation of SC? What enabling/mediating mechanisms facilitated the processes of SI and social capital formation (SCF) and third sector involvement? Are these mechanisms public spheres for increased third sector involvement in development? The findings can hopefully contribute to articulating the public value of creating more public spheres for third sector involvement in SI and SCF and stimulate reflections for post-Soviet Eurasia.

Keywords: *social innovation; social capital; social capital formation; third sector; Eurasia*

I. Motivations for the Study

A. Theoretical inquiries

1. Social innovation and the third sector

In Gallardo's (2014) study on three cases of social innovation in health, *social innovation* is defined as the generation and implementation of new idea/s about how people should organize interpersonal activities, which results to new products or processes or a combination of new and socially desirable social practices in certain areas of action. Social innovation (SI) is aimed at the common good and addresses social needs. In most cases, SI leads to the formation of other new forms such as new institutions, industries, policies, and forms of social interaction.

According to Murray et al in *The Open Book of Social Innovation* (2010), SI has six stages – (1) prompts, inspirations, and diagnosis; (2) proposals and ideas; (3) prototyping and pilots; (4) sustaining; (5) scaling and diffusion; and (6) systemic change. These stages are not always sequential and involve feedback loops in between. Other important features of SI in health as far as Philippines is concerned, based on the study by Gallardo (2014) are: (1) it is not identical to economic innovation; (2) it has drawn attention and support by different sectors of society such as government and the third sector; and (3) the fact that Local Government Code (LGC) of the Philippines is the enabling legal framework for SI.

Further, Gallardo (2014) found in her study that each case of health innovation has an overarching SI which she referred to as the *primary social innovation*. Inside the primary SI of the three cases are what she called the *pockets of social innovations*. The design of the three cases corresponded with literature such that when a SI reaches the last or *systemic change stage* the

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new framework is then made up of smaller innovations. Two major types of SI were identified in the study in the context of health, which can either be in the *preventive* or *curative* aspect of the local health system.

An interesting finding however surfaced – though beyond the scope and an unexplored dimension of Gallardo's (2014) study. In one of the cases studied where government was the institutional base for the SI, the latter has also seemingly developed *a space,* so *different parties come together to engage in discussions and debate* and in *solving common issues*.

In that space of engagement, one of the significant actors in the innovation was the third sector. The 2014 study did not examine the exact role of the *third sector*, or more popularly referred to as civil society organizations in the development of SI. Philippine Dr Cariño (2002, p. 18) describes the third sector, as "the space between the state and the market".

Along this line, reviewing the results and findings of Gallardo's study, one case appeared interesting due to the striking involvement or participation of citizens in the SI. In this case the third sector appeared to have actively participated in the delivery of services in a team composed of both government and third sector.

Guided by various studies on SI, the authors find myriad studies citing members of the third sector, including think tanks and grassroots movements, as influencing the growth of SI. Goldenberg et al (2009) paper regards the critical role of the third sector in SI to fill the gaps left by government. Bridging the gap of unserved responsibilities could take the form of ideas (Murray et al, 2010, p. 39), funding (Eng, 2004, p. 241).

Therefore, one research question posed by this study is: *What was the role of the third sector in the development of a social innovation in health in a local government unit?*

Knowledge on this will hopefully lead to the acknowledgement of the seeming significant role of the third sector in the development of a SI in health in a local government unit in selected countries in post-Soviet Eurasia. Also, this knowledge will hopefully stir discussion on third sector involvement such as the likes of *Mahalla* in Uzbekistan to contribute to the development of more innovative health services. Mahalla according to Nezhina & Ibrayeva, (2012) is a "*community of neighbours tied to each other by common need for cooperation and economic security*."

2. Social capital and social innovation

Still, another interesting finding of Gallardo's study in 2014 relates to what she mentions as **Stage 6** of social innovation, the period where "systemic change" is expected, and where a transformative process appears to be a requirement. This somewhat resonates with the study by Diola (2009) where she investigated what social capital (SC) formation can possibly produce - facilitation of development goals plus *new initiatives,* the latter being akin to the concept of SI.

Has the social innovation in health then in the case study by Gallardo been able to produce social capital? This was another motivation for pursuing the study. Furthermore, if the definition by Diola (2009, p. 48) of what SC means is adopted,

> *"Social capital refers to stocks of trust and networks that promote, facilitate, and maintain collective action for a mutual development purpose",*

it can be noted that SC has a close affinity to one aspect of Gallardo's stages of social innovations, which is **Stage 4**, "Sustaining" or maintaining the prototype or pilot.

