Making space for social innovation: What we can learn from the midwifery movement

by

Keita Demming

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Abstract

I contend that the emerging field of social innovation is at risk of “social innovation washing”—organizations capitalizing on the trend of social innovation, rather than actually innovating. The current discourse is loaded with language and approaches that suggest market-force solutions to social change and largely ignore the notion that each time we attempt social innovation we evoke a site of struggle. I draw on literature that is grounded in understanding society from a lens of domination of others to propose a strategic approach to social innovation as an alternative to current conceptualization of the term. The thesis explores the question, how can social innovation be understood or used as a strategic or intentional approach to social change? I use a reflective and iterative approach to conceptualize social innovation. I argue that for an activity or process to be considered a social innovation, it needs to accomplish three things: to have changed social practices, relations, or interactions; deeply challenged or changed our existing paradigms (or stances); and significantly changed resource flows within an existing social system. After considering several potential case studies (for example, credit unions, insurance, or the internal combustion engine), I selected midwifery. Midwifery was the only example I could find that had experienced social innovation.
multiple times. Prior to the invention of hospitals, all births happened in homes and within communities. Later, and in many parts of the world, birth moved into hospitals and many communities were excluded from the birthing process. Today, we are witnessing a trend toward births occurring in homes, birthing centres or hospitals, with varying degrees of community inclusion. The thesis argues that for agents to achieve social innovation they need free spaces where they can co-develop their collective identity. Next, agents need to transform current spatial and social practices, existing stances, and finally, the extent to which they can be autonomous or dependent on the existing system. The thesis explored, midwifery communities in Trinidad and Ontario and proposed a model that forefronts the production and reproduction of space as being integral to creating the conditions for generating social innovation.
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Before completing my Master's thesis, the prospects of attaining a Ph.D. seemed implausible for someone who always struggled in academia. Yet, the village - my network of support - has helped get to the end of this long journey. My village now includes several communities, cities and countries around the world who have all supported me to the end of this road.

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Dedication

To Hannah Demming the matriarch of the Demming family. You have inspired many throughout your life to pursue excellence. When you decided to get another degree at the age of eighty-five, you inspired me to pursue an undergraduate degree. Later, when you decided to continue on and pursue a Masters, I decided I had no excuse. As a teacher and principal, you have inspired many people to embrace a life of learning. I dedicate this thesis to you and the wisdom you still provide to the family.
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Chapter 1: A complex world of unmet social needs

“It always seems impossible until it is completed.”

Attributed to Nelson Mandela.

In 2009, the Obama administration launched its Office of Social Innovation and Civic Participation: since then, many post-secondary schools, such as the University of Waterloo, George Brown College, Stanford University, and Simon Fraser University, have all launched various programmes in social innovation. But there has been little agreement on what social innovation is. Popular examples of social innovation tend to be about making the world a better place, while more formal or academic accounts seem to place emphasis on systems change. With the increased popularity of social innovation, the field is at risk of “social innovation washing” — organizations capitalizing on the trend of social innovation, rather than actually innovating.

In this thesis, I explore the mechanism of social innovation by examining how two exemplary midwifery groups, in very different contexts, were able to generate social innovation. This research is guided by two overarching questions:

1. What do we mean by social innovation?
2. How do we create the conditions that support or generate social innovations?

The thesis draws on existing literature to redefine social innovation as an activity that profoundly changes social relations or interactions, deeply challenges or changes our existing paradigms (or stances), and significantly changes resource flows within an existing social system.
My interest in social innovation stems from the observation that very little critical theory focuses on the innovations that bring about the desired outcomes citizens hope to achieve (Biggs, Westley, & Carpenter, 2010; Pol & Ville, 2009). A focus on what is the innovation or the activity that will generate our desired outcomes serves as the overarching frame for this research project. In later chapters, I develop a substantive framework for identifying social innovations, and how this conceptualization can be used to foster the conditions that support social innovation. It is my hope that this thesis will be used to frame emerging approaches to social innovation that help improve well-being and provide practitioners with tools that help them build more inclusive societies. Social Innovation is not a silver bullet. There are no heroes. There is immense value in organizations that provide immediate support to people with high needs. For example, food banks, safe houses or emergency types of service provide a much-needed support of marginalized communities. Social innovation should be understood as a parallel approach and not a replacement for these services that are needed in the short-term. In general, social innovation should be understood as a medium to long-term strategy that helps address some of society’s most urgent challenges. Some people who are attracted to social innovation believe in power of entrepreneurship, while others blame or demonise entrepreneurial approaches to creating a more inclusive world. The approaches suggested within the pages of this thesis are not intended to be sector specific, but is an attempt to find a way for citizens with very different views to find ways of working together.

As I understand the social innovation landscape at the time of writing this thesis, many of practitioners in the sector are working in the arena of aspirational social innovation. This thesis is intended to provide a framework that helps practitioners move
from aspirational social innovation into the arena of strategic social innovation. I in no way hope to further the argument that we can use free markets to solve the world’s most pressing problems. Instead, I have drawn on theories and theorists who understand the world as being best explained in terms of domination by one group over others. The heuristics presented are intended to be used to alleviate the inequalities that exist within society. Although I avoid a normative understanding of social innovation, it must be made clear that the frameworks presented are designed to be used to identify domination and find ways to liberate citizens from their dominated contexts. We must vigilant about approaches that are intended to improve impact but continue domination.

**Why a focus on social innovation matters in today’s world**

The world is rife with examples of solutions that often generate new social challenges. For example, health care is often touted as one of the most important institutions in modern society (Yadavendu, 2013), yet these systems are imperfect, and do not meet all of our health needs (Rosen, 1959; Rosen & Parr, 1959; Wilsford, 2008; Yadavendu, 2013). Many systems have long waitlists, or citizens experience unequal access to services. There is a considerable lack of co-ordination between caregivers. Caregivers very often do not know their patients’ history (CHPES, 2004). Aging populations can very rarely find one institution that can manage all their needs (DeBusk, 1994; Korff, 1997; Wagner et al., 2001). The imperfections are particularly evident in two-tier systems—systems with both public and private health-care services, where outcomes are considerably worse (Coye, 2001; Kiil, 2012; Lameire, 1999; Schoen & Doty, 2004; Wilsford, 2008).
Similarly, in most western countries few would argue against the idea of free access to education (Boldrin, 2005). Yet counterculture movements like homeschooling (Bhatt, 2014; D’Escoto & D’Escoto, 2007; Green & Hoover-Dempsey, 2007; Hurlbutt, 2011; Macleod & Gaither, 2009) and charter schools continue to rise (Levine & Levine, 2014; Nathan, 1997; Rofes & Stulberg, 2012). Ken Robinson, in his now popular TED Talk, argues that our education system is failing to prepare the next generation for the world it will need to navigate.¹

The World Wide Web, or what we colloquially refer to as the Internet, is yet another example of an innovation that only meets some of our needs (McGowan & Westley, 2014). As a recent innovation, the Internet has transformed the way many people around the world communicate. It has provided the world with unprecedented access to information and has heralded a digital age in which many new social and technical challenges lie ahead. Issues including cyber-security, digital privacy (Kulesza, 2012; Sicari, Rizzardi, Grieco, & Coen-Porisini, 2015; Ziegeldorf, Morchon, & Wehrle, 2014), and digital citizenship or activism (Earl & Kimport, 2011; Hill & Hughes, 1999) are still problems we have yet to address.

One prominent example of how these types of innovations are producing new challenges is exemplified in the case of Aaron Swartz. Swartz was nothing short of an Internet prodigy. He used his programming skills to develop digital tools for social good. He helped co-design tools like RSS and services like Reddit. Much of the code that underlies the Creative Commons, a service that allows users to assign how they would like to attribute copyright laws to their digital work, can be attributed to him (Naughton,

¹ With more than 33 million views, Ken Robinson’s TEDTalk points to a system out of alignment. http://www.ted.com/talks/ken_robinson_says_schools_kill_creativity
Swartz saw open access to information as a human right. In one example, he had figured out how to download large numbers of articles from the popular academic platform or portal JSTOR. He had also downloaded a large number of medical articles and used data-mining to find links between the authors and pharmaceutical companies (Naughton, 2015). Swartz’s activity with JSTOR eventually landed him in court, where he faced thirty-five years in prison.\(^2\) The odd thing about the Swartz story is that the publishing company JSTOR had dropped the charges, but the state decided it needed to make an example of him. Faced with the prospect of prison, Swartz eventually committed suicide.

His case is a tragic example of someone who hoped to change the world, but was caught between emerging and existing paradigms. Swartz believed in a utopian world of open access to information, and built technology to reflect the world he believed in. His beliefs, and the innovations he developed, challenged deeply held assumptions and existing structures. Society is still trying to understand how to regulate and develop legislation that complements innovations like the Internet, and its many applications, such as Uber and Airbnb, that are challenging the status quo.

These problems are often situated at the intersections of public, private, and social sectors, yet many of the conversations seem to focus on the social sector, the social economy, or other activities with the prefix “social.” It would not be fair to argue that we have completely outsourced social change to the social sector, but there is a perception that social change should come from the social sector. I position social innovation as being centred on citizens changing the way they work together: their practice. Later in

\(^2\) You can sometimes view a documentary on YouTube titled, “The Internet’s Own Boy: The Story of Aaron Swartz” which chronicles his life.
this thesis I challenge our use of the word “social” to mean more than “doing good” and propose a process-oriented approach to social innovation that refers to changing our social interactions. For example, if we define organizations as “a series of interlocking routines, habituated action patterns that bring the same people together around the same activities in the same time and places” (Westley, 1990, p.339), then we see, as Weick (1993) points out, it does not take much to form an organization. Consequently, I adopt an approach to social innovation that focuses on organizations and organizing as the primary approach to fostering social innovation.

Often, many of us believe we know the changes that need to be made, but the process of overhauling our institutions and organizations to fit better with our new realities, or building new realities, can be uncomfortable, and painfully slow. Westley’s (1990, p.339) definition implies that if we are to accomplish change, we need to work with others to form organizations, either formal or informal ones, that can help actors accomplish their objectives. The literature on organizational change is full of examples of the kinds of challenges practitioners face as they try to bring about new realities (Grant & Marshak, 2011; Higgs & Rowland, 2005; Kotter, 1996; Lewin, 1947; Shaw, 2009; Todnem By, 2005). More recently, the innovation literature has tried to address the challenges of overcoming organizational inertia (Geiger & Antonacopoulou, 2009; Lazerson & Lorenzoni, 1999; Shekhar Mishra & Saji, 2013; van Witteloostuijn, 1998) and path dependency (Kay, 2005; Strambach & Halkier, 2013; Wilsford, 2008). As a result I choose to begin my understanding of social innovation from an organizational-change perspective.
The lens of social innovation

History reminds us that social problems have always been a by-product of social life. Our foreparents lived through slavery, wars, and the threat of deadly diseases, for instance. As the world gets increasingly complex, we need to develop models and approaches that help us navigate these emerging complexities. Two underlying assumptions explicitly inform the approach taken throughout this thesis. First, that change emerges through organizing and organizations (Westley, 1990). Second, the social world is complex, nonlinear and emergent.3

Literature on organizational change suggests that organizations or institutions are rarely able to change quickly enough to keep pace with the increasing complexities of our changing world (Senior & Fleming, 2006; Heger, Jung, & Wong, 2012; Rakotobe-Joel, McCarthy, & Tranfield, 2002; Reissner, 2008; Stickland, 1998; Todnem By, 2005). Although there are many approaches to organizational change, Higgs and Rowland (2005) described them as existing in four quadrants. Along one axis you have approaches that are uniform or differentiated. Along the other axis you have approaches that assume change is predictable or non-linear (or complex). Stacey (2010) argues that many organizations seem to be caught in a myriad of models, but there is a dominant emphasis on command-and-control versus approaches that embrace loose forms of control and self-organization (Karp, 2009; Stacey, 2003). Many theorists have argued that the command-and-control hangover of management is not compatible with the everyday reality of organizations (Burnes, 2005; Byrne, 1998; Mesjasz, 2010; Stacey, 2010). Current social

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3 Several authors have written about complexity and its implications for understanding organizations. For a good introductory article on complexity, see Burnes,(2005 Other authors that offer good introduction to complexity theory include: Byrne (1998), Mesjasz (2010), Plsek and Greenhalgh (2001), Stacey (1995),Mowles, C. (2011) and Stacey (2003). Zimmerman and Hurst (1993).
innovation theorists draw considerably on organizational theory and complexity theory. These theories provide helpful frameworks and metaphors for embracing loose control (Antadze, 2010a; Buckley, 1998; Schneider & Somers, 2006; Westley, Zimmerman, & Patton, 2009).

This notion of complexity is compatible with an emerging field of study that is concerned with addressing complex social problems. Complex social problems or intractable problems are well explained by Rittel and Webber’s notion of wicked problems (Rittel & Webber, 1973). For Rittel and Webber (1973, p.155) it made little “sense to talk about ‘optimal solutions’ to social problems unless severe qualifications are imposed first.” They argued that these problems are different from scientific problems. There are “no ‘solutions’ in the sense of definitive or objective answers.” Wicked problems were typified by eight characteristics: i) wicked problems have no stopping rule; ii) solutions to wicked problems are not true or false, but good or bad; iii) there is no immediate and no ultimate test of a solution to a wicked problem; iv) every solution to a wicked problem is a “one-shot operation”; because there is no opportunity to learn by trial and error, every attempt counts significantly; v) wicked problems do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan; vi) every wicked problem is essentially unique; vii) every wicked problem can be considered a symptom of another problem; viii) the existence of a discrepancy representing a wicked problem can be explained in numerous ways, and there is very rarely agreement on the way forward (Rittel & Webber, 1973, p.155). If we take wicked problems seriously, then
the frame we should adopt to address them should be compatible with the nonlinearity of these problems.

**Social innovation in context**

Very little theory exists to help us understand how we address pressing social needs using a social innovation lens. This thesis explores how we might use an historical example of a social innovation to provide insight into how we can generate conditions for social innovation.

Drawing on the conceptualization of social innovation as an activity or process that profoundly changes social relations or interactions, deeply challenges or changes our existing paradigms (or stances), and significantly changes resource flows within an existing social system, midwifery emerges as an ideal case study.

As one of the oldest female professions, midwifery reminds us that social innovation has always been part of the human story (Ehrenreich & English, 1975). Midwifery has had a long history of disappearing, re-emerging, and experiencing passive change. The cases presented in this thesis focus on a period (the 1990s in Ontario and the early 2000s in Trinidad and Tobago) when midwives used their savvy to reclaim birth—intentional change. The history of birth and midwifery shows three clear moments of social innovation: the pre-medicalization era, when most births happened in the home; the medicalization era, when most births moved into the male-dominated medical care systems; and, finally, the “post-medicalized” or “de-medicalization” era, where births are becoming a hybrid of home births and hospital births (Bourgeault, 2000; 2006; Bourgeault & Fynes, 1997; Bourgeault, Benoit, & Davis-Floyd, 2004; Rutherford, 2010).

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4 Went through profound changes in social relations or interactions, saw radical changes in existing paradigms (or stances) toward midwifery, and experienced significant changes of resource flows within the existing social systems.
This hybrid is not a mainstream phenomenon, but is a growing trend. Each era has involved a change in the way we think about births (the paradigm); how birth has been experienced and who was allowed to attend or assist with births (change in social relations, practice and interactions); and how we pay or barter for midwifery services (change in resource flow).

Despite the recent rise in popularity of the term “social innovation,” it is important to note that humans have been socially innovating for a long time and will continue to do so, with or without a well developed understanding of social innovation as theory. Good theory should help provide citizens with heuristics for navigating complex social problems (Weick, 1989). Although it is unlikely that we shall ever achieve a utopian world that has all its social needs met, this thesis is an attempt, naïve or not, to develop a conceptual framework that may improve our chances of bringing about a world that is more socially and environmentally sustainable.

Outline of the chapters

The decision to study midwifery as an example of a social innovation slowly emerged throughout the research process. In the early phases of the research, I made the assumption that collaboration played a major role in social innovation. Consequently, in the first phase of interviews I snowball-interviewed (brief explanation of that phrase here?) people who worked in a variety of contexts where collaboration played a major role. One informant suggested that I explore collaboration within the context of midwifery. Simultaneously, in my personal life, I was a bystander to midwives assisting my roommates with a home birth. It is in part through that experience that midwifery became the focus of this thesis.
In the process of telling the story of how a small group of midwives was able to bring about social innovation, this thesis will present a framework for how practitioners might be able to contribute to the generation of social innovation. To the best of my knowledge there is no literature or study that frames midwifery as a social innovation. This thesis contributes to the literature by conceptualizing a thick description of a socio-spatial approach to social innovation (Lefebvre, 1992; Stanek, 2008). “Socio-spatial” here means that space is not considered a neutral backdrop of the change process, but rather that space is explored as part of the social construct within the emerging theory.

This thesis has several objectives. First, it will demonstrate how a series of small or technical innovations has led to midwives changing the social interactions, practices, relations, and resource flows around birth in two very different contexts. Secondly, the thesis intends to develop a thick definition and description of social innovation as a way of demonstrating how we can avoid social innovation washing—when organizations appropriate the term without deep engagement—rather than actually innovating. The study will use well-established theoretical domains to develop a framework for social innovation. Thirdly, it will use a carefully selected case study to understand the role of space within the context of generating social innovation. Similarly to the way a doctor might use a dye to clearly identify and understand the boundaries that exist in the human body, not sure that simile works or is necessary I use midwifery as a case study to gain insight into social innovation. Just as the dye might have special properties to help the doctor understand the body, the history and development of midwifery have particular characteristics that make it an ideal way to understand space for social innovation.
This first chapter of this thesis provides an introduction to social innovation within the context of a complex world. It intentionally situates questions of social innovation very broadly. The second chapter, the methodology chapter, outlines the hybrid conceptual approach taken throughout the thesis. Here the author emphasizes the iterative approach used to develop a theory of social innovation. In Chapter 3, I problematize current definitions of social innovation to propose an alternative way of conceptualizing what counts as a social innovation. In Chapter 4 I build on this by walking the reader through the history of midwifery as a way of rethinking what counts as social innovation. Chapter 5 outlines the first conceptualization of space by exploring the preconditions or pre-formative aspects of creating space for social innovation. Here I outline how midwives were able to set the stage for social innovation before embarking on their social innovation journey. In Chapters 6, 7, and 8 I outline a triadic approach to generating social innovation: how social and spatial practices, stance, and autonomy versus interdependence all play an integrated role in generating social innovation. These chapters serve the role of synthesizing the presented framework, outlining the key findings of the study, and exploring the limitations or implications of the proposed approach to social innovation. In the final section, Chapter 9, I explore several implications of the proposed social innovation framework. In this section I move beyond synthesizing and describing the framework to explore the implications of spatial approach to social innovation.
Chapter 2: Towards a methodology for developing a theory of social innovation

“A theory must be tempered with reality” Nehru, (1964 p.235).

Introduction to methodology

“In its broadest sense, research is a systemic process by which we know more about something than we did before engaging in the process,” (Merriam, 2009, p.4). Given that all research is guided by the inquirer’s stance (Bryman, Bell, & Teevan, 2009; Creswell, 2012; Patton, 1982), this section also locates the inquirer’s stance in an effort to provide the reader with insight into the mental models that informed the methodological and theoretical choices made throughout the research journey (Greene, 2007).

It is important to note that this methodology is reported in a linear, step-by-step manner, but the research was an iterative process that utilized the constant-comparative method (Boeije, 2002). This meant that the researcher moved from method to method depending on the stage of the research and what was emerging in the data. The following is an attempt to present a clear roadmap of the inquirer’s research journey.

Research interest

The purpose of this research is to make a substantive contribution to the emerging field of social innovation. This section outlines the methods used and the approach taken
to answer the two main research questions (What do we mean by social innovation? and: How do we create the conditions that support or generate social innovations?).

These research questions demand a form of systemic inquiry that is inductive, interpretive, and exploratory. The methods chosen attempt to stay as close to these demands as possible and adopt an approach that integrates an iterative approach to qualitative research and case-study method (Halaweh, Fidler, & McRobb, 2008).

**Locating oneself in the research**

“Qualitative research usually emphasizes the meaning of words rather than quantification in the collection and analysis of data. As a research strategy, it is inductivist, constructionist, and interpretivist, but the research does not always subscribe to all three of these features” (Bryman et al., 2009, p.542). Qualitative research is mainly concerned with “understanding the phenomenon of interest from the participants’ perspective, not the researcher’s” (Merriam, 2009, p.14). This observation brings an inherent contradiction to the forefront. On the one hand, qualitative research is interested in the participants’ perspective, while acknowledging that the primary instrument of research is the inquirer. Admitting that the inquirer is the primary instrument of research evokes the reality that researcher has biases, or “subjectivities” (Bryman et al., 2009; Merriam, 2009). There are many ways to decrease these biases, some of which are presented at the end of this section, but one way is by making your biases explicit.

Greene (2007), in her popular book on mixed methods, explains that she asks all her students to locate themselves in their work as way of informing the reader of the inquirer’s stance. In making my stance explicit, I allow readers some access into the
mental models that brought me (the inquirer) to favour particular theoretical choices and to interpret the data in particular ways. Here I locate myself in the research in an attempt to improve reliability and validity. Different researchers might have chosen other theoretical approaches or themes, based on their own mental models.

My prior education and experience have had a great influence on how I have come to understand the world. I came to be interested in social innovation through life experiences that have left deep, haunting questions that either pertain to creating the conditions for change. For example, I pursued a master’s degree in organizational change, because I believe most change emerges out of organizing and organizations, as discussed by Westley (1990). It is through organizations and organizing that we are able to untangle the larger systemic structures that contain hidden barriers, glass ceilings, and invisible walls that limit individual choices (Schatzki, Cetina, & Savigny, 2001).

During my master’s degree I became deeply interested in complexity theory and its implications for organizational change. Although I have since moved away from complexity theory slightly, it is an approach that deeply informs the way I interpret the world. Complexity theorists argue that social systems are nonlinear, emergent, and self-organizing (Stacey, 2010; Zimmerman, Lindberg, & Plsek, 2001). They acknowledge that we are not in complete control of our social world or the activities which produce unwanted, unintended, unexpected, and expected outcomes (Stacey, 2010; Zimmerman et al., 2001). For these theorists, we would be far better off if we understood strategic decisions as temporary holding positions versus predetermined, planned approaches (Mowles, 2011; Stacey, 2010). My own views tend to support approaches to planning that are flexible and nondeterministic. I prefer approaches that do not force actors to
commit to early plans, and allow them to adjust as their projects unfold (Hassan, 2014; Patton, 2010; Stacey, 2010).

After completing my master’s program, I began working at Social Innovation Generation (SiG@Waterloo). At the time, my graduate work was deeply influenced by Ralph Stacey, who, coincidentally, supervised Brenda Zimmerman’s doctoral work. Brenda was one of the main thought leaders at SiG@Waterloo. Consequently, her thinking has greatly influenced my own understanding of the world. Zimmerman (1993) used the Stacey Matrix to develop a metaphor for understanding complex social problems that I outline in later sections of the thesis. She argued that problems could be understood as being simple, complicated, complex, or chaotic. Simple problems are described as being similar to baking a cake, where cause and effect are very closely linked in time. The rationale is that if one follows a recipe, then one can be fairly certain that the outcome will be positive or close to the intended result: even someone with very little experience can follow a recipe for baking a cake and get reliable results. With complicated problems, cause and effect are often separated by time. Complicated problems require high expertise, but with enough time and resources they can be solved. Complicated problems are most often compared to launching a rocket or planning a large outdoor festival, in that with enough planning and expertise the results can be reliably repeatable and attainable. Although complicated problems can often follow a particular formula, they usually require high levels of expertise and a considerable amount of planning, eventually leading to relatively high levels of certainty. Chaotic problems usually refer to crisis or emergency scenarios like storms or earthquakes.
Complex problems are different, in that they are often described as being analogous to raising children. What this analogy highlights is that children are not passive in the child-rearing process. As adults try new parenting strategies, children tend to change their responses. There are no formulas for raising children, nor are there right or wrong approaches. There are, however, better or worse strategies. In this situation cause and effect are only knowable in hindsight (Westley et al., 2009). One of the powerful contributions Zimmerman’s work has made is the simplicity with which practitioners can now use the metaphor to parse various aspects of their work into the domains of simple, complicated, and complex problems. This contribution allows practitioners to develop strategies that are compatible with the problems they are facing.

As the inquirer, many of the categories that would resonate with me would also be consistent with a complexity-theory lens. I have a preference for thick descriptions, or stories, as the way to understand human arrangements (Alvesson & Skoldberg, 2009; Tsoukas & Hatch, 2001). This view has led me to prefer qualitative research as an approach to understanding human arrangements. I am cautious about reductionist approaches to making sense of the world and prefer more qualitative accounts of the human experience (Krogh & Roos, 1994; Tsoukas & Hatch, 2001). There is much debate in the academic world about the value of qualitative research, but to delve into the debate would be beyond the scope of this thesis (see Alvesson & Skoldberg, 2009; Greene, 2007; Johnson & Onwuegbuzie, 2004; Maxwell & Loomis, 2003; Stacey, 1996).

Complexity theorist Ralph Stacey (2010) has also drawn on some classical sociologists to address some of the paradoxes he has observed while theorizing organizations using a complexity lens. For him, our social ties determine how much
autonomy or agency we are allowed to exercise within any system (Bourdieu, 1984; 1990; Elias, 2000; Giddens, 1986; 2013). Stacey (2010) argued that agents within a social system are rarely fully empowered or autonomous. These arguments have also been made in the classic structure-versus-agency debates throughout the humanities and social sciences (Bourdieu, 1984; Elias, 2000; Giddens, 1993; Paulle, van Heerikhuizen & Emirbayer, 2012). My own disposition is to the view that structure and agency cannot be conflated, but instead are in tension, or exist in polarity with each other. To privilege either would mean devaluing the other, when they are deeply connected. Structure generates behaviour but does not determine it. Agents’ decisions are influenced by structure, but they are not determined by it. That is to say, they exist in relationship with each other. At times it makes more sense to place emphasis on structure; at other times it is more appropriate to place emphasis on agency (Johnson, 1992).

Locating myself within the context of midwifery

Greene (2007) argues that locating oneself in the research improves the chances of increasing the validity of the study. I “locate myself” so the reader can have some insight into my subjectivity. This section is a vignette of some of the reflections I made while interpreting the data.

At the start of this research journey, I intended to study social labs and collective impact. In the first phase of the research I explored the terrain of the social innovation by conducting shallow interviews with key informants. In these interviews an informant suggested I explore midwifery as an exemplary model of collaboration. At first, I either ignored or underestimated its potential. In reflecting on why it took me some time to
explore midwifery as a case study for social innovation, I was reminded to forefront consistently my subjectivity as an inquirer. Had I been a father, a woman, or had a sister, I might have explored the option earlier. At the time, I lived with a couple who were having a baby and had opted for a home birth. In that very personal journey, I experienced the humanizing of a process that I had imagined as only possible among the bright lights and white walls of a hospital. This opening-up of my own conceptions of what was possible also helped shape how I understood the unfolding research. As a bystander to a midwife-led birth, I began to appreciate the importance of choice within the health-care system. I was impressed by the quality of care the family received, and personally witnessed the benefits that can come from parents having control over the birth process. My roommates could choose whom they wanted to share in the experience of their first-born. They were able to invite a photographer, who captured the story of their birth. (The labour in this case was relatively short, and fortunately, there was no need to transfer to the hospital: this birth went as well as births can.)

Although I did not make my decision then, my curiosity was piqued enough for me to turn to the literature on midwifery. The more I read about the art and practice of midwifery, the more I began to see it as a potential example of social innovation. Most importantly, midwifery matched the three-pronged definitional heuristic that I had developed. When I interviewed midwives, it was not uncommon for them to ask how I came to be interested in the topic. Today, when people learn that I am studying the topic of midwifery, I often get a look of surprise. I give a simple response: “I came to the topic by following where the research led.”
In this research, I explored midwifery through the eyes of an Afro-Caribbean male who was yet to have children. My own social position assumes that I will one day have children, and although this research is intended to explore social innovation, at times I needed to remind myself not to let the interesting details of midwifery distract from my focus. It is very easy for an interest in nuances around midwifery to inspire interesting questions that were not about social innovation. For example, during a period in the research, I became very interested in the oral history of men who were present at the birth of their children. How did these men make sense of their experience? How did they perceive that it affected their parenting? These are interesting questions, but they were distractions. For curious minds, it is important that we remember that this thesis explores social innovation through midwifery.

My most looming bias is perhaps an experience I had as a teenager that has helped shape how I understand the world. It began because, as with many children, school did not excite or engage me. I was utterly bored by the reading that teachers were assigning, so my parents suggested I read a few books from their library. The first one I read was about Malcolm X, and I loved it. My parents insisted I read about Martin Luther King, and I remember when I finished reading these books I asked them something like, “How was it that one man promoted peace and the other promoted equality by any means, yet they were both murdered?” I remember a long conversation at the table, with my parents stumbling to answer the question. What I took away was that it was not fair or just for citizens to have to be willing to die to be able to participate fully in the world. Perhaps this is why the word “activism” has never been something I have connected with. I have always found it strange that we label people with a word that implies “rebel,”
when activists are usually citizens fighting for full participation. For example, the fight for civil rights, marriage equality, a living wage, or environmental protection has been about citizens wanting to be able to participate fully and without limitations in our world. Even those who are anti-immigrant, racist, or xenophobic have a legitimate fear that others are trying to revoke some part of their own full citizenship. So my biggest bias has to be that although social movements are important, I am not convinced they are the most strategic approach to change. They are part of the puzzle, but just that, part of the puzzle. Audre Lorde is often credited with the quote: “The master’s tools will never dismantle the master’s house.” Yet when I read stories of revolts and rebellions, slaves often stole the tools of their masters when they rebelled. Social innovation is an additional strategy to social protest, resistance, and fighting the power.

Concluding comments on locating yourself in research

Many of the research choices taken in this thesis are consistent with seeing the world as being complex, and from the stance of a constructivist and subjectivist. This brief attempt to outline my own mental models is an effort to provide the reader with an understanding of my biases. The hope is that through making my mental models explicit, readers can help illuminate places that may need further evidence or alternative explanations. “All social inquiry is conducted from within the inquirer’s particular way of seeing, hearing and understanding the social world,” (Greene, 2007, p.67). Researchers bring their stance, mental models, or way of understanding the world to their research. Making these mental models explicit can help increase transparency and improve the validity of qualitative research. The rationale for this approach comes from a long history
of debate over the objectivity and subjectivity of research, and in particular qualitative research (see Greene, 2007, for a summary).

**Structure of the study**

The research was divided into what can be loosely defined as four unordered, overlapping phases:

1. Zooming out by making sense of the literature;
2. Shallow zooming in by beginning to understand the perspectives of actors in the field;
3. Zooming in by engaging in deep-dive conversations with practitioners; and finally,
4. Zooming out by developing substantive conceptual frameworks.

All phases adopted a multi-methodological approach to making sense of the emerging research, while sensitizing oneself to the existing literature and theory. The study used an emergent design and snowball methodology to follow the conversations where they led. This zooming-in and zooming-out approach was informed by the work of practice theorist Nicolini (2012), who argues for a pragmatic approach to researching organizations. His language of zooming in and out was helpful for a process that was nonlinear and could be loosely divided into phases.

Although the approach is presented linearly, phases almost always occurred in tandem with each other. Figure 2.1 attempts to provide a visual representation of what the process might look like.
Figure 2.1: Methodological phases for building a framework of social innovation

Zooming-out phase by making sense of the literature

This study began by examining documents, reports, blogs, publications, Twitter feeds, and academic publications to begin to develop categories and properties of social innovation, while simultaneously interviewing eight key informants who identified as working in the social innovation space. As an insider, I began with purposive and snowball interviewing with two key informants (see Appendix A for interview protocol).

Following these shallow interviews, I returned to the theory, drawing on theoretical sampling and constant comparative (Boeije, 2002). As themes emerged from the conversations, they informed the emerging conceptualization of social innovation (Boeije, 2002). In using constant comparative and theoretical sampling to develop codes, categories, themes and properties of social innovation, I was able to build the theory as
the research progressed (Bryant & Charmaz, 2010; Creswell & Clark, 2007; Greene, 2007). The approach was designed to be pluralistic and was intended to move me closer to being able to develop a framework for generating social innovation (Feldman & Orlikowski, 2011).

Shallow zooming-in phase by interviewing key informants

In the shallow zooming-in process, I attended gatherings, meetings, workshops, and training sessions where practitioners shared learning and insights. Using a combination of purposive sampling and snowball sampling, I focused more on informal conversations on what social innovation meant to these practitioners, and the challenges in the field. In this phase I used only field notes to record codes, categories, and themes as they emerged. This phase helped set the frame for conceptualizing social innovation and acted as a launch pad for developing the framework for social innovation.

Zooming out: Building a substantive conceptual framework phase

As stated previously, this study took an iterative approach to theory-building. It is important to note that phases occurred in parallel. They were also iterative in the sense that I cycled through these phases at several points throughout the research journey. In the zooming-out phase, I continued to use constant comparative and theoretical sampling as a way of developing the emerging theory (Boeije, 2002). Although each phase is described separately, this is only done for clarity. Each phase fed into the other, and with
each interview, codes became richer and more defined. With each interview I could focus on critical incidents as way of focusing the research journey (Holloway & Schwartz, 2014). This phase involved extensive data analysis. After transcribing the interviews, I used ATLAS.ti to code and analyze the data collected. This approach drew extensively from grounded theory as a systematic way of analyzing the data (Hall & Callery, 2001; Starks & Trinidad, 2007; Urquhart, 2012).

**Zooming in: Mobile exploration phase**

After completing the exploratory interviews, I developed selection criteria for determining the unit of analysis. In selecting a unit of analysis—the case—I began conversations with key informants. These conversations were recorded, then transcribed within forty-eight hours and coded within a week. With each interview, I returned to my list of themes and categories, while being mindful to let the data determine the categories and not to let the pre-existing theory inform the categories that emerged (Appendix B).