The societal, systemic implication of SC as well as its possibility for bringing about change or improvements to society resembles the significance of SI. The sociologist Robert Putnam sought to explore the concept of SC as a property of large aggregates. Putnam's (1993) study defined SC as "*features of social organization, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions" (p. 167).*

For this study, the proxy indicators for SC that were used by Diola in her 2009 study is adopted, to wit: *trust, collective action and responsibility, and density of linkages* (p. 49) but we now add a fourth important ingredient that has critical significance to governance and in all of social organizations, that is, the existence of *norms* that bind social relations (Coleman, 1990, p. 310). If this study theoretically assumes that SC can be a product that the SI has used as resource to implement health services until its systemic diffusion, then one objective of the study is to trace these SC forms in the case.

Thus, this research now seeks to ask a corollary question that examines a possible link between social capital and social innovation: If social innovation passes through stages of *sustaining* and *systemic change*, which are potentially what SC can be expected to drive, and recognizing social capital's facilitative role, *"Was social capital (defined by trust and networks that promote, facilitate, and maintain collective action for a mutual development purpose) formed as the social innovation in health was evolving*?"

The above question enables readers to understand how SC may possibly be tapped either as a by-product of or as an ingredient for facilitating the development of SI. The above question is significant to selected countries in post-Soviet Eurasia if studies on determining existence of SC in health as well as studies locating SC in SI in health will be pursued in the future. Such study may then be guided by what d' Hombres, Rocco, Suhrcke and McKee (2007) in their study, "Does social capital determine health? Evidence from eight transition countries," said: "*analysis suggests that policymakers interested in improving health may be well-advised to consider promoting social capital as one relevant means by which to achieve this objective*".

3. Social capital and the third sector

Woolcock's, and Putnam's definitions of SC above are suggestive of equating SC with the dynamics and functioning of networks and the relationships between and among actors. Putnam's (1993) work on democracy and SC was notable for its study on civic associations, or what we may commonly equate with civil society organizations.

This attribution of SC to networks and social organizations can also be traced to Coleman (1990, p. 304-313) who said that the forms of capital include obligations and expectations, information potential, norms and effective sanctions, authority relations, *appropriable social organization*, and *intentional organization*.

The notion that SC inheres in relationships among actors is also propounded by Coleman (1990, p. 302) who argues that: "…Unlike other forms of capital, social capital inheres in the structure of relations between actors and among actors."

4. Public sphere and the development of social innovation and social capital

Earlier, the likelihood that a public space was developed as government engaged civil society representatives and other parties was pointed out in the 2014 study of Gallardo. Diola's 2015 (p. 4) journal article where she studied the idea of a *public sphere* in rural areas in the Philippines and in Thailand considered public space as

> *a dimension conceptually or physically constructed, where public administrators engage citizens and where both parties express their citizenship, consciously or unconsciously, in trying to solve common problems.*

In the study Diola (2015, p. 4) portrays the public sphere as a means by which both public administrators and citizens engage themselves in a dialogue, debate, or in a simple discussion of issues and where access to public goods and services is lodged. Diola's concept of a public space in her study entails not just a physical territory but also embraces a psychological space where citizens have "opportunities to engage in an enlightened debate or dialogue and negotiate with the government, nongovernment organizations, and the private sector."

In public administration, from the idea that civil society is an "alternative delivery mechanism", current discussion by governance scholars has shifted back to the concept of ***public*** in governance, cognizant of the need to engage the public, especially civil society, to complement the delivery of public goods and services. Examining the importance of public spheres above, we note that the coming together of the different parties to engage in discussions and debate and in solving common issues occupies space -- a conceptual public sphere where the other major actors in governance, i.e., government and the private sector are able to act together in a collaborative mode.

5. Link between social capital, social innovation, and the third sector

The link between social capital, third sector and social innovation were succinctly put by Edwards-Schachter (2012). Edwards-Schachter (2012, p. 678) said that "*Mulgan (2006a, 2006b), Morales Gutiérrez (2008), Andrew and Klein (2010), and Echeverría (2010) affirmed that the key distinction between SI and other types of innovation is that SI is oriented to the social and public good and not to the market. SI is conceived as a process involving social interactions and is not explained solely by the combination of tangible forms of capital (physical, financial) but also includes the combination of intangible forms of capital, especially social capital*". Further, according to them, "*social innovation is associated primarily with the non-profit, civil, or third sector, but its practices have evolved, and current innovative social solutions cut across the boundaries that traditionally separated the not-for-profit, public, and business sectors*"(Edwards-Schachter, 2012, p. 677).

6. The public sphere and third sector involvement in social innovation

Andion et al (2017, p. 370) pointed out that the studies by Galli et al (2014), Cook (2015), and Healey (2015) highlight clearly the relationship between civil society and SI: "*Social innovation is focused as a way for civil society to become involved in the public sphere and to 'collaborate' with the government in solving problems, mainly through the co-production of public service*".

Given therefore the missing link in Gallardo's (2014) study on examining the role of the third sector in the development of SI in health, and while theorizing that there is a link between and among *social innovation*, *social capital* and the *third sector* and that the dynamics in the interactions among the actors in the innovation happens in a *public sphere* this study then further asks the following: *What enabling/mediating mechanisms facilitated the processes of social innovation and social capital formation and third sector involvement in the social innovation on health*? *Can this space where the dynamics among the interaction of these processes be considered public spheres where third sector involvement can possibly be highlighted in development?*

The findings regarding the enabling mechanisms can hopefully contribute to future researches in post-Soviet Eurasia especially in cases on enabling/mediating mechanisms facilitating the processes of SI and SC formation and third sector involvement in the SI on health. Also for purposes of future research, considering that in countries like Kazakhstan and Kyr-

gyzstan there are documented cases on innovation and third sector involvements in health as documented by Jütting (1999) it would be interesting to look into the respective enabling/mediating mechanisms that facilitated family group practices (FGP), not-for-profit, voluntary based entities to provide primary health care on a decentralized level as well as determine if there is presence of public spheres where third sector involvement can possibly be highlighted in development. To highlight, Jutting documented that Kazakhstan and Kyrgyzstan "have the greatest experience in reforming the health sector."

> *"The institutional "innovation" in the health sector was the creation of family group practices, not-for-profit, voluntary based entities which provide primary health care on a decentralized level to all family members of a group from a single location. The creation of FGP set the stage for Family Group Practice Associations (FGPA), which are intermediary organizations between the government and the FGP. The FGPA's closely work together with government health services and participate in direct service provision, health status monitoring and reporting. Although in both countries the role of FGAPs includes the representation of their members and the lobbying for a better access to health services, it seems that in neither of the countries health advocacy of FGAPs was achieved."*

B. The Pockets of Social Innovation in Health

The concepts of social capital, third sector, and public sphere are used as leads to examine how SIs may be mainstreamed and upscaled in other local government units. As documented by Gallardo (2014), organizing the Women's Health Team (WHT) is one of the pockets of SI of the primary SI for maternal health that was awarded by *Galing Pook*[3] in 2010 to the province of Surigao del Sur in Southern Philippines**.** The Women's Health Teams were created as part of the Women's Health and Safe Motherhood (WHSM) Project of the Department of Health (DOH).

Adopting the operational definition of SI presented earlier, the creation of the Women's Health Team (WHT) is considered the SI in health for this study. The WHT is aimed at a common good and is socially desirable since the thrust is to reduce maternal mortality rate by employing a new idea on how both citizens organizations such as Traditional Birth Attendants (TBAs) and midwives, as well as Barangay[4] Health Workers (BHWs), who are volunteers for the government's health services programs, can group together instead of competing as regards their clientele; rather, they work in collaboration and cooperation with each other to ensure that pregnant women fulfil their individual pregnancy tracking form and deliver in at least a basic emergency obstetric and new-born care (BEmONC).

C. Methodology

This predominantly qualitative study is an attempt at what Patton (2002) calls an anticipatory research and prospective policy analysis. According to Patton (2002, p. 200), prospective studies can include "doing a synthesis of existing knowledge to pull together a research base that will help inform policymaking". As such the study's research design was guided by Patton who suggested that such types of studies mainly employ rapid field work to quickly get a sense of the emerging developments. The researchers in this study examined unexplored areas of the case on health innovation that may be significant to forward-looking processes, such as policy and planning, which serve as important constructs for future investigation on government-led attempts at SI. Key interviews and secondary data reviews were carried out

[3] Galing Pook (GP) is an award-giving body that looks into the innovations of local government units in the Philippines.

[4] Barangay is the smallest administrative division in the Philippines.

in examining the selected case of health SI in the Philippines, and employed secondary data review to look into SI, SC and public sphere in selected countries in post-soviet Eurasia. Overall, the purpose of the study was to gain new insights in both the theoretical foundation of the concepts of social innovation, social capital, third sector involvement and public spheres discussed above and their practical application to anticipatory (policy) research in the future. Also, another purpose of this paper is to draw reflections from the study for future studies of selected countries in post-Soviet Eurasia.

D. Limitations of the Study

Since the study is predominantly qualitative, anticipatory research using prospective policy analysis for third sector involvement, the findings and implications for application will be limited to similar cases in health innovation initiated by local governments. The study mainly employed rapid field work to quickly get a sense of the emerging developments, extensive data gathering involving other actors, especially from the third sector's perspective were not done, although secondary data based on an earlier study by Gallardo (2014) were used as reference.

II. Findings and Analysis

A. Role of the third sector in social innovation

This study partly used discourse analysis, making sense of the key informants' account, and reviews of past documents. Relevant findings are cursorily discussed here in order to focus on the role of third sector or the Traditional Birth Attendants (TBAs) and the Barangay Health Workers (BHWs) in the case of the Women's Health Team (WHT) as the SI. BHWs are volunteers and given incentives on top of the honorarium given to them by the municipal government and or barangay. The significant role these entities play are as front-liners in collaboration and cooperation with the other members of the WHT. The TBAs and BHWs as well provided information as they provide feedbacks that were significant inputs to the local and regional policymaking bodies.