This phase of the research was an in-depth exploration of the selected case study. Here I also collected documents from the birthing centre in Trinidad and Tobago, as a way of confirming what was disclosed in the interviews. Traditional language would describe these as semi-structured interviews. I use the term “conversations,” since the “interviews” were crafted to evoke storytelling and deep conversations with informants. The rationale for this approach is discussed later in this section.
The benefit of the iterative approach

Drawing on Nicolini’s (2012) zoom-in-versus-zoom-out approach has some distinct advantages. Firstly, I was able to draw on the constant comparative and theoretical sampling to build an approach from the ground up. Since I was using existing literature, my approach did not fall strictly into grounded theory, but grounded theory provided a framework for me to answer my first research question. What do we mean by social innovation? In analyzing existing definitions, social innovation meant: an activity or process that profoundly changed social relations or interactions, deeply challenged or changed our existing paradigms, and significantly changed resource flows within an existing social system. Using this definition, I was then able to identify a case study that met these criteria so I could then understand how agents in that system were able to generate social innovation.

This approach helped answer my second research question: how do we create the conditions that support or generate social innovations? The first cycle through Nicolini’s (2012) approach, as illustrated in Figure 2.1, shaped how the rest of the study would unfold.

The false start. Finding a better road

The study was always intended to use an emergent design to better understand the phenomenon of social innovation. The initial proposal was concerned with how people work together to design and implement collaborative social interventions (CSIs) with the intention of shifting systems, i.e. to generate social innovation.
CSI

s were defined as organisations that met the following criteria: 1) collaborate with other organisations or sectors around an agreed-upon problem domain; 2) explicitly and actively try to develop approaches that produce system-wide change; 3) consist of practitioners explicitly seeking to address the root causes of their chosen problem domain; 4) actively engage in a prototyping approach to generating interventions or placing emphasis on shared measurements and mutually reinforcing activity; and 5) explicitly seeking ways of measuring the success of their interventions.

The study was designed to explore social labs⁵ and collective impact groups⁶ who explicitly identified as working to generate social innovation. The initial proposal drew heavily on practice theory, which privileged an ethnographic or observational case-study approach. The study would have been divided into four phases. Phase I was designed to examine CSIs using a combination of grounded theory and snowball sampling. This was intended to be used as a way of developing categories and properties of these CSIs (Bryant & Charmaz, 2010; Creswell, 2012; Urquhart, 2012). This phase was designed to be exploratory. The study would have used snowball sampling to identify organizations that were taking novel approaches to collaboration as a way of identifying potential case-study sites.

In Phase II, the study was designed to use grounded theory as a way of analyzing and coding data from the field to achieve the following objectives: 1) generate a framework for understanding CSIs; 2) develop a practice-oriented line of social-

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⁵ Social labs are a collaborative experimental approach to solving complex social problems. The approach is very similar to that of traditional laboratories where research and development teams work hard to develop innovations (Bresnen, Edelman, Newell, & Scarbrough, 2003; Chakrabarti & O’Keefe, 1977).

⁶ Collective impact organisations hold as a guiding principle that “large-scale social change comes from better cross-sector co-ordination rather than from the isolated intervention of individual organisations,” (Kania & Kramer, 2011, p. 38).
intervention inquiry; and 3) to gain methodological insights into understanding collaborative approaches to social interventions. With insights from these early phases of the study, I intended to select a case study and engage the selected organization on the basis of criteria refined in earlier phases of the study. Phase III would have involved data collection at the selected site and Phase IV would have consisted of framework development.

**Insight from early phases of the study**

From the early phases of the research, it was concluded that collective impact organizations and social labs were too early in their development to determine whether they were successful, or they had not yet demonstrated that they generated social innovation. It was always the intention to use the shallow interviews to answer: what did we mean by social innovation? What had changed was that instead of exploring social labs or collective impact organizations, I was now searching to find a case study that met the newly developed criteria for what could count as social innovation. Thankfully, I had included in my ethics approval a line that included collaborative social intervention organizations that did not identify as social labs or collective impact organizations. Midwifery met the same criteria as collaborative social intervention.

With the new insight of a clear approach to deciding what could count as social innovation, I could now focus my efforts on identifying a case study that met the criteria for social innovation. The following sections outline the approach taken after early evidence suggested that social labs and collective impact organizations were too much in
their infancy to contribute to a substantive conceptual framework for generating the conditions of social innovation.

**Inclusion criteria**

One informant suggested that some of the most interesting collaborators she knew of were midwives. Fortunately, the study used an emergent design as a way of being responsive to new insights or developments that emerged along the research journey (Patton, 1990). In identifying the three key themes or commonalities of the various existing definitions of social innovation. I conceptualized social innovation as an activity that **profoundly changes social relations or interactions, deeply challenges or changes our existing paradigms (or stances), and significantly changes resource flows within an existing social system.** This conceptualization directed the inclusion criteria for the study.
Figure 2.2: Yin’s framework for design case studies. Adapted from Yin (2012, p.7).

The winding road to determining the appropriate unit of analysis or case study

In the pursuit of theorizing social innovation within the context of a small body of supporting academic social innovation literature, I began with the usual prescribed literature review. This phase was used to sensitize myself to existing literature (only to be drawn upon if it emerged from the data). Drawing on grounded theory, I used literature as data to help refine a conceptualization of social innovation (Bryant & Charmaz, 2010) and to inform the research journey (Glaser, 1992). The goal of the literature review was to develop a conceptualization of social innovation and to start the sensitizing process (Bowen, 2008). This approach was analogous to theoretical sampling, the “sampling carried out so that emerging theoretical considerations guide the selection of cases and/or research participants,” (Bryman et al., 2009, p.544). I intentionally spent time refining the
conceptualization of social innovation early in the study, to allow me the opportunity to solicit feedback from key informants. That way, participants could comment on what was missing, if they felt the conceptualization was too simplistic, or needed additional categories or explanations.

Instead of using the literature review to develop a preconceived framework or theory, I began to compile a list of codes, concepts, categories, or themes that might have become relevant during data analysis. After developing a conceptualization of social innovation, I could begin to have conversations with Phase I informants about examples that fitted the refined conceptualization. The conceptualization also allowed me to explore options independently as a way of narrowing potential case-study sites. Table 2.1 outlines some of the options considered as potential case studies.

The criteria for selecting a case study were largely informed by the thematic analysis that was applied to the literature review (see Figure 2.2). This review produced key themes that would comprise a conceptualization of social innovation, which was then used to help select a suitable case study. Yin (2012, p.7) proposes a three-step framework to designing case studies: 1) defining the case study, 2) selecting the study design, and 3) deciding whether and how to use theory to complete any essential methodological steps. The first step in defining your case study involves deciding on the bounded entity—the person, organization, behavioural condition, event, or other social phenomenon—that will serve as the main unit of analysis (Creswell, 2012; Yin, 2012; 2013). Yin (2012) suggests that it is worth investing time in a case study that is as important, interesting, or as significant as possible. If the case study you have chosen has some distinctive feature, be it extreme, unique, or revelatory, then it will likely serve as a good choice.
Step two of Yin’s (2012) framework is designing your case study. This involves selecting one of four design approaches—single-case design, multiple-case designs, embedded single-case study or embedded multiple-case design (Yin, 2012). (“Embedded” in this case refers to subclasses within a larger case.) The final step uses theory to guide the path of your research, for example, using theory to help decide what data to collect and pay attention to, the key methodological steps, research questions, and selecting your case study.

It is unclear if Yin (2012) intended his steps to be sequential, but the approach taken here assumes an iterative process and begins by using theory to select the case study. To understand the criteria used to select the final case study it is helpful to return to the conceptualization of social innovation proposed in earlier sections. Consequently, in selecting a case study, I used the conceptualization to develop early-phase selection criteria. The conceptualization was then translated into three closed-ended questions:

- Have social interactions or social relations connected to, or related to the proposed case changed significantly as a result of activity associated with the case under consideration? Yes/No
- Has the case contributed to significant shifts in paradigms (mental models, beliefs, norms, or values) as a result of the activity associated with the case under consideration? Yes/No
- Can a significant change in resource flows be directly attributed to the case under consideration? Yes/No

During an interview, one informant, after being presented with the conceptualization of social innovation, suggested a few key insights:

- I should consider a case study that has a long history, since social labs and collective impact have not been around long enough to draw significant conclusions.
• This informant also suggested that I look into birth and midwifery if I was interested in a group who collaborated really well and changed social interactions, paradigms, and resource flows.

    This insight significantly changed the nature of the research. Suddenly it was no longer my own, but had become a project that was co-informed by participant input. With this move, the research became reflexive, since the informants began to influence the direction of the research.

    On reviewing literature on birth and midwifery, I noted that it met all three criteria. The one observation that made birth most significant was that it was the only example I considered that had experienced repeated system shifts (see also “regime shift,” Scheffer & Carpenter, 2003, p.648). There are three time periods where midwifery underwent system shifts\(^7\)—clear examples of change in resource flows, changes in social interactions, and paradigm shifts. Other potential social innovation case-study examples had only experienced one system shift. Being able to compare each of these system shifts provides considerable analytical advantages.

    Prior to medicalization, birth and midwifery commonly occurred in the home, with considerable family and community involvement; then moved to the hospital, where family and community involvement was much reduced. Today, midwifery is in the midst of another potential system shift, as births are only just beginning to move towards birthing centres and are slowly returning to homes, where family and community involvement is increasing. In all three system shifts, you witness change in resource flows, social interactions, and paradigm shifts, with change in social interactions carrying

\(^7\) See also “regime shift,” a term borrowed from ecology. It usually refers to an abrupt shift in regime, but I have borrowed the term here to indicate a dramatic shift in the way of being. (R. Biggs, Carpenter, & Brock, 2009; Folke et al., 2004; Scheffer & Carpenter, 2003)
the most significance. In looking at critical incidents around these system shifts, I am able to develop a substantive conceptual framework of social innovation.

Table 2.1. Sample of cases considered for social innovation

<table>
<thead>
<tr>
<th>Change in social relations</th>
<th>Paradigm shift</th>
<th>Resource flow</th>
<th># of Regime shifts</th>
<th>Has desirable and undesirable outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Labs</td>
<td>Too early</td>
<td>Yes</td>
<td>Somewhat</td>
<td>Too early</td>
</tr>
<tr>
<td>Collective Impact</td>
<td>Too early</td>
<td>Yes</td>
<td>Somewhat</td>
<td>Too early</td>
</tr>
<tr>
<td>Worker Co-operatives</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Credit Unions</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Mutual Funds</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Insurance</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Public Schools</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Universities</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Once</td>
</tr>
<tr>
<td>Weekend and notion of leisure</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Unclear</td>
</tr>
</tbody>
</table>
Conceptual analysis informed by grounded-theory method and Nicolini’s zooming-in and zooming-out model

Grounded-theory method is known as a ground-up, inductive, iterative, or recursive approach to theory development (Bryman et al., 2009). Using this approach, “theories are thus believed to emerge slowly in a process of gradual abstraction from the data,” (Bryant & Charmaz, 2016a, p.412). In other words, the research should be grounded in an interactive dance between data, analysis, and theory (Merriam, 2009). Grounded theory offers a tested process that allowed me to use theoretical sampling and constant comparative in a rigorous way.

Grounded theory was first proposed by Glaser and Strauss (1967), and has since become a ground-breaking qualitative methodology. Despite the wide array of approaches and interpretations, or the many debates about what counts as grounded theory, it remains one of the most popular qualitative methods (Corbin & Strauss, 1990; Sbaraini, Carter, Evans, & Blinkhorn, 2011; Urquhart, 2012). Bryant & Charmaz (2016b) citing Charmaz (2000, p.524) argue that much of the debate can be attributed “to a lack of explicitness in the seminal work of Glaser and Strauss (1967) and hence, the subsequent search to fit the method to accepted research paradigms.” Others attribute the confusion to the public disagreement between Glaser and Strauss about the role of theory in grounded-theory method. Glaser (1992) argued that grounded theory should be theory-less, and data should inform theory development (Bryant & Charmaz, 2016a), while Strauss argued that pre-knowledge informs analysis and theory development (Corbin & Strauss, 1990; Strauss, 1987). This split has caused a considerable amount of debate within the field (Charmaz, 2014; see also Kelle, 2007; Kendall, 1999; Strübing, 2014).
Sbaraini (2011) for example, identifies five distinct approaches to grounded theory, while Dey (1999, p.2) states, “There are probably as many versions of grounded theory as there were grounded theorists.” Bryant & Charmaz (2016b) state:

Grounded-theory methodology, in the classic sense, does not fit within established research paradigms whether positivist, interpretivist, postmodern, or otherwise; rather, as a general methodology, classic grounded theory transcends the specific boundaries of established paradigms to accommodate any type of data sourced and expressed through any epistemological lens. Yet, the varying perspectives on what constitutes grounded theory and how it should be conducted presents the researcher with a baffling array of methodological options that have more the shape of a maze than a roadmap for guidance and clarification.

Deciding when and how to use grounded theory can be a confusing and overwhelming exercise. Grounded theory is used for three main reasons: 1) it is appropriate for studying process and change; 2) it is very useful when little previous theory exists; 3) finally, it is well designed for integrating complex organizational dynamics into the emerging theory (Creswell, 2012; Orlikowski, 1993; Urquhart & Fernandez, 2006).

This thesis, however, draws considerably on existing concepts and the insights observed from existing theory to develop a substantive approach to social innovation, so is not a grounded-theory approach.
Integrating grounded-theory method

It is important to note that grounded-theory method is not used to prove or disprove theory (Urquhart, 2012). Instead, theory is “inductively generated from fieldwork, that is, theory that emerges from the researcher’s observations and interviews out in the real world rather than in the laboratory or the academy,” (Patton, 1994, p.11). The notion that the inquirer begins with a blank slate is a common misconception of the grounded-theory method (Orlikowski, 1993). For example, most graduate students begin their research by broadly reading within their chosen topic, or by strategically enrolling in courses they think relate to the topic under investigation. It is in this process that they begin to sensitize themselves to existing or related concepts or theories. This makes it difficult for the emerging theory to be purely data-driven, since every inquirer would have some explicit or implicit theory from which they are working (Urquhart & Fernandez, 2013). This study applied a grounded-theory approach to the existing theory, so during the course of the literature review, themes, and concepts were identified as possible themes related to social innovation.

The methodology for this thesis began long before I sat down to write the thesis proposal. Like most Ph.D. students, I had already written course papers on the intended topic and had already subscribed to existing theories or ways of understanding the world. It is unrealistic or idealistic to expect an inquirer to be “theory-less” (Urquhart & Fernandez, 2006). Most graduate programs require students to write papers or proposals. In that process, students argue for theories that appeal to their worldview. A more realistic approach is for inquirers to aim to be noncommittal, while sensitizing themselves to existing theories, concepts, or categories which may or may not be integrated into the
emerging theory (Urquhart, 2012). This approach acknowledges the subjectivity of qualitative research and allows inquirers to be transparent in the reporting of their research, thus increasing the reliability and validity of a study.

**Figure 2.3. Methodology Framework Part 1. Adapted from Bryman (2009, p.404).**

Grounded theory is a structured approach to qualitative research (Bryant & Charmaz, 2010; Charmaz, 2014). Figure 2.3 is adapted from Bryman (2009, p.404) who outlines twelve steps of the grounded-theory method. Grounded-theory analysis hinges
on a cluster of methods: theoretical sampling, collecting data, coding (open, axial, and selective coding), category formation, and constant comparative analysis.

Theoretical sampling is an ongoing process whereby the researcher analyzes data to refine ideas, categories, or concepts (Bryman et al., 2009; Charmaz, 2014; Patton, 1994). “The sample becomes, by definition and selection, representative of the phenomenon of interest,” (Patton, 1994, p.238). In theoretical sampling, the inquirer samples relevant data to be included in the emerging theory. Bryman (2009, p.404) frames the next step as “collect data”; but how does one conduct theoretical sampling without collecting data? This is resolved by taking a nonlinear approach to grounded theory. Take, for example, an inquirer who is interested in researching topic A. They begin to read on topic A, and, in that very action, they have data and can begin to refine their ideas, categories, and concepts. It is difficult to identify where grounded theory starts, but I would argue that you just start and begin recording your steps.

Returning to the example of a researcher being interested in topic A: as they begin to read, they might underline and make notes of key ideas, concepts, and themes. Here they have begun to code. Grounded theorists begin to code while they are collecting data (Bryant & Charmaz, 2010). Grounded theory recognizes different types of coding. Open coding is the segmenting of data into concepts that when grouped, produce categories (Corbin & Strauss, 2007). In this process, the inquirer is usually coding for things that are of general interest or that they deem important. Later, these concepts can be grouped into categories (Creswell, 2012, p.236). Open coding is usually followed by axial coding, which refers to “a set of procedures whereby data are put back together in new ways after open coding, by making connection between categories,” (Corbin & Strauss, 2007, p.98).
Axial coding “focuses on the conditions that give rise to a category (phenomenon), the context (specific set of properties) in which it is embedded, the action/interactional strategies by which the processes are carried out, and the consequences of the strategies,” (Kendall, 1999).

The third analytical level of grounded-theory coding is selective coding. At this level, the inquirer is grouping categories and deciding what is the story that is emerging. Here the research is searching for the core categories (the essential issues) and selectively coding for these core issues.