Note that in the formation of the Women's Health Teams, the presence of BHWs during the development of the SI is at the latter part of the SI stage, i.e., only during the sustaining stage, while nil during the diagnosis and proposal stages. However, in the Local Area Health Development Zones (LAHDZ) system, a glimpse of the involvement of the BHWs from prototyping to the sustaining then scaling and diffusion stages could be discerned.

Table 1 below depicts the involvement of the BHWs and the WHTs in the evolution of the social innovation.

According to a key informant Dr Joseph Orquio, Chief of Hospital of Marihatag District Hospital and Vice-Chairperson of LAHDZ III, "the BHWs were the front-liners in the social innovation. BHWs followed the protocol and process set in the project and actively gave feedback to both their respective municipal health boards as well as the inter-local health board through their representatives." Further, in a text message, he expounded when asked how government in general made use of BHWs as delivery mechanism for health services, he said, "BHWs serve as educators, organizers, assistants during data gathering, monitoring, and treatment partners."

Table 1
Involvement of the third sector in the stages of social innovation in the province of Surigao del Sur

Pockets of Social innovation in Health in the province of Surigao del Sur	Form of BHW involvement	Stages clearly undergone (Murray 2010)
Formation of Women's Health Team (WHT)	No presence	Prompts, inspirations and diagnoses
	No presence	Proposals and ideas
	Front liner in delivery of services Input to policy feedback	Sustaining
LAHDZ system	No presence	Prompts, inspirations and diagnoses
	Presence of BHW representatives in policy meetings and their inputs on WHT related matters as well as on other issues	Prototyping and pilots
	Presence of BHW representatives in policy meetings and their inputs on WHT related matters as well as on other issues	Sustaining
	Presence of BHW representatives in policy meetings and their inputs on WHT related matters as well as on other issues	Scaling and diffusion

Notice the facilitator role of the third sector as front-liner in the provision of public services such as health. This role is significant especially because the government needs to have a face while responding to community residents as first responders. With this role as front-liner comes a strong spirit of volunteerism among the BHWs. In short, the third sector has brought in the spirit of volunteerism. Thus, the BHWs are important gateways by which government or the originators of any SI in the community to hatch whatever social innovation needs to diffuse to and mainstreamed in the community, or **Step 5** Murray's stages of SI. In the case of the BHWs in Surigao del Sur, the basic role of TBAs and BHWs as validated by our key informants is to prepare the pregnant woman. They prepare these women physically and psychologically. Psychological preparations are very important among women in rural areas and more so among the Indigenous Peoples since these women are mortified of only the fact that other people might see parts of their body. They are traditionally compelled to give birth only in the presence of an attendant who belongs to their tribe. According to our WHT informants some tribes even impose that women only give birth in the presence of their mother.

This information potential is further validated by the Department of Health (DOH) website when it said that the WHSMP "*sought to change fundamental societal dynamics that influence decision making on matters related to pregnancy and childbirth while it tries to bring quality emergency obstetrics and new-born care facilities nearest to homes*".[5] At the same time, the WHT served as the active campaigner for the WHSMP. According to Ms Marcelinita Pareja, Administrative Officer of the Provincial Health Office (PHO), "…The objective of having a WHT is to enable

[5] https://www.doh.gov.ph/national-safe-motherhood-program

the health system to reach out to clients in remote barangays. It is through the creation of WHTs at the community level headed by the Rural Health Midwife and BHW and TBA as members that the reproductive health care needs of women are addressed especially in recognizing the danger signs and symptoms of pregnancy and likewise on the area of birth planning where mothers are given the necessary assistance in preparation for her delivery in the hospital or a birthing facility attended by skilled health professionals."

The other potentially powerful role in terms of community strengthening mentioned above is the solicitation of feedback from the community in terms of diagnoses of problems, not only with regard to health, but also with regard to socially related problems such as fear of facility-based delivery in the case of Surigao del Sur. This is an important step towards engendering more participatory approaches to the development of social innovation in the future, or **Stage 1** in Murray's evolution of SI. In the case of Surigao del Sur, WHT informants from San Miguel pounded on the fact that the establishment of WHTs has aided in the constant increase of facility-based delivery indicator of the province as well as availability of the pregnancy tracking form. Indeed, more women were motivated to deliver at the health facility. WHT informants reported that those women especially belonging to Indigenous Peoples (IPs) who have tried facility-based delivery usually share their positive experience to the community after giving birth and have encouraged others to deliver in at least a birthing clinic.

B. Role of the third sector in the formation of social capital

The experience of the formation of the WHTs and their implementation of the provision of health services described earlier suggests that one important element of SC, i.e., the existence of collective action and mutual responsibility was most possibly a requirement for the WHTs to carry out its task effectively. Their task is aimed at a common good and no doubt is socially desirable since the thrust is to reduce maternal mortality rate by employing a new approach on how Traditional Birth Attendants (TBAs), Barangay Health Workers (BHWs), and midwives can group together and not compete for clients, but rather work in collaboration and cooperation with each other to ensure that pregnant women fulfil their individual pregnancy tracking form and deliver in at least a basic emergency obstetric and new-born care (BEmONC).