The main approach to analysis in grounded theory is the use of constant comparison. “Constant comparison goes hand in hand with theoretical sampling. This principle implies that the researcher decides what data will be gathered next and where to find them on the basis of provisionary theoretical ideas,” (Boeije, 2002, p.393). All new data are compared with emerging data, concepts are constantly refined, and boundaries are drawn. In this way, constant comparison compares and contrasts all emerging data, themes, categories, and concepts until category saturation is achieved and no more categories emerge (Boeije, 2002; Bryman et al., 2009). In the process of developing themes and categories, the inquirer also develops a different hypothesis about the data. Hypothesis in this case refers to “the relationship between categories” (Bryman et al., 2009, p.404). When strong connections between categories are observed, the inquirer can begin to tell various stories about the data, and to develop different hypotheses. It is in testing these hypotheses that a substantive contribution can be made. It is important to recognize that the inquirer is usually moving backward and forward between these steps. Rarely is it in a linear, unified format; many of these steps are often occurring in parallel.
As previously detailed, the methodology for this study draws from Nicolini’s (2012) notion of zooming in and zooming out, overlaid with a grounded-theory approach to unearth the phenomenon under question.

This study was originally intended to be a single-case design (Yin, 2012; 2013). As the research unfolded, it was revealed that the selected case study, a small birthing centre in Trinidad and Tobago, had a unique connection with the Ontario midwifery movement. This unique attribute added considerable richness to the study. Since the Ontario midwifery movement was well documented, it was felt that even if accessing informants who were part of the movement was not possible, there was enough secondary data to contribute to the emerging framework. Given that the goal of the project was to develop a substantive conceptual framework of social innovation, adding the additional case study was interpreted as a way of adding rigour to the emerging framework, and not as a comparative study. Figure 2.4 is a visual representation of the way the research unfolded. Readers should consider that qualitative research is rarely a straightforward process, and the diagram is merely a way of providing a map of how the research unfolded.
Figure 2.4 outlines the research approach taken in identifying a case study. The top half of Figure 2.4 does not include Phase IV, Zooming in: Mobile interviews. This
stage was reserved for after I had identified a case study. The conceptual framework can be thought of as being divided into the three parts:

1. What is social innovation?
2. How do we generate social innovation?
3. Why do we need the social innovation? What is the problem?

Making sense of the data that emerged

In the previous section I outlined criteria for identifying social innovation and how these criteria shaped my choice to explore midwifery as an example of social innovation. Until now, the conceptual framework was developed by identifying the main themes in existing definitions of social innovation. Using these themes, I have proposed a triadic approach for identifying social innovation.

Coding

All interviews were transcribed and coded using ATLAS.ti software. Interviews were added to the program and the inquirer used open coding, axial coding, and selective coding as the interviews progressed. Open coding produced a large amount of data (Appendix C). In qualitative research, the inquirer often begins coding while collecting data (Bryant & Charmaz, 2010). Three different approaches to coding are often used: open coding, axial coding and selective coding. Open coding—coding for things that are of general interest—produced 256 codes that were deemed to be interesting or to have potential for future research. This was then followed by axial coding, where I looked for connections between categories or arranged the data in new ways (Corbin & Strauss,
This process produced twenty-seven categories. Following axial coding, and at times during axial coding, I began the process of selective coding. Selective coding allowed me to identify relationships between emerging categories; as a result, theory development and category development were continually evolving.

Theoretical sampling and constant comparative guided much of the analysis. In constant comparative method, when a relationship with an emerging category is perceived to have been identified, it is referred to as a hypothesis (Bryman et al., 2009). Hypotheses refer to the relationships between categories and serve as the starting point for developing substantive conceptual frameworks (Bryman et al., 2009). From this analysis, three overlapping, yet distinct, categories emerged: space, autonomy versus interdependence, and stance (perspective or gaze). These themes also connected well with the conceptualization of what counted as social innovation.

**Generating social innovation as theoretical framework**

Underlying all research is a theoretical framework which simultaneously reveals and conceals meaning and understanding (Merriam, 2009). The theoretical framework is usually developed from the literature review (Creswell, 2012; Merriam, 2009; Morgan, 1998). Here I have used both a literature review and the insights revealed from the data to develop a framework for generating social innovation.

In later chapters I delve more deeply into the theory that informs the proposed framework. Three themes emerged from the coding. None is intended to exist independently, but should be understood as being in relationship with the others. The
framework builds on the theory, and the data explored, to develop a framework for generating space for social innovation.

Figure 2.5: The process of creating the conditions for social innovation.

To understand how these themes connect to the previous conceptualization of social innovation, it is helpful to take a step back for a moment. I conceptualized social innovation as an activity that profoundly changes social relations or interactions, deeply challenges or changes our existing paradigms (or stances), and significantly

---

8 Imagine the framework as being similar to dial. The current alignment makes sense, but each node can change depending on what you are exploring.
changes resource flows within an existing social systems, as illustrated by the blue section in Figure 2.5.

Four major themes emerged from the coding and categorizing. There were major cross-cutting themes, as illustrated by the green layer of Figure 2.5. The final theme focused on the social space where the motivation—the “why” of the social innovation—was fostered, the orange layer in Figure 2.5. These themes were as follows:

- **Social and spatial practices (Space):** everyday doings and sayings that are influenced by spatial-temporal and socio-material activity (Lefebvre 1992, 2014).
- **Stance:** socio-cognitive frames, or the dominant discourse that influences the doings and sayings of agents and the perceived positions they occupy (Bourdieu, 1992, 1998; Evans and Boyte, 1992; Lefebvre, 2014; Martin, 2009). “Stance” mainly refers to our perceptions and the dominant discourse of our time.
- **Autonomy versus interdependence:** the social networks that both enable and constrain the everyday activity of agents within the systems they occupy (Bourdieu, 1992, 1998; Stacey, 2010).
- **Free spaces:** “places relatively free from surveillance where oppositional ideas and tactics can develop,” (Goodwin & Jasper, 2009, p.253).

Table 2.2 shows twenty-seven categories that emerged from axial coding. These categories were narrowed into the four major themes outlined above. Bryman *et al.* (2009) suggest that in developing hypothesis or theories, themes should be selected because they are perceived to have discernible similarity, connection, or relationships to each other. I used my previous conceptualization of what counts as social innovation—
the blue layer of Figure 2.5—to determine the discernible similarities, connections, and relationships (Bryman et al., 2009). Other categories were excluded because I either did not perceive them to have a discernible connection to what counted as social innovation or felt the category was a subset of the three themes identified (see Appendix D). For example, “prefigurative” is strongly connected to the free-space literature, but was not included as a primary theme because it was felt that the concept of free space adequately captured the notion of prefigurative spaces. Similarly, the theme “structure and systems” was perceived to be a subset of “stance,” since it was assumed that people develop structures based on their stance (Bourdieu, 1990; Senge, 1990). The theme “structure” could also be considered a subset of “social and spatial practices,” but I did not think it needed to be its own primary theme. There was considerable overlap between categories, but these four major themes were perceived to represent best the emerging theory.

For midwives, stance, autonomy versus interdependence, and social and spatial practice were the three dominant themes that the author perceived to be most connected to the conceptualization of social innovation. Table 2.2 outlines the narrowed categories in order of prevalence by number of codes per category and number of quotes per category. The colours indicated the top ten categories in each column. It was a way of thinking about which themes might be most relevant. I then wrote all the categories on cards and began to group them for themes. I renamed themes a number of times to determine which were most relevant to the conceptualization of what counts as social innovation. In Figure 2.6, I mapped each category (categories are groups of codes derived in open coding) according to their sub-codes to determine which categories overlapped and which were related to the conceptualization of social innovation. I then used the
codes in the category-number column of Figure 2.6 to map each of the categories into the three major themes—stance, autonomy and interdependence, and space—to produce a

Table 2.2. Sample of prevalence of categories derived from the data.

<table>
<thead>
<tr>
<th>Category number</th>
<th>Code Family</th>
<th>Number of Codes</th>
<th>Number of quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Autonomy</td>
<td>26</td>
<td>687</td>
</tr>
<tr>
<td>2</td>
<td>Stance (gaze or perspective)</td>
<td>23</td>
<td>569</td>
</tr>
<tr>
<td>3</td>
<td>Organizational Dynamics</td>
<td>27</td>
<td>425</td>
</tr>
<tr>
<td>4</td>
<td>Midwifery-defined</td>
<td>31</td>
<td>379</td>
</tr>
<tr>
<td>5</td>
<td>Disrupting Systems</td>
<td>31</td>
<td>355</td>
</tr>
<tr>
<td>6</td>
<td>Structure and Systems</td>
<td>16</td>
<td>260</td>
</tr>
<tr>
<td>7</td>
<td>Space and Free Space</td>
<td>14</td>
<td>245</td>
</tr>
<tr>
<td>8</td>
<td>Social-justice stance</td>
<td>11</td>
<td>227</td>
</tr>
<tr>
<td>9</td>
<td>Organizing for social innovation</td>
<td>16</td>
<td>185</td>
</tr>
<tr>
<td>10</td>
<td>Scope of midwifery</td>
<td>8</td>
<td>174</td>
</tr>
<tr>
<td>11</td>
<td>Care of service</td>
<td>8</td>
<td>168</td>
</tr>
<tr>
<td>12</td>
<td>Authority</td>
<td>5</td>
<td>133</td>
</tr>
<tr>
<td>13</td>
<td>Obstetric Gaze</td>
<td>3</td>
<td>107</td>
</tr>
<tr>
<td>14</td>
<td>Leverage Points</td>
<td>3</td>
<td>98</td>
</tr>
<tr>
<td>15</td>
<td>Empowerment</td>
<td>3</td>
<td>97</td>
</tr>
<tr>
<td>16</td>
<td>Threats</td>
<td>9</td>
<td>93</td>
</tr>
<tr>
<td>17</td>
<td>Typology of Actors</td>
<td>7</td>
<td>89</td>
</tr>
<tr>
<td>18</td>
<td>Status-quo holders</td>
<td>7</td>
<td>79</td>
</tr>
<tr>
<td>19</td>
<td>Deviance</td>
<td>5</td>
<td>79</td>
</tr>
<tr>
<td>20</td>
<td>Resources</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>21</td>
<td>Education</td>
<td>3</td>
<td>48</td>
</tr>
<tr>
<td>22</td>
<td>Prefiguration/Preconditions that help with organizing</td>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>23</td>
<td>Ethnographic insights</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>24</td>
<td>Collaboration</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>
visual representation of where there might be overlaps between themes and categories. Appendix D outlines all the code descriptions used, while Appendix E provides a breakdown of each of the themes derived and their sub-codes.

It is important to note that although these observations may be specific to midwives, I suggest that they can provide insight into other domains of social innovation. For midwives, autonomy versus interdependence and space were closely connected. At times, distinguishing between them became challenging, but they were distinct enough to be interpreted as separate categories. Figure 2.6 shows which categories overlapped with these three main themes. To make sense of these themes, I drew on literature related to space to develop the substantive theory proposed.
Figure 2.6. Codes divided into the major themes of the conceptual framework.

In Chapter 4 I expand on the theory of space for social innovation by using existing theory to develop conceptual understandings of the themes that emerged. In qualitative research, comparing and contrasting is the main tool of analysis (Merriam, 2009). For example, from the interviews I could determine that space was a major theme for the midwives I interviewed.

At times it is difficult to make a clear demarcation between data analysis and theory-building, since the research process was iterative. An important component of the way this research unfolded is that the second phase of research was used to test the hypotheses developed from the case study of the Trinidadian midwives. Later I tell the
story of the Ontario midwifery movement. Much of it has been well documented in the form of books, papers and theses (see Table 2.3).

The following list outlines the secondary material that helped inform the insights developed from understanding the evolution of the Ontario midwifery movement. I interviewed eight senior midwives, whom I refer to as elite interviews (Aberbach & Rockman, 2002; Goldstein, 2002), which served as a way of corroborating insights found in the secondary data and searching for insight into what I interpreted as gaps in the emerging research.

The secondary data mainly served as a way of focusing the conversation with the elite interviewees. Using this technique I was able to focus on key incidents that I identified in the secondary data in and from primary data (see Appendix F for list of critical incidents).

Table 2.3. List of main sources of secondary data for Ontario case study.

<table>
<thead>
<tr>
<th>Document type</th>
<th>Document citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**The theory of the approach taken to conducting interviews**

An implicit assumption of this thesis is that organizational reality is best accessed through the subjective and inter-subjective experiences of everyday actors (Alvesson & Skoldberg, 2009; Higgs & Rowland, 2005). The argument is that a narrative approach is more compatible with subjective and inter-subjective understanding of human arrangements. As a result, subjective phenomena can be understood using two compatible modes of thought: “logico-scientific” and the “narrative” mode (Bruner, 1986). This distinction highlights different modes of thought that cannot be conflated (Tsoukas & Hatch, 2001). Take, for example, the proposition: “if x then y” (logico-scientific). This proposition implies a type of causality that assumes universal truths. Conversely, the
proposition: “The king died and the queen died” leaves open multiple possible truths—“mortal grief, suicide, foul play” (Bruner, 1986, p.11). The first approach assumes that the truth exists out there in the form of an objective reality, while the second approach leaves space for subjective and inter-subjective realities.

Tsoukas & Hatch (2001, p.?981) refer to this second proposition as second-order complexity. They argue that this second-order complexity is more likely to be uncovered in stories, since stories provide the inquirer with access to logic in the form of: “If the king died and the queen died”—then why? (Alvesson & Skoldberg, 2009; see also Higgs & Rowland, 2005). It is through stories that meaning is produced (Bruner, 1990). If humans use conversations, metaphors, stories, and symbols to interpret the subjective world around them, then in understanding human interactions, we should use these media as our window into subjectivity.

**General approach to interviews**

Informants were asked to tell stories about critical incidents relating to the evolution of midwifery within their context (Holloway & Schwartz, 2014). As much as possible, I tried to use open-ended questions that asked one question at a time (Easterby-Smith et al., 2008). Asking one question at a time allowed me to focus on particular concepts and helped build clarity. The first question was usually related to how the informant got involved with midwifery. This question was designed to build rapport while giving me an opportunity to listen for themes or to identify conversation entry points.
It is important to note that the skill of trying to evoke stories, conversations, or metaphors is not easily replicable. Different inquirers would pursue different lines of interest. The approach also does not lend itself well to informants who are not comfortable telling stories. Appendix B outlines the conversation protocol used while interviewing midwives.

**Shallow exploratory interviews**

In previous sections, I outlined the structure of the study. One of the phases highlighted referred to the label “shallow zooming-in.” In this phase, I used snowball sampling to conduct informal, semi-structured interviews with key informants who identified as working in the field of social innovation. In this phase I asked about emerging themes and was able to refine ideas before choosing the unit of analysis or case study. These interviews were originally intended to focus on collaboration for social innovation, and were not recorded or transcribed, but notes and memos were taken during the interview. After each one, I wrote a small summary of things that were either interesting or important. At times, I eliminated themes that did not resonate with informants or had not come up in the stories. These exploratory interviews were designed to help select an appropriate case study, but proved to be very valuable in identifying and refining the concepts, categories, and themes that were emerging (see Appendix A).

**Deep interviews**

The first phase of the research journey, the shallow exploratory phase, allowed the inquirer to refine and discard themes before interviewing informants who would be part
of the chosen case study. During the zooming in: mobile exploration phase, interview questions were framed by the themes that had begun to emerge. As the research progressed, the number of themes that emerged began to stabilize (Glaser & Strauss, 1967) and the inquirer used these themes to inform the semi-structured interviews (see Appendix C for a list of themes). Prior to each interview, the inquirer would write down a list of themes that had emerged.

Each interview would start with: How did you get involved in the midwifery movement? What is your favourite story about the early midwifery days? After those opening questions, the inquirer and the informant would have a conversation about midwifery. Questions were guided by the list of themes, and when a theme had been sufficiently addressed the inquirer would draw a line through the theme.

The interviews initially focused on the available founding members and staff who had worked at the birthing centre for more than five years. Of the five founding members, one was not available. This meant that I could only interview six people directly connected to the birthing centre: four founding members and two doulas. Both doulas held roles within the organization, one as the human resource manager and the other as the administrator for the birthing centre. Table 2.4 provides an overview of the interviews conducted with Trinidadian midwives.

The accepted norm in qualitative research is to continue interviewing until you have achieved saturation—no new themes or relevant stories are emerging (Bryman et al., 2009; Creswell, 2012; Merriam, 2009). The size of the organization limited the number of available informants. To increase validity, I interviewed professionals who had worked with the birthing centre. These included a paediatrician, an obstetrician, the
principal of the local nursing school, the head of the midwifery association, a retired midwife who had worked at the birthing centre, and a founding member of the midwifery association. Twelve in-person interviews were eventually conducted.

Focus group

After completing the interviews and analyzing the data, I conducted a focus group with three of the founding members to review the findings. At the focus group, I presented the findings to the group for feedback as way of increasing the validity of the research. One member had moved out of the country and could not participate in the focus group.

Ontario interviews

Within the context of Ontario, the interviews were conducted with midwives who had been part of the process of regulating midwifery in Ontario. One midwife joined later, but was included because of her current position and knowledge in the field. Prior to each interview, I would write a list of themes and began by asking for the story of how the informant came to be involved in the midwifery movement. Table 2.5 provides an overview of the interviews conducted with Ontario midwives. All interviews were recorded, transcribed, and later coded. Since the interviews were conducted later in the research journey, I interviewed on the basis of the themes that had emerged. I also solicited feedback on early versions of the frameworks that had emerged as a way of analyzing the findings of the data in another context (Bryman et al., 2009).

Table 2.4. Overview of Trinidad and Tobago birthing centre interviews

<table>
<thead>
<tr>
<th>Length of Qualification</th>
<th>Connection to Centre</th>
</tr>
</thead>
</table>

56
Table 2.5. Overview of Ontario midwifery movement interviews

<table>
<thead>
<tr>
<th>Length of interview</th>
<th>Qualification</th>
<th>Role in Ontario Midwifery movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0:57:32</td>
<td>Director of a major midwifery education program in Ontario</td>
<td>Was a practicing midwife prior to regulation</td>
</tr>
<tr>
<td>3:17:00</td>
<td>Toronto midwife, former head of ICM</td>
<td>Supporter &amp; mother, very involved in midwifery prior to regulation.</td>
</tr>
<tr>
<td>0:36:53</td>
<td>Professor in the Telfer School of Management and Institute of Population Health at the University of Ottawa</td>
<td>Academic who has documented much of the history.</td>
</tr>
<tr>
<td>2:00:04</td>
<td>Director of a university-based midwifery program in Ontario.</td>
<td>Was a midwife and activist on the frontlines. A practicing midwife prior to regulation</td>
</tr>
<tr>
<td>1:45:28</td>
<td>Former assistant dean for a midwifery program in Ontario</td>
<td>Participated in high-level policy research and writing during the time of regulation. Was a practicing midwife prior to</td>
</tr>
</tbody>
</table>

Table 2.5.
<table>
<thead>
<tr>
<th>Time</th>
<th>Role Description</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:41:00</td>
<td>Author on midwifery, childbirth reform activist and a prenatal teacher.</td>
<td>Activist and supporter. Provided birthing classes for years.</td>
</tr>
<tr>
<td>1:05:05</td>
<td>Very prominent active midwife. Held a senior public-facing position at the time of the interviews.</td>
<td>Requested anonymity</td>
</tr>
<tr>
<td>1:37:20</td>
<td>Author of very popular book on midwifery in Ontario.</td>
<td>Possibly the first book on midwifery in Ontario</td>
</tr>
</tbody>
</table>

**Document analysis**

In the Trinidad and Tobago case study, not much of the history of midwifery is well documented, if at all. I was able to gain access to many of the documents related to the birthing centre, for example, past proposals, strategic plans, minutes, past presentations, the employee handbook, and samples of the forms patients receive when they enter the centre.

The Ontario midwifery movement was well documented by other researchers (see Table 2.6). Several books were read, coded, and analyzed for themes, trends and patterns that might inform a substantive conceptual framework of social innovation. Although each book focused on a different aspect of midwifery in Ontario, they offered several points of triangulation that helped tell the social innovation story. Many of these books were written for an academic audience and there were some peer-reviewed papers. Although they were not originally intended to tell the story of midwifery, they provided rich contextual data.
Informed consent

All research students at the University of Toronto are required to gain approval from the Research Ethics Board before conducting their studies. This study was approved by the board and implemented in accordance with its guidelines. All participants signed the approved informed consent form (see Appendix D).

The first version of the consent form asked participants to be anonymous. Given that there was only one birthing centre in the entire Caribbean, and I could not guarantee anonymity, I requested and gained approval from the Research Ethics Board for a letter of informed consent that allowed participants to choose whether they wished to remain anonymous. All founding members gave consent to be named in the research. Ontario midwives also received the updated individual consent form and were given the option to remain anonymous or give permission to be identified. One Ontario midwife requested anonymity because she is still a very active midwife with a senior position.

For the Trinidad and Tobago midwives, informed consent was also gained from the organization. This consent form indicated that the organization knew of the research and was willing to participate in the study. This did not apply to Ontario midwives, since their context was not organizational, and many of them operated as independent practitioners.

Despite being given permission to identify informants, I have chosen to use pseudonyms throughout my thesis. I maintain a code sheet that maps real names to pseudonyms. These files, along with all other recordings and transcripts, are all stored in an encrypted folder on my personal external hard drive.
Navigating the ethical review

My original ethics review was for collaborative social interventions that identified either as social labs or collective impacts. I included researching organizations that were working collaboratively, but did not call themselves social labs or collective impact organizations. Since midwives fitted with the collective impact model, I did not need to apply for additional ethics.

Gaining access to midwifery informants

I had long admired the work of the midwives in Trinidad and Tobago. I had already worked with one of the founding members, while another founding member was a close family friend. In the early phase of interviews, I interviewed one of these midwives. During the interview it was revealed that if I did select their organization as a case study, then gaining access to documents and staff would be very easy. They were willing to give both organizational and individual consent.

Gaining access to the Ontario midwives

In the Ontario context, I did not have a personal relationship with any of the midwives, and, as an outsider, there was a good chance that none of the midwives would take the time to meet with me. Additionally, many of the key informants now held very senior positions in universities and birthing centres, making them elite interviews. “Elite interviews” simply refers to interviews conducted with informants who hold elite positions (Harvey, 2011). Kenneth Goldstein (2002) suggests that the biggest challenge with elite interviews is getting one’s foot in the door. For me this came via the Trinidad
and Tobago midwives (Goldstein, 2002). Since their model was based on the Canadian model and they had developed a very strong relationship with a few midwives in Ontario, they were able to introduce me to my first key informant. She was very willing to meet with me, and, using the snowballing approach, I was then introduced to other midwives in her network. This first interview lasted almost three hours.

My second opportunity came through my own personal networks. I was meeting with a colleague on social innovation and mentioned that I would be interested in interviewing midwives in Ontario. She knew a midwife who had practiced before midwifery was regulated, and was able to connect me to her. From there, I was able to gain access to some very senior-level midwives, many of whom were key participants in the regulation of midwifery in Ontario, held senior positions in universities, and had written books on midwifery. I treated them as elite interviews (Aberbach & Rockman, 2002; Goldstein, 2002). I also made sure that I had read their books, if they had authored any, before meeting with them. I used these interviews to gain access to stories about key incidents I had identified in the literature, and to test the emerging frameworks and hypotheses.

These interviews were conducted in the same narrative style as the Trinidad and Tobago interviews, but because I had developed some theory by then, I was able to have conversations about the emerging theories with the Ontario midwives (Table 2.6). I conducted seven in-person interviews, one other by Skype interview and another by telephone. All interviews were recorded, transcribed, and later coded.

Table 2.6: Overview of interviews conducted.
<table>
<thead>
<tr>
<th>Interview group</th>
<th># of interviews</th>
<th>Average time of interview</th>
<th>Data capture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploratory interviews</td>
<td>8</td>
<td>0:58:23</td>
<td>Recorded but not transcribed</td>
</tr>
<tr>
<td>Trinidad and Tobago midwives</td>
<td>15</td>
<td>1:15:41</td>
<td>All recorded interviews recorded, transcribed and coded</td>
</tr>
<tr>
<td>Ontario midwives</td>
<td>9</td>
<td>1:35:49</td>
<td>All recorded interviews recorded, transcribed and coded</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Improving rigour, authenticity and trustworthiness**

I began this section by locating myself in the research as a way of making my own subjectivity explicit. There are many ways to improve rigour, authenticity, or trustworthiness in a study (Marvasti, 2004; Merriam, 2009). In qualitative research, the inquirer is the main instrument of research. The objective is to elicit the views of the participants; one way of improving rigour is by allowing respondents to comment on your findings.

**Respondent validation**

At the end of my research with the Trinidad and Tobago midwives, I conducted a focus group with the founding members of the birthing centre. In the focus group, I presented informants with my findings. Some were not interested in reading the transcripts of their previous interviews, but were interested in the final thesis (Merriam,
2009). One even stated, “I was there—I know what I said.” The focus group allowed them to comment on the frameworks and make valuable contributions.

Deciding to pursue research within the context of the Ontario midwives allowed me a unique opportunity: I was able to test the theory that had emerged from the research on midwives in a different context and update it as new evidence emerged.

Triangulating data from multiple sources

This approach suggests there is an increased likelihood of accuracy when “three (or more) sources all point to the same set of events, facts, or interpretations,” (Yin, 2012, p.13). This is not always the case, as organizations can often have collective stories that they have all bought into. For example, midwives in Trinidad all told stories about nurses being very rude or behaving inappropriately to pregnant mothers or mothers in labour. They reported that nurses in the hospitals might say things like, “You were not crying when you were getting pregnant, so why are you crying now?” In the interviews I suspected that the midwives had bought into this narrative because it was a story told by the mother who insisted they start the birthing centre. She recalled an interaction with a nurse in the public hospital as follows:

“Shame on you.” She [the attending nurse] didn’t say it, but her attitude said it. She was pissed. My mother was not upset—she was, but she didn’t show me, because she knew that she just had to clock into “good mother mode” now. This woman was just making all kinds of ridiculous remarks.
Then she had to examine me and she didn’t prepare me. All of a sudden I was lying on my back, and I got a hot metal prong inside of me, and I flinched. She says to me, “When you was getting it you wasn’t flinching, though.”

I was like, “Excuse me?” I said, “First of all, a penis was made for a vagina. My vagina was not made for a metal hot prong being thrust in by you.”

She shut up one time.

From the time she answered me that way, I thought, “Wow! Wow!” I’m like, “Wow! What am I doing here?”

She finished the thing and I came out and I said, “Mommy, I am never going back to this woman.” (Trinidad interviewee 10).

One of the midwives I interviewed told a story about how patients would be treated: “Client comes in, she is in a lot of pain, didn’t do classes. The nurse is screaming at them, ‘When you was getting it, you didn’t scream then. What are you screaming for now?’” (Trinidad interviewee 4).

Another midwife recalled a similar story:

“Now they’re going to someone where they’re told, “Shut up and get on with it.” And they don’t really get the explanations that they expected, because they know that they have a right to have that information.” (Trinidad interviewee 7).
A version of this story was repeated in some form by every midwife I interviewed in Trinidad. I deliberately asked the paediatrician and the obstetrician to give me some examples of how a mother might be treated in the public institutions as opposed to the birthing centre, and they both repeated the story of a mother being shouted at during birth. When I interviewed a rural midwife, she also reiterated a similar story. It is difficult to determine if this has become a dominant narrative or if this happens on a regular basis, but given the number of times and the variety of settings where the story was repeated, I assumed that there was some merit to it. Using multiple sources is a good way of helping to improve the chance of reliability of the data (Greene, 2007).

Open-ended interviews

Open-ended interviews allow participants to construct their own reality (Yin, 2013). In this study, I focused on storytelling and, as far as possible, tried to adhere to open-ended interviewing. I used the open-ended interviews to allow for flexibility in the interviewing process so that I did not guide the research to the data I saw emerging.

Alternative explanations

One way of improving the rigour of research is to have a keen eye out for alternative explanations. By adopting the attitude of a skeptic, the inquirer can keep a discerning eye out for “discrepant evidence,” actively seeking plausible alternative explanations (Patton, 1994). It is not easy to identify these alternative explanations, because in doing so one is attempting to prove the current explanations to be false.
Conclusion

As mentioned above, the nonlinear, emergent nature of qualitative research is often challenging to fit into the structure of a thesis. Few qualitative studies follow a linear path. This study was no different. This methods section has tried to present an accurate account of the approach taken. For example, the astute reader will have noticed that interviews in the Trinidad and Tobago case study were not always sequential. This is because I labelled the interviews in the order that I conducted them and some of the Ontario interviews were conducted before the final set of Trinidad and Tobago interviews.

This arose because I was trying to find an informant who could speak to some of the history that I thought was lacking in the Trinidad and Tobago case study. I visited a few remote regions on the island to talk to older midwives. This jumping back and forth is possible because constant comparison allows the researcher to attend to emerging data. So although much of the focus had moved to the Ontario case study, I was at the time trying to find missing data from the Trinidad and Tobago study.

Inclusion and analysis of the Ontario midwifery movement came at a later stage in the research journey. The use of the constant comparative as a major method meant that the inquirer was constantly jumping back and forth between data collection, analysis, and theory development. The interviews with the Ontario midwives served as what would traditionally be labelled “testing the hypothesis.” I used these interviews as way of testing the frameworks developed to determine whether similar patterns emerged in both contexts. Since the midwifery movement had been well documented, I could use the text
as data and analyze the history of this movement against the frameworks that had been emerging. The interviews with the Ontario midwives served as a way of testing the extent to which these frameworks resonated with these midwives and their experience of the regulation process. Informants were presented with frameworks that emerged out of the first case study and asked for their feedback. Much of the coding and concept-building at this stage jumped between manual coding and software-assisted coding. This documentary analysis, in combination with interviews, contributed considerably to developing and refining many of the frameworks that would eventually emerge.
Chapter 3: Conceptualizing, problematizing and developing a theory of social innovation

“I keep changing what I said. Any person who is intellectually alive changes his ideas. If anyone at the university is teaching the same thing they were teaching five years ago, either the field is dead, or they haven’t been thinking.”


Conceptualizing social innovation

Here I have taken an approach in which I used the theory as data. This chapter addresses what counts as a social innovation by examining previous definitions of social innovation. Given the rich body of literature that has attempted to address social change, it makes sense to use these theories as data sources. This approach allows us to stand on the shoulders of those who have come before us. It allows us to use existing theories to identify common concepts, categories, and themes (Glaser & Strauss, 1967). To the purist, this would be an unsightly violation of ontological assumptions (Greene, 2007). My own view is that all theories are analogous to mental models. Just as all mental models are incomplete, imperfect and can be improved, so too are theories (Greene, 2007; Martin, 2009). A theory that is formed by ontological assumptions can only serve to enrich the emerging field (Greene, 2007; Mair & Martí, 2006).

In examining the emerging theories of social innovation and related theoretical domains, I begin by analyzing existing definitions of social innovation in an attempt to conceptualize social innovation. This approach draws on the first section of the grounded-theory diagram explained in the methods section of this study (Figure 3.1).
Starting on the left of the model, I develop themes and concepts related to social innovation by coding current theories of social innovation and related theories of change. The shallow interviews with key informants who identify as social innovation practitioners also help guide the kind of theories I explored. This “dance” created a cycle of bouncing between theory and practitioner perspectives to refine a concept of social innovation. The goal here is to aim to be noncommittal and to be open to emerging insight. This section begins to sensitize the inquirer to existing theories, concepts, or categories (Urquhart, 2012). These theories may be integrated into the theory if enough data supports their integration. Admittedly, the decision as to what counts as important is a subjective decision on the part of the inquirer.

Figure 3.1. **Methodology framework part 2 (shortened).** Adapted from Bryman (2009, p. 404).
Existing social innovation frameworks

Before embarking on developing a theory of social innovation, it is helpful to review existing literature. Several authors or research groups have attempted to develop social innovation frameworks, but much of it has been published as grey literature. For example, Preskill and Beer (2012) published a paper on how evaluation can help generate social innovation. In their paper, they argue that social innovation can be achieved by creating a loop between evaluation and strategy. If evaluation consistently contributes to strategy, then the chances of generating social innovation are greatly improved. I do not explicitly use Preskill and Beer (2012) in the proposed social innovation framework, but I assume that under the stance component of the model, evaluation, and strategy, actors can draw on their approach to inform an emerging social innovation practice. Pantzar & Shove (2010) present a practice-theory approach to social innovation, using Nordic Walking as their case study. In their approach they look at how the everyday activity of both consumers and producers generated social innovation. Their approach links concepts related to the sociology of consumption, innovation studies, science studies, and theories of material culture to propose an integrated-approach enquiry. Their approach allows them to move between micro- and macro-enquiry, which is compatible with the focus on practice adopted throughout this thesis. Pue and Breznitz (2015 p.12) argue that social innovations reconfigure social relations through two “engines”: “an agentic engine and a structural engine”. For them, the agentic structure refers to what they call socially creative interventions, while the structural engine refers to social structures that determine the uptake of the social creative strategies. They describe social innovation as
process with no end point, but one that continues on. Similarly to Pantzar & Shove (2010), the proposed framework for social innovation is informed by a practice theory. The think tank DRIFT developed a white paper based on resilience theory of how it has conceptualized social innovation (Haxeltine et al., 2013). Later in this thesis I discuss the stance of complexity, which also includes resilience theory, within the context of complexity theory (Martin, 2009). There I refer to stance as being an approach that is informed by a complexity theory, which is compatible with the approach taken by DRIFT. Although it places complexity theory at its centre, the approach discussed later in this chapter shares similar assumptions about the social world and how it unfolds. The European Commission has also produced a Guide to Social Innovation (Bulakovskiy, 2013).

These last two approaches focus considerably on changing minds, paying close attention to implementation, and bringing innovations to scale. Of these approaches to social innovation, the only one that has been published in peer-review journals is known as the adaptive cycle. The adaptive cycle is based on a complexity approach to understanding the dynamics of change. The theory was originally developed on the basis of research that explored ecological systems. The framework is an excellent introduction to a complexity approach to social innovation and is explored briefly here.
The adaptive cycle

Figure 3.2. Adapted from Gunderson & Holling (2002) and Patton (2011).

The adaptive cycle (see Figure 3.2) is a model of systemic change that was developed by ecologists Lance. H. Gunderson and C.S. Holling. The model reflects the patterns of change in ecological and socio-ecological systems, and has since been applied to social systems and social innovation through the work of Frances Westley and her colleagues at Social Innovation Generation, Waterloo (Antadze, 2010b; R. Biggs et al., 2010; Moore & Westley, 2011; R. Plummer, 2010; Westley, 2002).