An important form of SC is *information potential* according to Coleman (1990, p. 310), who stated that one way to acquire information is by using social relations that are maintained even for other purposes. The BHWs, by giving feedback as input to *policy dialogues* on health services are providing a form of information. It is possible that this information potential is a product of the social structure that BHWs are embedded in, whose features inhere in the social relations among them. Such condition closely approximates the examples given by Coleman (1990, p. 310) of social relations constituting SC in providing information that facilitates action, in the case of the study, information that is useful to policy analysis and action for health services.

The second possible form of SC that probably exists in the social relations among the BHWs is what is termed by Coleman as *appropriable social organizations* (1990, p. 312). The term alludes to *volunteer organizations* or organizations that may be brought into existence for one set of purpose that can also aid others for another set of purpose. In other words, Coleman says it is SC that exists in organizations that is available for new purposes. In the case of BHWs, as mentioned earlier, they perform several roles ranging from psychological to technical to some kind of political roles, educators and campaigners for the use of birthing facilities, as well as functions as treatment partners.

Using the indicators mentioned earlier, traces of social capital and its formation are highlighted below.

1. Trust formation

Dr Joseph Orquio explained that one of the functions of LAHDZ is to define, monitor and evaluate public health and hospital services within the area. Dr Orquio strongly agrees that there are traces of all the indicators of trust formation adopted in this study such as – freely share their ideas, feelings and hopes; freely talk to any individual in the project implementation team members about difficulties; members of the project implementation team treat each other fairly and justly; members of the project implementation team or the city/municipality development council tell the truth during deliberations or when making negotiations; project implementation team or the city/municipality development council does not mislead the project beneficiaries; - which are evident during the process of SI development and implementation. For example, trust was manifested in the regular meetings of the Municipal Health Boards (MHBs) of the three municipalities. These MHBs are members of the LAHDZ health board. Dr Orquio said that the BHW representative as member of the board freely talks on issues like continuity of volunteerism and engagement of BHWs in the whole Service Delivery Network. Further resolutions passed by the inter-local health board were born out of feedbacks of the members of the board, including the BHW representative, and their collegial discussion on how to resolve and address issues.

2. Presence of mutually beneficial collective action and responsibility

The social innovation in health studied garnered a *Galing Pook* award sealing the innovative practice; the latter is considered a new idea on how people should organize in order to access a public health service. The result is a new process whereby, not only do TBAs, BHWs, and midwives work together, as a team; they also proactively campaign for a facility-based delivery. WHT has led to a stronger Women's Health Team (WHT)-Barangay Health Station (BHS)-Rural Health Unit (RHU) district hospital connectedness. This also addressed the social need of pregnant mothers who are unable to access health facilities, for reasons of culture and tradition.

Dr Orquio affirmed that a pervading sense of a mutually beneficial collective action and responsibility pervade among different actors during the development and the implementation of the SI, considering that there is a consultative body or mechanism that functions regularly for dialogues or consultations; they can turn to anyone for help or assistance; and the relationship among the different actors in the project is generally harmonious. According to him "all BHW presidents are regular members of the LAHDZ board. The LAHDZ board is the policymaking body of the LAHDZ." He also forwarded the text message of Dr Sherwin Mantilla, Municipal Health Officer (MHO) of the municipality of Cagwait, agreeing to the active engagement of the BHWs in the consultative body that functions regularly for dialogues or consultations. Dr Mantilla said that "ila (their) meeting not all clusters have the same monthly meetings, some cluster area quarterly and the president [of BHWs in each cluster] attend LAHDZ and they have all the reason to be part of [the] cluster policymaking body under the cluster area."

3. Density of networks and linkages

The presence of a dense network as a result of the development of the social innovation was confirmed by Dr Joseph. He further validated that the network has fulfilled a common goal of making sure that the Service Delivery Network works. And it is not just the numbers that count: for Dr Joseph, "the members in the inter-local health board are not only well repre-

sented but competent in implementing the project specially the front-liners – the BHWs." Further, accountabilities for specific roles and responsibilities defined clearly, and in fact the responsibilities of the WHT were already mandated in a provincial ordinance.

As an organization, the Women's Health Teams (WHT) "guarantees an effective community level support system in the implementation of the Women's Health and Safe Motherhood." (Operations Guidelines Women's Health and Safe Motherhood Project 2, 2008, p. 94) WHT is part of the network of the Service Delivery Teams at various levels – community, facility, and local government.

4. Presence of Norms

Dr Orquio thinks that different norms and codes of conduct govern the Project such as the ordinances enacted by the provincial government. Indeed, there is a provincial ordinance that was issued and is being implemented down to the level of the BHWs on this project.

The WHT was established in Surigao del Sur simultaneously because of the non-facility-based health seeking behaviour of pregnant women as well as the fact that the creation is a component of WHSMP. The proposal to include penalties and TBAs in the team in the ordinance was mostly done by the PHO staff. When Ms. Marcelinita Pareja, Administrative Officer of the Provincial Health Office of Surigao del Sur and Coordinator of the Women's Health and Safe Motherhood Program was asked whether she sees the presence and involvement of WHT in the community as sustainable she replied in the affirmative since local ordinances are enforced in most local government units.

According to our key informants, organizing the WHTs was simultaneously done throughout the province and it was done per purok[6]. According to the Operations Guidelines of the DOH, WHTs must be established in every barangay. The case of Surigao del Sur therefore is more advanced. Also "the ordinance mainstreaming the membership of the TBAs to the WHT [is an]… innovation [of the] provincial government… [and] the initiative towards penalizing was really [the initiative of] those who are working for it and lobbying in the Sanggunian Panlalawigan Committee on Health… it was not something that was designed by the project…"

III. Enabling Mechanisms: Platforms for Social Innovation and Social Capital Formation

As to the enabling conditions that paved the way to address maternal mortality are the Local Government Code which has enshrined the local health boards – a mechanism meant for broader community participation and involvement in the local government units as well as approval of Ordinance No 34-2008 (5.8.2008); the informal platforms and consultative style of both Governors Vicente Pimentel and Johnny Pimentel which facilitated dialogue and collective action between third sectors; and the positive feedback from the community. Ms. Pareja mentioned that the positive reaction and feedback of potential clients to the WHTs, due to familiarity, helped in creating a conducive environment for sustainability.

To operationalize the WHT in Surigao del Sur, the provincial government approved Ordinance No 34-2008, which defined the new roles of the TBAs, BHWs, and midwives. Ordinance No 34-2008 also provided penalties for deliveries made outside the birthing facility/hospital to both TBAs and pregnant women as indicated in Section 5 (Prohibited Acts) of Ordinance No 43-2008 (28.10.2008). According to Governor Johnny Pimentel, the ordinance is implemented. In fact, he said that "one or two years ago [a TBA] was arrested but eventu-

[6] Purok is a division within a barangay.

ally released. But she was reprimanded not to do it anymore. We have an ordinance penalizing not only the "hilots" but also the mothers."

The TBAs and BHWs are considered volunteers in this undertaking according to our WHT informants and later validated by Ms. Pareja since the WHT members, except for the midwife, are not regular employees of the municipal government. The WHT members are however given incentives as shown in Table 2 on top of the honorarium, if there is any that they get from the municipal government and or barangay. The following monetary incentives are given to a TBA/BHW/midwife if she escorts a pregnant woman to a birthing clinic or RHU as listed in the table below.

Table 2
Surigao del Sur: Incentives to WHT members

Patient	Amount (in Pesos)[7]
Non PhilHealth	100[8]
PhilHealth beneficiary in the same purok as the WHT	300
PhilHealth beneficiary not in the same purok as the WHT	200

Source: WHT key informants

The Non PhilHealth patients, if it is normal delivery, are charged P2,000. The PhilHealth beneficiaries whether normal or caesarean are free of charge provided that they deliver in government-owned hospitals or birthing clinics or RHUs.

Our WHT informants in the municipality of San Miguel said that although the TBAs were displaced since they are now prohibited from attending to women giving birth, involving them in WHT links them to the health care system. The ordinance which clarified the new role of the TBAs operationalized their ideal role as advocating "for skilled professional care during delivery, in facilities providing basic emergency obstetric and new-born care (BEm ONC). In line with the emergency obstetric care (EmOC)[9] approach the TBA shall act as assistant to the midwife or any other professional health care provider during delivery."

The data above show that rules and ***procedures or norms***, is the third important form of SC that is embedded in the organizational structure of the SI in place. It is most likely the presence of such norms that has tightened the social relations among the BHWs and the WHTs in general. Thus, the formal laws and policies are the ingredients or enabling mechanisms for SC formation; at the same time the shared norms and policies may also been the product of the engagement of the third sector with the SI in health.

IV. Tracing the Public Sphere in the Social Innovation and Social Capital Formation

The seeming public sphere has become a space for volunteerism. This is an important source of the development of informal institutions, participated in by the representatives of the people, in this case the BHWs. The TBAs and BHWs are considered volunteers in this undertaking, except for the midwives, are not regular employees of the municipal government.

The public good aspect of SC - that is, the product of the norms and codes of conduct, trust that has been formed, the collective action and mutual responsibility, and the networks formed - has become a public property of the collective in the implementation of the SI.