Gunderson and Holling observed that the health and resilience of a forest included four phases that make up the adaptive cycle. The first phase, release or creative
destruction, occurs when a system for some reason or another enters into a phase of destruction (e.g., forest fires, bank collapse, drought, or a failed company). Holling and Gunderson view these periods of destruction as an opportunity for resources that were trapped in these systems to be released and to support new life or new endeavours. When applied to organizations, it usually implies that it is a time of high stress, uncertainty and high staff turnover. During this phase, if systems or organizations fail to release these resources, they can become trapped, which Gunderson and Holling call the “rigidity trap.”

After the system has released its resources, it enters into a reorganization phase. In this phase, new plant life, undergrowth, ideas, or groups begin to emerge. In this phase agents or plant life compete for limited space and resources, and new plant life or employees begin to emerge. Some plants will die while others flourish; some ideas die while others thrive. Systems or organizations can also get trapped in this phase or collapse. When ideas fail to take root or flourish, the system can get caught in a “poverty trap” (see Figure 3.2). When this happens, ideas seem to bounce around and little action is taken.

If the system is able to transition out of the reorganization phase, it enters the phase of exploitation. In this phase, the system exploits available resources and invests heavily in its agents, species, or project proposals.

In the final stage, the conservation or maturity stage, plants or organizations achieve full maturity and dominate the landscape. These mature trees and plants consume most of the resources and prevent new plants from growing. In organizations or social systems, projects and programs achieve full implementation by consuming most of the
resources available. It is in this stage that agents reap the benefits of their hard work, but if they are not careful about recognizing when it is time to release resources, then they can become caught in the rigidity trap (Gunderson & Holling, 2002; Westley et al., 2009). Organizations that can avoid the various traps (the poverty trap or rigidity trap) are considered resilient organizations. Organizations that can experience “massive change and yet still maintain the integrity of the original” organization are also considered resilient organizations (Westley et al., 2009, p.65).

Challenges of the adaptive cycle

The adaptive cycle is a good metaphor for understanding change processes. It helps us conceptualize the journey that individuals, organizations or systems experience as they go through changes. The framework uses observations made in ecological and socio-ecological systems as its primary source of analysis. Although it has been consistently observed in ecological systems, work on its application in social systems is relatively under-studied, or in its early stages (Cundill & Fabricius, 2009; Cundill, Cumming, Biggs, & Fabricus, 2012; Moore & Westley, 2011; R. Plummer, 2010; Westley & Michele-Lee, 2011).

The adaptive cycle, or panarchy, is heavily informed by theories related to systems thinking, complexity theory, and complex adaptive systems. The insights generated by these theories have become popular among many academics, particularly among organizational theorists, management theorists, and ecologists (Anderson, 1999; Campbell-Hunt, 2007; Folke, Hahn, Olsson, & Norberg, 2005; Tsoukas, 1998). These theorists have also been heavily criticized for the assumption that theories based on
studying natural systems can be applied to social systems (Anderson, 1999; Forrester, 1994; Payne, 1992; Stacey, 1995; 2010; Ulrich, 2003). Many authors have tried to bridge the divide between these two domains, but the jury is still out on the applicability of complexity theory and system theories to social systems (Chesters & Welsh, 2006; Flood, 1990; D. Griffin & Stacey, 2005; M.C. Jackson, 2000; 2009; Mowles & Griffin, 2008; Westley et al., 2009).

Nilsson and Paddock (2013) argue that much of social innovation theory stays at the macro-level (see also Borzaga & Bodini, 2012). The adaptive cycle does not offer much insight into the micro-level processes of social innovation. Although the adaptive cycle is very helpful in providing some insights into the kind of macro-processes that occur along the innovation journey, this thesis is concerned with exploring potential theoretical frameworks that address micro-level processes of social innovation.

The adaptive cycle assumes a complexity perspective on the world. It assumes that organizations and the organizing of the world emerge in nonlinear, non-sequential, fluctuating ways. Stacey (2010), in his work on the reality of organizational change, draws on complexity theory to argue that social arrangements should be understood as being in a perpetual state of construction where functions and symmetries of time bring about new social arrangements. The inclusion of time forefronts the contextual importance of working in and understanding organizational dynamics. Drawing on Bourdieu (1998), Stacey (2010) argues that human arrangements are formed through the interactions of interdependent agents. It is through the local interactions of these interdependent agents that population-wide patterns emerge. What Stacey (2010, p.57) is describing is his interpretation of transformational change, that “entities are forming
patterns of interactions and at the same time, […]are being formed by these patterns of interactions.” It is this perspective that informs the forthcoming discussion on stance.

In the first chapter, I described social innovations as an approach to addressing wicked problems (Rittel & Webber, 1973, p.155; and see pp.14–15). These problems are complex in nature and adopting the stance of complexity has much to contribute to social innovation.

**Digging into the concept of social innovation**

In attempting to conceptualize social innovation, it is useful to explore what we mean when we use the term “social,” and what we mean when we use the term “innovation.” As it turns out, both terms are poorly defined. This complicates the task of defining social innovation, as it combines two fuzzy concepts. Within the social-entrepreneurship literature, authors have also struggled with the merging of two fuzzy concepts. Mair and Martí (2006, pp.36–37) argue that in addition to being poorly defined, the term “social entrepreneurship” encounters challenges related to establishing disciplinary boundaries. They argue that having several disciplines working in tandem to understand social entrepreneurship enriches the field with a diversity of perspectives (Mair & Martí, 2006). For them, it is also an opportunity for a multidisciplinary approach to conceptualizing, defining, and rethinking central concepts or assumptions in the field (Mair & Martí, 2006). Similarly, social innovation should embrace the rich insights that can emerge from a multidisciplinary approach and avoid polarized theoretical debates.
What makes social innovation social?

So the search for invariant forms of perception or of construction of social reality masks different things: firstly, that this construction is not carried out in a social vacuum, but subjected to structural constraints; secondly, that structuring structures—cognitive influencing structures—are themselves socially structured, because they have a social genesis; thirdly, that the construction of social reality is not only an individual enterprise but may also become a collective enterprise (Bourdieu, 1989, p.18).

A dominant theme in the existing definitions of social innovation is an assumption that the term “social” refers to common good. If we add the term “social” before a word, does that then make it a descriptor for something that adds social good? How does adding the term “social” to the front of “innovation” change its meaning?

It is a widely held view that all human activity is inherently social (Bourdieu, 1990; Elias, 2000; Giddens, 1986; Shaw, 2009). This suggests that all innovation is social, and always has a social genesis (Bourdieu, 1989). Dolwick (2009) in his examination of classic and contemporary uses of the term “social,” concluded that as a theoretical object, when we use the term we are often not speaking the same language. Dolwick (2009) argues that the term “social” can be interpreted in a number of ways. In its most narrow interpretation, “social” refers only to human actors and their interactions. It discounts material artefacts, plants, or animals. These non-human things become part of a passive background, unworthy of empirical or theoretical exploration. “Social” in this context refers to structures and associations between humans. The socio-material is completely ignored.
In its broadest interpretation, “social” means association. In this version, actors could be humans, places, animals, physical space, or material artefacts. Actors create social reality through relational effects, be they human or non-human actors. Dolwick (2009) draws on a tradition of socio-materiality and is interested in understanding maritime archaeology as the social object for study. He concludes, “Actors are relationally linked with one another in webs or networks. They make a difference to each. They make each other be,” (Dolwick, 2009, p.24).

Social activity does not happen in a vacuum and is deeply relational (Bourdieu, 1989). We live in a socially constructed world that emerges in concert with other actors in our social space (Bourdieu, 1990; Elias, 2000; Giddens, 1986). Although the term “social” is poorly defined and hotly debated within the field of sociology, at a minimum, the social is relational. One school of thought within the field of innovation argues that “[s]ocial relations are essential in innovation,” (Tzeng, 2014, p.385). Theorizing social innovation is a conversation about a social phenomenon that seeks to change social relations and constructs. If actors within a social system produce social reality by interacting with other actors, then changing that social reality should also emphasize a relational approach. At a minimum, social innovation should involve a transformation in our social relations (see also Pue and Breznitz, 2015).

If taken literally, social innovations would be defined as a new idea, method, or device that profoundly changes the interactions of individuals or groups. Consequently, however we define social innovation, its minimum condition should involve changing the interactions of individuals and groups (Pue and Breznitz, 2015)
What do we mean by innovation?

Social innovation should be about understanding how the innovation has affected the social milieu of society or communities. If we agree that social innovation should, at a minimum, change the social interactions of individuals and groups, then we have addressed what we mean by “social” in this context.

This understanding evokes the question: how then should the term “innovation” be understood when referring to social innovation? There have been many attempts to make distinctions between different types of innovation. The challenge here is to avoid pedantic, detail-oriented discussions and instead place emphasis on frameworks that are helpful to practitioners and policy-makers, so we can reflect on how innovations occur.

One common approach to categorizing innovation is to refer to it as being incremental, radical, or disruptive (Christensen, 2003; Tidd, Bessant, & Pavitt, 2005; Yu & Hang, 2010). “Incremental innovation” refers to gradual changes or improvements. “Radical innovations” refers to completely new processes, products or services, while “disruptive innovations” refers to innovations that create new markets, value networks, or systems.

When scholars refer to disruptive innovations they often refer to examples like MP3 players displacing CD players, or mobile phones displacing regular phones, and how the telephone industry will never be the same because of the disruptive technology of the mobile phone (Deiglmeier & Miller, 2008; Markides, 2012). Disruptive innovations completely change industries, while social innovations completely change social arrangements. The Internet, as an example of a technical innovation that became a social innovation, has changed the way we socialize, communicate, and share
information. Another common example of a social innovation is the public-school systems (Boliver & Swift, 2011). Before we had them, education was only available to a privileged few. School systems have created entirely new ways of socializing. They have been the social ladder that has made possible social mobility in many societies (Boliver & Swift, 2011; Iannelli, 2013).

A more recent and insightful example comes from Vancouver and the Planned Lifetime Advocacy Network (PLAN), led by life partners Al Etmanski and Vickie Cammack. PLAN began as a group of concerned citizens who wanted better care for people with developmental disabilities. Al Etmanski and Vickie Cammack were part of a group of parents trying to find support for their differently abled children. Etmanski (2015, p.34) has a great passage in his book that gives insight into how two fathers in their group reframed the challenge they thought they were facing:

“Well, young fella, we’re facing something you won’t have to for a while,” said Chuck, one of the dads. “We’re going to die sooner rather than later. And when we look around, we don’t see the kind of supports my and Jack’s daughter will need when we’re gone. We’re afraid. Will you help us?”

Those two fathers had put their finger on a brand-new social challenge. Thanks to medical advances and social inclusion, the son and daughter of these parents, and hundreds like them, would soon become the first generation of people with disabilities to outlive their parents.
After years of working to improve the lives of people with disabilities, PLAN was able to fundamentally shift the kinds of supports families are able to receive. Through its work, British Columbia now recognizes the ability to develop trusting relationships as an indicator for legal competence. If people with developmental disabilities can demonstrate long-term relationships, they can now legally participate in the appointment of their own guardianship (Nilsson & Paddock, 2013; Westley et al., 2009, p.73). In every other jurisdiction in the world, legal participation is determined by cognitive ability (Nilsson & Paddock, 2013, p.51). For a small group of citizens, this improvement has changed the ability of some to choose their guardian.

PLAN has also played an instrumental role in collaborating with government and with commercial banks to develop the Registered Disability Savings Plan (RDSP). This provides people with disabilities and their families with a way to invest or save for their long-term financial security: the government provides incentives in the form of grants (Nilsson & Paddock, 2013). Parents and families can feel more comfortable knowing that their children have some form of financial security. The advantage is that for those on government assistance, the RDSP contributions adds extra security, so people are allowed to have both, while with other financial mechanisms, you would be required to use all current investments before you can receive government assistance. Etmanski and Cammack were able to achieve the dream the fathers in the excerpt above were longing for.

These examples are improvements with demonstrable systems-level effects that produce discernible changes in the way individuals and groups interact. When improvements lead to noticeable changes in social arrangements, we can call them social
innovations. It is important to note that what led to the need for this particular social innovation was the changing reality in the lifetime of the differently abled. Improvements in health care meant that these children might outlive their parents, and this reality required a new approach. So although it is easy to think that improvements in health care are always good, these improvements can generate new challenges that require social innovation.

The examples of how local-level activities, like the RDSP, can shift entire systems are the focus of this thesis. I intend to hold a magnifying glass to the kinds of improvements within the social-intervention space that lead to potential social innovations. Social innovation is a process that involves several dynamics working simultaneously to produce desired outcomes. In the innovation literature, it is well established that disruptive innovations emerge as a result of incremental or technical innovations. Similarly, social innovations are the result of a combination of incremental and technical innovations.

As not all innovations are the same, then it follows that being able to identify types of social innovations would be useful for social innovation practitioners. The incremental, radical, and disruptive distinctions do not provide us with a place for intervention. Tidd et al. (2005) offer a useful typology for understanding where in the process of innovation groups may want to consider intervening. They identify four types of innovations: process, product, positional, and paradigm innovation. Process innovations focus on the inner life of organizations; product innovations relate to changes in what is delivered to individuals and entities outside the organization; positional innovations refer to a product or service being placed in a new context and thus gaining
new significance for the user, or a new target market; and finally, “paradigm innovation” refers to when existing mental models within organizations are completely changed. Tidd et al. (2005) provide us with a framework that we can use to help us analyze social innovations. For the purpose of social innovations, it is helpful also to include a fifth ‘p’ un their framework. This refers to policy innovations. Policy-level changes within the context of social innovation are particularly important to stimulating social innovation.

**Improvement vs. innovation**

Many scholars have long held the view that innovation is about newness (Gopalakrishnan & Damanpour, 1997). Bason (2011), in writing on public-sector innovation, argues that although innovation is about something new, determining the newness can be challenging. Many innovation authors have asked questions that loosely refer to the “it.” How is “it”—the product, service or program—new? To whom is it new? Is it new or is it a tweak? Is it an improvement on a previously existing process? By finding new solutions to problems, innovation destroys existing markets, transforms old ones, or creates new ones. Innovation can bring down giant incumbents while propelling small outsiders into dominant positions,” (Hauser, Tellis, & Griffin, 2006, p.687). where does this quotation begin?

In the previous section I refer to incremental innovations as being slow, gradual improvements. Many innovations come about as a result of step-by-step improvements that eventually lead to an innovation. But social innovations, however they are to be defined, should be about more than just an improvement. In the field of evaluation, there is a very well established typology called formative evaluation that is wholly concerned
with measuring improvements (Patton, 1996; Reichardt, 1994; Stetler et al., 2006). From this work, it is well acknowledged that most social-intervention programs are seeking improvements, but very few of them make the transition to radical or disruptive innovations (Patton, 2010, 2016). If we intend to move the needle on social issues, organizations would need to move into the radical and disruptive domains. But few organizations are able to achieve the holy grail of disruptive innovation. Even the organizations that led to the theory of disruptive innovations have been brought into question, with research claiming that these organizations were not as disruptive as they were once thought to be (Danneels, 2004; Markides, 2006; Yu & Hang, 2010). Disruptive innovations are rare, and we should not expect organizations to able to produce them on a regular basis (O’Reilly & Tushman, 1997; Rolstadås, Henriksen, & O’Sullivan, 2012; Yu & Hang, 2010). Not all organizations need to be disruptive. We can, however, work towards increasing our chances of generating these radical innovations, but we should expect them to move towards improved outcomes.

Patton (2010) makes a distinction between improvement and innovation. Within the context of evaluation for social innovation, he draws on a metaphor introduced by Bob Stake (as cited by Scriven, 1991, p.169). In making a distinction between formative and summative evaluation, Stake argues that: “When the cook tastes the soup, that’s formative; when the guest(s) taste[s] the soup, that’s summative.” “Formative evaluation” here refers to evaluation for the sake of making improvements, while summative evaluation refers to evaluation for the sake of determining merit or worth. Patton (2010, p.27) argues that when the chef tastes the soup and makes improvements in the kitchen, then this is an improvement (formative evaluation). When the guests taste the soup, they
are deciding if they like the soup or not, and at this point it is too late to make substantial improvements (summative evaluation) (Patton, 2016). If the chef returns to the market and buys new ingredients with her guest(s), then this is what he calls a development. It is in tracking these developments that he wants to say we are able to help support innovation. His argument is that developments, not improvements, are more likely to lead to innovations (Patton, 2010, 2016).

Additionally, Patton (2010), although he does not state this, calls our attention to involving the end user in the development process. He calls his approach to evaluation “developmental evaluation,” as it focuses on tracking and identifying the developments that are likely to generate social innovations. In this approach, the end user also participates in the development of the meal. These approaches have a striking similarity to ethnographic research, action research, and design thinking.