[7] USD 1 = Philippine Pesos 53 (as of 27 October 2018).
[8] Paid by the management of the birthing clinic or RHU.
[9] Emergency obstetric care (EmOC) approach means that all births must take place in appropriate health facilities (http://www.unfpa.org/public/home/mothers/pid/4385).

Coleman (1990, p. 317) stresses on this public good aspect of SC, which makes it an important resource for individuals which he says can "greatly affect their ability to act and their perceived quality of life." He says that "they have the capacity of bringing such capital into being".

To build SC, Coleman conceives of the importance of having "closure" of social networks for the emergence of norms (1990, p. 318). He links the importance of closure also to an important ingredient of SC which is trust. To this he points out: "Closure is also important if trust is to reach the level that is warranted by the trustworthiness of the potential trustees." In some cases Coleman says intermediaries may serve as substitute for closure. In the case of Surigao del Sur, the BHWs and the whole WHT team may serve this very closure to seal off trust and develop norms to govern the development activity. Thus, the interactions among the actors in a trust system, enclosed by a norm or code of conduct including rewards and penalties such as in the case of Surigao del Sur is the public space where governance systems comprised of formal and informal institutions may be found and more consciously managed.

One of the assumed evidences of services accessed by the citizens in a public sphere are what the outputs and outcomes of this pocket of social innovation**.** In terms of output, WHT informants from the municipality of San Miguel and key informants emphasized that the establishment of WHTs has aided in the constant increase of facility-based delivery indicator of the province as well as availability of the pregnancy tracking form. Indeed, more women were motivated to deliver at the health facility. WHT informants reported that those women especially belonging to Indigenous Peoples who have tried facility-based delivery usually share their positive experience to the community after giving birth and have encouraged others to deliver in at least a birthing clinic.

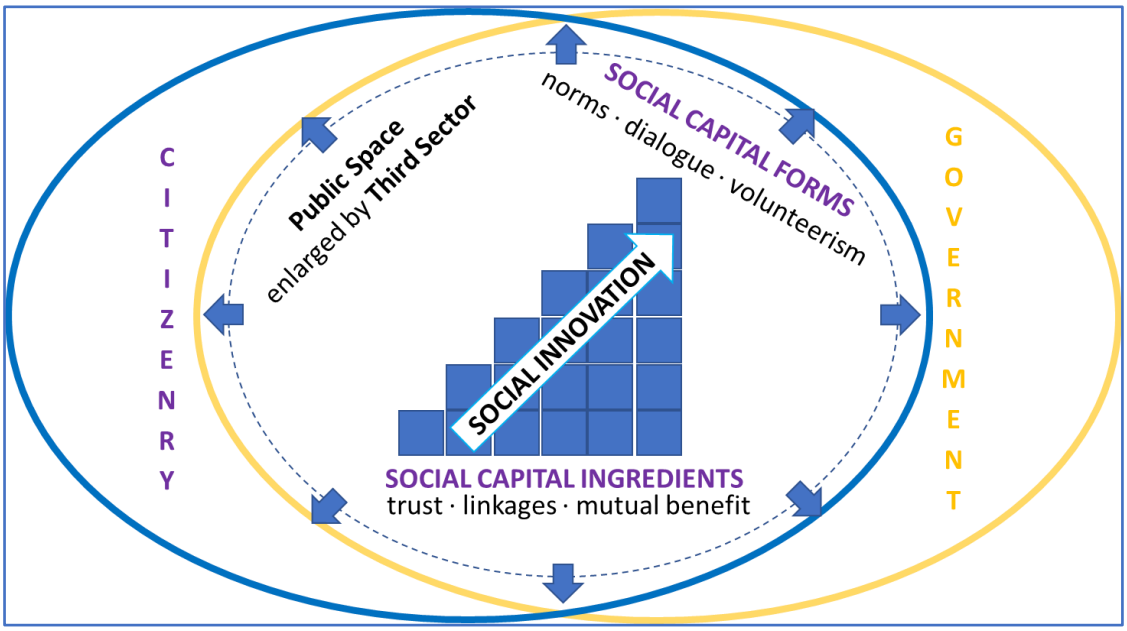
As to how the financial future of the program will be assessed, Ms. Pareja said that "MLGUs' enrolment of the poor to PhilHealth indigency program" can be an indicator. MLGUs' enrolment has increased through the years as validated in the data gathered from PhilHealth, Surigao del Sur. Ms. Pareja also mentioned that the outcome of the creation of WHT's would be "improvement of the health-seeking behaviour of women in the community as well as their husbands." Dr Joselita Quisil, Chief of Hospital, Lianga District Hospital, stressed on the "behaviour shift" of mothers and even husbands to go to facilities. This to her can be credited to the proactive campaign of WHT and health workers. She said further that now, there is "involvement of the community…" At the national level, Ms. Pareja said that WHT took-off and now became "the community health team … [since] the whole design was patterned from **our** WHT…"

The sustainability at the local level is assured because of legislation. Although the project implementation from DOH has ended in 2013, the province of Surigao del Sur has already enacted the needed ordinance defining the roles of the TBA, BHW, and midwife. The municipal governments are also having some adjustments and are tightening their policies to give continuous support to the WHT. Some local arrangements with regard WHT are however not as successful to that of LAHDZ III.