What Patton (2010, p.27) is proposing is a radical approach of using evaluation as way of generating innovative ideas rather than improving old ideas, or judging them to be good or bad. He implies that we need to be prepared to abandon our existing meal, even if we have invested considerably in it. This notion deeply challenges existing organizational practices. The approach suggests a radical question: are we improving or innovating? Further, we need to think about for whom, and with whom, we are innovating or improving. If the product does not work for the end user, sometimes we need to get new ingredients, rather than trying to improve existing meals. This metaphor resonates with me because there are meals that, no matter how much salt or spice you add, you cannot make edible again. You need to start all over.
With this metaphor, Patton (2010, p.27) has challenged the reader to rethink what we mean by “innovation.” He implicitly asks the question: is innovation about more than improvement? Here, he implies that innovation is sometimes about returning to previously held assumptions and divesting from current investments. I interpret his work as saying innovation requires a willingness to embark on creative destruction (Gunderson & Holling, 2002). The most powerful implication of his metaphors is the suggestion that we need to involve stakeholders in all stages of the process, including evaluation and decision-making, an approach that is often given lip service, but is not always genuinely implemented.

Seeing with new eyes

In the field of social entrepreneurship, Mair & Martí (2006) in their widely cited study of three successful social enterprises—the Grameen Bank in Bangladesh, the Aravind Eye Hospital in India, and Sekem in Egypt—identify shifts in resource flows as a commonality of these three enterprises. They observe that each organization creatively combines resources as a means of addressing a social problem and disrupting existing social structures. Although Mair and Martí (2006) used structuration theory and institutional entrepreneurship as their theoretical frame, they demonstrate how these three social-enterprise organizations creatively recombine resources to catalyze social transformation. For example, the Grameen Bank dared to provide loans as a poverty-reduction strategy (Yunus, 2003). This reframing of who has the right to credit, and how it can change the lives of those in need, was a considerable paradigm shift. To generate the conditions for social change, Grameen Bank needed to reframe the paradigm of who
qualifies for loans. This change greatly influenced the level of transformation the bank was able to achieve.

**So how then do we conceptualize social innovation?**

I have argued that a minimum condition for social innovation should be a change in social arrangements, relationships, or interactions. Drawing on Patton’s (2010) observations, social innovation demands more than improvements, and asks that we be willing to embark on creative destruction. The insight from Mair & Marti’s (2006) work on successful social enterprises suggests that these organizations were able to generate social transformation because they were able to recombine resources creatively. Often this reconfiguration of resources also involved reframing the problem or changing the existing paradigm.

By analyzing the major themes within existing definitions of social innovation, I was able to code these definitions for and develop major themes of “What is social innovation?” Additionally, I drew on insights derived from shallow interviews with social-innovation practitioners. After grouping these themes, I narrowed this work down to three core themes:

- Changes in resource flows
- Changes or challenges in our paradigms
- Changes in our social interactions or social relationships.

This approach allowed me to conceptualize social innovation as an activity that profoundly changes social relations or interactions, deeply challenges or shifts our existing paradigms, and significantly changes resource flows within an existing social
system. This allowed focusing social innovation around specific conceptualization so as to increase the opportunity for analysis. This framing allowed me then to search for a case study that met the criteria for this new conceptualization.

Existing definitions of social innovation were inappropriate in a number of ways: for example, Mulgan (2006) describes social innovations as: “activities and services that are motivated by the goal of meeting a social need and that are predominantly diffused through organizations whose primary purposes are social,” (Mulgan, 2006b, p.146). Under this definition, any organization that is meeting a social need can be considered socially innovative. A definition this wide does not help us make a distinction between “social innovation” and other social-good activities. Mulgan (2006a, p.8) defines social innovation as “new solutions (products, services, models, markets, processes, etc.) that simultaneously meet a social need (more effectively than existing solutions) and lead to new or improved capabilities and relationships and make better use of assets and resources,” (Mulgan, 2006a, p.8). Meanwhile, Deiglmeier and Miller (2008, p.36) define social innovations as “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 as a whole rather than private individuals.” These definitions focus on activities that accrue benefit primarily to society as a whole. They say nothing of transformation or changing systems that produce the social problems we seek to address. Frances Westley and her colleagues at Social Innovation Generation define social innovation as “an initiative, product, process or program that profoundly changes the basic routines, resource and authority flows or beliefs of any social system. Successful social innovations have durability and broad impact,” (Biggs et al., 2010). This definition
addresses the need for transformation by placing emphasis on profoundly changing the basic routines, resources, and authority flows of social systems, but is still problematic.

**Shallow zooming in: interviews with key informants**

In the early phases of this study, I conducted interviews with practitioners who identified as working in the field of social innovation. In those conversations, I made a distinction between a social intervention and a social innovation within the context of organizations collaborating for social change. These exploratory conversations served two objectives. First, they were an opportunity to have a conversation about the theory being explored and how it resonated with their experience as practitioners. Secondly, it gave me (the inquirer) insight into which theoretical domains to pursue, and which were missing from the research.

For example, three practitioners referred to the definition of social innovation as confusing. At the time, I would read Frances Westley’s definition: “Social innovation is an initiative, product, process, or program that profoundly changes the basic routines, resource and authority flows or beliefs of any social system. Successful social innovations have durability and broad impact.” One informant stated that when she first heard that definition, she had no idea what social innovation was about. Three informants were not happy with current definitions of social innovation, so I began testing my own definitions of social innovation in future interviews.

With another informant I had a rich conversation about needing space for social innovation. She referred to needing physical, cognitive, and social space to engage in the work of shifting systems. Until then, I had not considered space as a theoretical construct.
She spoke about creating “safe space” where possible and acknowledged that few spaces are ever completely safe, but participants need to feel unrestricted by the tentacles or politics of their organization. Participants needed thinking time, so she found that it was important for time to be allowed not to work on other responsibilities and to think about shifting spaces. This also meant not getting caught up in the past. She argued that participants needed to enter the space feeling open. Then she talked about where the work happened as being important, saying that some work needs to be off-site, or in neutral physical space, while other work needs to be done where the work is happening. From this conversation, I returned to the literature to explore various conceptual approaches to understanding space.

I identified three bodies of literature that I found useful for conceptualizing an approach to generating space for social innovation: Bourdieu’s (1990, 1998) notions of symbolic space and everyday practice; Evan and Boyte’s (1992) idea on free spaces; and Lefebvre’s (1992, 2014) notions of socio-material space. Each theorist provides insight into how we can conceptualize space within the context of social innovation.

Another informant was very dissatisfied with existing definitions of social innovation. Her major quarrel was that current definitions of social innovation could include, specifically, World War II and what Hitler was doing in Nazi Germany and elsewhere. At first, it was tempting to agree with the informant’s proposal of a value-based definition of social innovation so that it did not include things like genocide. Later I discuss this within the context of social movements and the need to study movements we do not like. It was this conversation that made me explore that theoretical line.
Another conversation discussed in the interviews was the issue of power, and who
decides what future we can bring into the world. Future research should focus on critical
questions such as: social innovation for whom, by whom, and with whom?

Similarly, practitioners often struggled to make a distinction between a social
intervention and a social innovation. These early-stage interviews suggested a need for
clarifying definitions within the space of social innovation.

One informant spoke about her time in international development, saying one of
the reasons she left that space was because she found it too top-down. She started
working in social labs because she liked the approach that focused on co-production
rather than imposing solutions onto communities. She preferred a system that approached
change from top, bottom and middle, in a sort of emergent and strategic fashion. She
spoke particularly negatively about predetermined methodologies and accepting that
sometimes interventions may not work.

There was a dominant narrative among this group of informants that current
approaches are too invested in knowing too much in advance, and that before we
intervene in a system, practitioners need to have a deep understanding of the existing
system. In later chapters of this thesis, these issues are addressed, using the case study as
a model for addressing some of these themes.

Should we avoid a normative definition of social innovation?

Mulgan’s (2006) and Phills & Deiglmeier’s (2008) definitions of social
innovation, previously presented, place emphasis on contributing to the common good or
producing social value. Their definitions assume that social innovation should produce social good. Several examples of social innovations demonstrate that they are neither good nor bad. Take, for example, modern medicine. Porter (1999) argues that modern medicine and the rise of hospitals were one of the most important innovations throughout human history. Modern medicine underwent a change in paradigm, a change in resource flow, and a change in social relations. The major paradigm that has shifted has been that we no longer think of medicine as the domain of wizards and witches, but rather a profession and institution supported by years of scientific research. We now pay doctors wages and have dedicated educational and research institutes that help build knowledge of medicine. This is a major shift in the way we allocate resources to medicine. Finally, our social relationships have also changed; we have constructed categories of professions like doctors, surgeons, and nurses who wield significant social capital and power within society. Doctors in particular are held in a sort of reverence in our society.

But modern medicine is not a wholly good or bad innovation: there are aspects of modern medicine that produce desirable outcomes, while others need significant improvement. Innovations cannot produce only desirable outcomes, nor should we expect them to. With all its benefits, modern medicine has produced some very negative outcomes. Thorny questions emerge, such as: when should we let someone die? If we can save a life through modern medicine, should we? This question arises at the start and at the end of life. For example, one interviewee, a paediatrician, explained that it is widely accepted that at twenty-four weeks’ gestation the fetus has a fifty percent chance of survival (Roe vs. Wade). Prior to twenty-four weeks, the fetus is significantly underdeveloped. But with advances in modern medicine, it is possible to save the life of a
child born at twenty-three weeks. That child, however, is likely to be medically compromised and to need special care for the rest of his or her life. This can place a significant burden on the parents. At the other end of the life journey, medical interventions can prolong life even when patients and families no longer wish to carry on (Guo & Jacelon, 2014; Meyer, 1995). The dying-with-dignity movement has gained momentum with the advance of modern medicine, without which, people would simply have died without our having to ask these complex medical and ethical questions (Meyer, 1995). So social innovations do not always contribute to social good. Sometimes we need to take the good with the bad.

Another example of a social innovation that can be considered to have contributed to the development of modern society is the internal combustion engine. As demand for it grew, so too did the demand for fossil fuel. Today we think of our consumption of fossil fuel as a major contributor to climate change.

For many, social innovation is about a newness that contributes to the common good or produces social benefit. This tendency has also been observed in the fields of social entrepreneurship and social-movement theory. Within the social-movement literature Edelman (2001, pp.298–303) argues that social scientists devote disproportionate attention “to movements they like...,” and give “infrequent [attention] to theoriz[ing] right-wing movements.” He argues that by researching the full spectrum of social movements—right- and left-wing—researchers gain considerable insight into emerging disciplines. For example, some right-wing movements try to overthrow the state, while others promote the downward distribution of wealth (Edelman, 2001, p.302). These observations are rarely highlighted when we think of right-wing movements. An
exercise I often do in workshops or presentations is to ask attendees to name a social movement. Participants often respond with examples like the civil-rights movement, the environmental movement, the feminist movement, human-rights movements, etc. Very rarely do they identify groups like the White Power Movement, the Ku Klux Klan, Hamas, or Boko Haram.

But research that fails to place a lens on right-wing movements only serves to reinforce common-sense perceptions that these movements are irrational and reactionary (Edelman, 2001). Findings suggest that right-wing movements, like the White Power Movement (Blazak, 2001; Dobratz & Shanks-Meile, 1997; Futrell, Simi, & Gottschalk, 2006), climate-change deniers and organizations like the British National Party not only have legitimacy and power within society, but also make rational strategic choices to promote what they perceive to be legitimate claims, fears, and agendas (see also Berlet & Lyons, 2000; Futrell et al., 2006; Koopmans & Olzak, 2004; Lienesch, 1982). Researchers rarely explore social movements that do not align with their values, yet there is much to learn from them. Robert Futrell (2004) and his colleagues, in their study of white-power social movements, demonstrate how these movements very often engage in strategy, recruiting, and planning of activities that are similar to those of most social movements (Futrell et al., 2006; Futrell & Simi, 2004; Simi & Futrell, 2006). These observations, if applied to social innovation, suggest that not only may social innovation have outcomes that do not align with our values, but researchers may also benefit from insights derived from exploring social innovations we do not like. If we wish to avoid only studying social innovations we like, we need to conceptualize social innovation in a way that includes examples with both desirable and undesirable outcomes (Edelman,
Considerable insight can be gained from understanding social innovations that do not produce “left-wing” social benefit (Edelman 2001, p.302).

Further, the term “social need” is not necessarily helpful within this context. Many organizations meet social needs, for example, public transportation, coffee shops, homework centres, gun stores, co-operatives, daycare centres, or computer stores—but are they social innovations? Under many of these definitions, any organization that is meeting a social need can be considered to be socially innovative, which does not help us make a distinction between “social innovation” and other social activities.

**Discussion: defining social innovation**

I have conceptualized social innovation as an activity that profoundly changes social relations or interactions, deeply challenges or shifts our existing paradigms, and significantly changes resource flows within an existing social system. If we take microcredit as an example of social innovation, we can track how changes in the way we think about who should be entitled to receive credit have shaped our approaches to poverty reduction. The notion that credit should be a human right is a significant change in paradigms. Microcredit is by definition a change in resource flow, which has transformed social arrangements in communities around the world.

But with all its social good, it has also created social ills. Muhammad Yunus has been quoted as saying, “We created microcredit to fight the loan sharks; we didn’t create microcredit to encourage new loan sharks,” (MacFarquhar, 2010, p.1). He argued, “Microcredit should be seen as an opportunity to help people get out of poverty in a
business way, but not as an opportunity to make money out of poor people,”
(MacFarquhar, 2010, p.1). Microcredit has transformed the lives of many of the world’s
poorest, but several reports have highlighted how it has not always produced social good
(Brau & Woller, 2004; Sengupta & Aubuchon, 2008; Yunus, 2011).

Social innovations can generate outcomes that are both good and bad. I am
arguing for a more rigours conceptualization of social innovation that brings us towards
generating the conditions of such innovation.

Social innovation needs to be about more than improvements. I have argued that
by adding the word “social” as a prefix to “innovation,” we are referring to more than
doing good. “Social” is relational, and actors within systems both shape and are shaped
by each other (Bourdieu, 1990; Elias, 2000; Giddens, 1986). Social innovations reshape
relations that are both social and socio-material (Dolwick, 2009).

“Words do not have real meaning. They just have uses and different applications:
And our job is to analyse the concepts and map out the uses and applications,” (Wilson,
1970, p.10). What I have proposed is not a definition of social innovation, but a proposal
for a particular use of the term “social innovation.” Curzan (2014), in her book *Fixing
English: Prescriptivism and Language History*, argues that words have always changed
meaning and there are times when prescribing meaning to words has been very valuable.
For her, language has always been policed for instances of correct use, but languages are
fluid; and at times prescribed uses are helpful. Words in many ways have no inherent
meaning; their meaning is constructed (Wilson, 1970). How we use words is determined
by the construction of that meaning. Drawing from a broad body of related literature, I
have tried to make explicit what I mean by “social innovation.” The following
conceptualization has been refined many times throughout this research journey and some insights have come from literature that is presented in later chapters (Figure 3.3).

The purpose of the foregoing section is to direct attention to the most salient aspects of social innovation in an attempt to move towards a substantive conceptualization of social innovation. Although it is unlikely that everyone will agree with the presented approaches, for the purpose of this thesis, the conceptual framework of social innovation that I use will be: an activity that profoundly changes social relations or interactions, deeply challenges or shifts our existing paradigms, and significantly changes resource flows within an existing social system.

Figure 3.3. Conceptualizing social innovation as a framework.
Garvey (1994), in writing about coaching and mentoring, puts forward a descriptive framework for making a distinction between the two concepts. Drawing on his work, I use a descriptive framework to conceptualize social innovation. This approach allows practitioners to consider their context as they evaluate their social innovation by placing themselves in the dyadic framework proposed. The framework is a nonlinear framework in which each node exists as part of a complementary triad. Each node leads to the next, depending on the social innovation in question. It is tempting to ask which node comes first: each can lead to another, and when they exist in parallel, then they can produce social innovations.

Figure 3.4 demonstrates how one may be able to rank a social innovation along the three scales. It provides a way for practitioners to have an explicit conversation about social innovation and where to devote time and energy. If we return to the story of microcredit, Muhammad Yunus (2003), in his book *Banker to the Poor*, described how a shift in paradigm led him to create a bank for the poor. His belief that credit should be a human right helped him envision a mechanism that provided a shift in resources that dramatically reshaped the lived experiences of these women. It changed their social reality. The scale in Figure 3.4 allows us to have an explicit conversation about how much of a social innovation was the Grameen Bank.

<table>
<thead>
<tr>
<th>Small Δ in social interaction</th>
<th>X</th>
<th>Large Δ in social interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Δ in paradigm</td>
<td>X</td>
<td>Large Δ in paradigm</td>
</tr>
<tr>
<td>Small Δ in resource flow</td>
<td>X</td>
<td>Large Δ in social resource flow</td>
</tr>
</tbody>
</table>

**Figure 3.4. A Descriptive approach to conceptualizing social innovation adapted from Garvey (1994, p.20).**
Roadmap of the following chapters:

- **The why** - Setting the stage for social innovation
  - What inspired midwives?
  - How did they create the preconditions for social innovation?
- **The process/how** - Exploring how midwives were able to generate social innovation
  - What did they do to generate social innovation?
- **The what** - What midwives were able to achieve - the social innovation
  - What resources flows, paradigms and social relationships did they change?

**Figure 3.5. Outline of how the chapters unfold.**

This thesis evolved in a non-linear manner. This segment serves as an orienting paragraph to provide the reader with signposts to where the conversation is heading next.