Available metrics used to judge whether WHT works or not are facility-based delivery and maternal mortality ratio according to our key informants. As to actors, those involved in the inception are "PHO staff, chiefs of hospitals, MHOs, public health nurses, DOH central office" according to Ms. Pareja, together with the MLGUs and the provincial government of Surigao del Sur. All throughout the project, Ms. Pareja stressed that "it [was a] collaborative [effort] that is why we do meet and sit in one forum… we sit down together as LAHDZ

where in the TWG of the LAHDZ …" The public space governing the dynamics above may be represented in the following illustration:

Figure 1
Emergent Framework to Account for Third sector Role in Social Innovation and Social Capital Formation in a Public Sphere



The third sector in this case is equated or assumed as a major actor or bearer of social capital from an original state with its ingredients (trust, linkages, mutual benefit, and even formal laws) to its various forms or products: volunteerism (a.k.a. appropriable organization), dialogue (or feedback mechanisms), and shared norms. The involvement of the third sector tends to enlarge public space mainly as a structural and cognitive mechanism for feedback and inputs to the social innovation. It may also facilitate: the diffusion of the innovation from the government to the citizenry; the formation of norms, and the spurring of non-material resources such as volunteerism. Hence, the products of social capital formation seem to also point to what the building blocks for creating public spaces for social innovation can look like. Ideally, third sector input pervades from the initial stage to the final stage of social innovation.

V. Conclusions and Recommendations

An important finding in this highly qualitative study is the significance of the third sector, the BHWs, in the development of the social innovation, although they were not actively engaged or involved in the early stage or conceptualization stage of the innovation. The role of the government in this case is to provide the direction and focus and physical as well as financial resources for the social innovation as well as the political or public space in which the third sector such as the BHWs can be involved with an expanded role in mainstreaming the social innovation. Originally, the BHWs were organized for one purpose. If indeed social capital exists in their social relationships, then it is possible that they can be tapped for other purposes. This remains to be seen however.

Adopting Coleman's forms of social capital, three main forms of social capital derived from social capital formation may be evident in this social innovation: ***information potential*** (in the form of dialogues), ***BHWs as volunteers*** or what Coleman calls an appropriable organi-

zation, and the presence of ***norms***, which has seemed to galvanize and shaped the public space.

As to the public sphere of the social innovation, enabling mechanism for sustaining the social innovation as well as building and renewing their resource of social capital are their norms and codes of conduct, formally governed by the Local Government Code, PHO and LAHDZ, and informally governed by whatever rules or codes of conduct are followed by the actors involved, together with the health beneficiaries at the community level. The public sphere is the political space where policy and decision making takes place. This was crucial in the development of the social innovation. If the social innovation on health is to persist and be sustained, as well as supported by the relevant stakeholders, this space shall serve as the accounting or reckoning unit in assessing how actively various actors, including the third sector is involved, and how responsive the health services being offered are to the authentic health needs of the communities.

It is apparent that social capital exists in the abovementioned forms, embedded in the health teams. New guidelines may have to be formulated to recognize and govern the important roles played by BHWs and the third sector in serving as information potential or source of community inputs to any new innovations on health, from the birthing stage of the innovation up to the diffusion stage in order to extend ownership of the public space especially by citizens. Earlier, the anticipatory nature of this research for policy use was mentioned as a contribution of this study.

This study did not explore the actual mutuality of relationships between and among the actors in the social innovation. We have already seen how social capital may have propelled the social innovation reviewed in this study. If social capital inheres in the relations among the actors, traces of which were already traced in the study, it might be worthwhile to have a sense of the reciprocity of these relationships in terms of obligations and expectations, as proposed by Coleman (1990, p. 314). A more enduring relationship among actors is said to be one where equilibrium exists, which forebodes how social capital may be built or destroyed in the long term. However, for as long as there are norms allowing for third sector participation adhered to and respected by the players in the social innovation in this study, social capital will likely continue to persist as a resource embedded in the social relations of the actors - perhaps not only for health services but also for other purposes.

Reflecting on the context of post-Soviet Eurasia, considering that in countries like Kazakhstan and Kyrgyzstan there are documented cases on innovation and third sector involvements in health as documented by Jütting (1999), this study could aid future researches that might try to look into the role of the third sector in this particular case as well as maybe further the research in testing if such case is indeed social innovation as the authors defined it and trace social capital formation in a public sphere. Further, examine the enabling mechanisms that glued this particular innovation with the goal of using it for replication purposes. Furthermore, perhaps in the case of Uzbekistan review the role of *Mahalla* in social innovation and social capital in health, if there is any, as well as Mahalla's involvement in a public sphere.

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