This chapter addressed the “what” of social innovation, the outer ring in Figure 3.5. Chapter 4 continues to refer to the outer ring of Figure 3.5, but outlines how midwifery qualifies as a social innovation. Chapter 5 explains the centre of Figure 3.5, the “why.” Why did women want to embark on a social innovation journey? What motivated them? The chapter explores the middle of the framework and refers to how midwives were able to create the preconditions for social innovation. Chapter 6 focuses on the middle layer of Figure 3.5 and explores the role of social and spatial practices within the larger framework. Chapters 7 and 8 serve as synthesizing chapters that
demonstrate how midwives were able to generate social innovation. These chapters focus on the process of social innovation, and here I address the three major themes that emerged from the data to form the proposed triadic framework for social innovation. Chapter 9 outlines the implications of the study.
Chapter 4: Contextualizing midwifery as a social innovation

“I don’t have much to comment on the topic of social innovation. I was just a young woman at the time who was passionate about the availability of choice.”

Shawn Gallagher (Canadian Midwife 9).

In this chapter, I provide additional context for how one of the world’s oldest female professions came to be an example of social innovation (Marland, 2005). Midwifery was also the only example considered that experienced three phase shifts or time periods where resource flows, paradigm, and social interactions changed considerably. The section begins with a cautionary tale in reading and understanding midwifery as an example of social innovation.

Preface to the herstory of midwifery

In the telling the story of midwifery, I use the word “herstory” instead of “history.” “Herstory” is used for a history told from the perspective of women. I use the word in telling of the history of midwifery as a way of honouring the feminist work that has helped make this research possible.

Chimamanda Ngozi Adichie is an accomplished author and storyteller who gave a wildly popular TED Talk titled, “The danger of a single story.” In it she discusses the danger of thinking about the African continent using a single narrative. Similarly, it would be a misrepresentation to provide a single story of midwifery in any part of the world. As social scientists we often comb data in search of the counter-narrative. The
herstory of midwifery is plural, diverse, complicated, and nonlinear, and can be examined from many perspectives. Bourgeault (2000) has examined midwifery in Ontario as a professionalization project. Nestel (2004) explored the regulation process of midwifery in Ontario through an “equity” lens. Benoit (1991) examined the herstory to challenge the dominant narrative that midwifery had once disappeared throughout various parts of Canada, unearthing a wealth of evidence to argue that midwifery existed in many communities throughout Ontario, particularly immigrant communities. MacDonald (2008) explores the many interpretations of what it means to have had a natural birth. Combined, these many perspectives give a pluralistic account of how midwives have struggled to be the guardians of birth.

Most studies of midwifery are an attempt to understand midwifery, as distinct from seeing midwifery as a social innovation. Here I use midwifery to highlight various aspects of social innovation, though it is easy to get distracted by interesting characteristics of midwifery and lose sight of this focus. Consequently the herstory presented is not intended to be comprehensive, but to demonstrate how midwifery has unfolded in relation to the three dimensions of social innovation proposed. There is no single story of midwifery, nor can any analysis explore the many possible interpretations.

What is midwifery?

Worldwide, the International Confederation of Midwives (ICM) governs midwifery. It is believed that a thousand women met in Antwerp, Belgium, in 1900 to share knowledge of midwifery.\(^9\) The ICM conference dates back to this gathering.

\(^9\) ICM website: [http://internationalmidwives.org/who-we-are/history/](http://internationalmidwives.org/who-we-are/history/)
Surviving records indicate that midwives have been meeting every three years since 1928, with the exception of World Wars I and II. The ICM sets the guiding principles for more than a hundred autonomous midwifery associations around the world. When you consider the size of their network, the number of women whose lives they have influenced, and the number of women who are part of their professional network, it is simply staggering. I define the ICM as a social-movement organization, and it is possibly one of the world’s largest and most networked social-movement organizations; yet few people would be aware of the size of this network.

The ICM defines a midwife as:

a person who has successfully completed a midwifery education programme that is recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title “midwife”; and who demonstrates competency in the practice of midwifery. (International Confederation of Midwives, n.d.)

The ICM defines the midwife’s scope as being that of an independent practitioner who is able to practice in any of a variety of settings, including the home, community, hospital, clinics or health units. Midwives provide support for births that do not require medical interventions. They give care and advice during pregnancy, as well as determining appropriate assistance during the antenatal period, labour, and postpartum periods. Midwives detect complications in mother and child, promote a woman’s right to
choose how she gives birth, and plan or implement emergency measures. Midwives also provide health counselling and education to women, the family, and community in the antenatal and postpartum periods. They assist with the preparation for parenthood, which may include health, sexual, or reproductive health and childcare.

“Born to birth” is a common adage within the midwifery community. Midwives see birth as natural, and assume the woman’s body knows what to do. Many midwives would say that they do not deliver babies, they catch babies, or assist with birth (Barrington, 1985; Bourgeault, 2000; Bourgeault et al., 2004). For example, one midwife informant said midwives “hold the place of protecting reproductive health, the normalcy of the capacity of the female, the reproductive capacity, and, importantly for me, we’re the only profession that supports the dyad,” (Canadian interviewee 2).\(^\text{10}\) In many ways, midwives are the guardians of a medical-intervention-free birth, or natural childbirth (For a more in-depth discussion on what it means to have natural or normal birth, see MacDonald, 2008.)

Since almost all midwifery associations around the world follow the guidelines of the ICM, it can be assumed that the ICM guidelines have a homogenizing effect on the global practice of midwifery (see Figure 4.1). This characteristic makes midwifery groups a relatively uniform unit of analysis that can be studied in a variety of contexts. Each country, culture or region may have some unique traditions, but in general midwifery practice is governed by the ICM and the local midwifery associations or governing bodies.

\(^{10}\) Dyad here refers to the connection between the mother and newborn. Recent guidelines from the NHS suggest that the umbilical cord should not be cut before one minute after birth, but no longer than five minutes after.
Figure 4.1. The uniforming characteristics of ICM that make it an ideal case study.

Stumbling onto midwifery as an example of social innovation

Yin (2012) suggests that it is worth investing time in a case study if it is extreme, unique or revelatory. Case studies do not need to meet all three criteria, but deciding which criterion they should meet is important, and should be determined by the type of
research being pursued. In developing a substantive conceptual framework of social innovation, I did not want an example that was extreme, or an outlier, since I felt that the more extreme the example, the less generalizable it might be. Similarly, the study needed to be unique in the sense that it was an ideal example of a social innovation, but it could not be unique in the sense that the context was so different that there would be little transferable knowledge. I instead opted for an example that would be either revelatory or a unique type of social innovation.

Society is constantly evolving and midwives have long been part of that story. Midwifery as a case study proved to be revelatory, since it highlights that social innovation is neither new nor static. Midwifery is under constant threat of becoming increasingly medicalized. The practice is never stagnant. Midwifery was unique in that it had undergone three clear transitional phases or system shifts (see p.16). Other examples of social innovation have only experienced one system shift, and these tended to be technical innovations. Midwifery’s multiple transformations allow for an analysis of consistent characteristics over time.

The proposed definition of social innovation suggests that it involves a change in paradigm, flow of resources, and social relations. In Ontario, and in Trinidad, there was a time when most births occurred in homes, villages, and communities (Bourgeault et al., 2004; Marland, 2005; Rutherford, 2010). As modern medicine developed, birth almost completely moved into hospitals and out of the hands of communities, women, and midwives (McIntosh 2013; Porter 1999). The medicalization era brought about the first shift in paradigm and resource flow (McIntosh 2013; Porter 1999).
“Paradigm,” in the conceptualization of social innovation, refers to how changes in discourse bring about larger paradigm shifts. As discourse around birth changed, so too did the larger paradigms. Frame theorists in particular have written considerably about how mental models influence the activity of agents within a system (Johnston & Noakes, 2005; Kaplan, 2008; Oliver & Johnston, 2004). In my methodology section, I spoke about the subjectivity of qualitative research and how an inquirer’s mental models influence the kind of research they might pursue (Greene, 2007). How we perceive or understand our context greatly contributes to the approaches we adopt.

As medicine moved into the hands of physicians, beliefs about who could be considered an appropriate birth attendant, or who could safely assist with birth, also began to change (Bourgeault et al., 2004; Marland, 2005; McIntosh 2013). Prior to the Second World War, birth and death were closely related. It is estimated that before World War II, complications during birth were the leading cause of death among women (Rutherdale, 2010). One commentator reflecting on the time stated:

It seems entirely fitting to me in pioneer times the local midwife usually served also as an unofficial, behind-the-scenes undertaker. Who would understand better than a midwife that the squirming, squalling new human emerging so eagerly from the womb must some day end in the marble dignity of the dead, all care, woes and fleeting joys gone forever (Rutherdale, 2010, p.61)?

It was not uncommon for a woman who was expecting to give birth soon to prepare for her death by laying out what she wished to be buried in while simultaneously
preparing for a newborn (Rutherdale, 2010). During the late nineteenth and early twenty-first century it is believed that with respect to female deaths, perinatal mortality was second only to tuberculosis (Rutherdale, 2010). The midwife held a complex, paradoxical responsibility in society, which was closely linked to life and death. “For most of human history, women have given birth in their homes, either alone or assisted by family members or neighbours, by lay or professional midwives, or by doctors,” (Rutherdale 2010, p.61). In Canada, until 1938, more births occurred in the home than in hospitals. Midwives, prior to the medicalization era, served as the primary caregiver to pregnant women (Bourgeault, 2006; Jasen, 1997; Mason, 1987; Plummer, 2000; Rutherdale, 2010).

The medicalization era brought substantially different discourse about health care. The discourse of only family members assisting with birth greatly contradicts contemporary thinking about safe birth. Up to World War II it was not uncommon for the midwife to arrive after the birth (Rutherdale, 2010). But the medicalization of birth has come about for well-substantiated reasons. It has greatly improved (infant and maternal) mortality rates throughout most of the world (UNFPA, 2014). Contemporary experiences of birth have changed considerably since pre-World War II times. Today in the developed world, or in well-resourced health-care systems, very few women die in childbirth (UNFPA, 2014; WHO, 2015), whereas in contexts where women do not have access to midwives or hospitals, morbidity rates are still very high. The Lancet reported that mortality rates for children under five have fallen globally from ninety to six per 1,000 live births (You et al., 2015). The WHO (2015) fact sheet reports that globally the maternal mortality rate has fallen by forty-three percent since 1990.
While we have seen considerable improvements in birth outcomes, the rates of caesarean sections have continued to increase globally (UNFPA, 2014). In 2012, the Canadian Institute for Health Information (CIHI) reported that caesarean-section surgery was the most common inpatient surgery in Canada, second only to knee surgeries (CIHI, 2015). Medicalization and the changes in practices have improved the outcomes of births, but have also significantly changed our paradigms related to birth.

How we think about birth is also heavily context-dependent. Public perception of the safest place for delivery and who should be the primary birth attendant can be very fickle. Birth is a deeply personal activity, and the discourse around appropriate places and practices of birth can change depending on what is happening in society. One informant recalls how SARS (severe acute respiratory syndrome) affected mothers in labour and how the ideas of opening birthing centres were, she thinks, related to major health scares like SARS and Ebola. She recalls:

The first time we were looking at birth centres in this province was before SARS. During SARS I was at St. Michael’s Hospital. North York had closed down their labour and delivery unit. That night I was at St. Mike’s when Mt. Sinai announced that they were shutting down because SARS had been found in the hospital. We were in St. Mike’s going, “Oh, my God. Where are women in labour and delivery going to go tonight?” We had women in trolleys in the hallway because everybody was being redirected to St. Mike’s. […]

Why would [women] be going into hospital, where they could potentially get SARS and they’re not sick in the first place? What the heck are we doing anyway? Why is anybody who is low-risk in a hospital? […]
These two new birth centres are actually, I believe, a release valve

(Informant 13).

In cases like this a woman who might have been resistant to an out-of-hospital birth might change her perspective when faced with the prospect of exposing her newborn to a disease like SARS. This is an example of how quickly discourse can shift. These quick shifts have the potential to lead to shifts in paradigms, resource flows, and social interactions.

Moving birth into the hospital has had the desirable effect of improving health outcomes for both mother and baby (UNFPA, 2014; WHO, 2015). It has also had the effect of increasing the rates of medical intervention (Sandall et al., 2014; Sandall et al., 2015). The transition from the pre-medicalized era to the medicalized era has had both positive and negative outcomes. Medicalization has improved mortality rates associated with birth, but caesarean rates have also increased considerably (Sandall et al., 2014; Sandall et al., 2015).

I argue that social innovations can have other outcomes that are both desirable and undesirable. As birth became increasingly medicalized, the experience of birth moved out of the community and into hospital settings and midwives were slowly and somewhat deliberately pushed out of the role of primary caregivers (McIntosh, 2013; Porter, 1999). This change in who was considered to be the primary birth attendant also contributed to a shift in who could be considered the guardian of birth and who could be present at birth. A report by CIHI (2012) states that midwives attend about four percent of all births in Ontario. These changes in who may be present at a birth also change the
social relationships associated with birth. In Trinidad men are completely excluded from the experience of birth in the public health system. There was a time in Canadian hospitals when families were not allowed in the room during birth.

These shifts in paradigms and social relations also contribute to shifts in resource flows.

In my interview with a senior Canadian midwife, she reminded me that although this may seem like a small number, if you consider that in 1994, Ontario had only fifty-three registered midwives and today the Association of Midwives reports some seven hundred and fifty registered midwives, then that is almost a fifteen-fold increase in the number in Ontario. There are three institutions that train midwives in Ontario, each with a capacity to graduate between twenty and thirty annually; that is, a total of between sixty and ninety midwives a year. But although four percent may seem like a small shift in resources, the government’s commitment to educating and training these midwives is a sizeable relative shift from 1995. Additionally, midwifery is also covered under Ontario Health Insurance, which means that women from any socioeconomic background can, in theory, access the services of a midwife. Nevertheless, according to the Association of Midwives, Ontario, forty percent of women who request their services are turned away: they report that the demand for midwifery services far exceeds the capacity for midwifery care in Ontario.

Although discussed in more detail later in this chapter, in Trinidad, midwives in the Birthing Centre service forty births a year. The small group of women who are able to choose how they give birth are generating social innovation on a small scale. They are shifting the flow of resources, out of private hospitals and into their non-profit hospital.
The midwives use a three-tier pricing model: free, subsidized and full-price. They are thus able to serve a few women from lower socio-economic groups with their model. Although working on a small scale, they are shifting resource flows, paradigms, and social interactions. Many of their most recent clients have been homosexual couples who are treated poorly in the public hospitals and Muslim women who do not want men to assist with birth.

Midwifery has witnessed demonstrable changes in the way people have thought about birthing and midwifery (a paradigm shift); changes in the way resources were allocated (resource shift); and changes in who and thus how communities participated in birth (social relations or interactions). It is these shifts in how birth is practiced that make birth and midwifery a suitable case study for social innovation.

Earlier in this thesis, I drew on social-movement literature to argue that as in social-movement studies, examples that have had both desirable and undesirable outcomes can enrich the study of social innovation. McGowan & Westley’s (2014) chapter on social innovation and the historical development of intelligence testing points out that although this is a controversial topic, it is an example of social innovation. Intelligence testing has had a significant impact on our education systems and the workplace. They considered examples of social innovation like the development of the American national parks systems, the World Wide Web, financial derivatives, contraception, and the Dutch spice trade. They point out that research which focuses less on outcomes or results, and more on “common mechanisms of trends across disparate disruptive shifts” can help deepen insights into the conceptualizing and theorizing of social innovation. By looking at discrete moments or critical incidents like institutional
shifts (changes in laws, legislation, or policy), new combinations or organizational structures, windows of opportunity, and changes in paradigm (the discourse), researchers can begin to understand social innovation as a process. Similarly to McGowan & Westley (2014) and their tracing of intelligence testing, I used theoretical insights to develop the criteria that guided my decision to choose midwifery as an exemplary case study of social innovation.

**Unfolding the herstory of midwifery**

One of the earliest references to midwifery can be found in the Bible, Exodus 1:15, which tells the story of a Pharaoh who ordered two midwives, Shiphrah and Puah, to kill all male Jewish babies. The midwives did not follow the Pharaoh’s orders, because they feared God, and let the boys live. This 1500 BC reference provides some legitimacy to the claim that midwifery is one of the world’s oldest female professions (Marland, 2005). In ancient Greece, midwives were required by law to have given birth themselves (Pilkenton & Schorn, 2008). Although the image of a midwife is usually presented as a woman, there is a history of male midwives. Within western culture, midwives are generally assumed traditionally to have been women, with very few exceptions. Yet midwives have also been male, female, and two-spirited. In Europe, male midwives are usually associated with the first step in relegating female midwives to the sidelines of birth (Donegan, 1978; Kontoyannis & Katsetos, 2011; Pilkenton & Schorn, 2008). Gianno (2004) provides a fascinating account of a South Asian tribe, the Laujes of Sulawesi, who traditionally only have male midwives.
Throughout history there have been times when midwives were portrayed as respected, upstanding members of the community, while at other times they and other female medical professionals have been demonized, presented as witches, handmaids, or as untrustworthy (Bourgeault et al., 2004; Marland, 2005; McIntosh, 2013; Rutherford, 2010). Some of this can be traced to midwives’ having had some part in practices like infanticide (Marland, 2005; Rutherford, 2010). For the most part, however, midwives have been healers within communities, and at times they were called upon as expert witnesses to testify against suspected cases of infanticide or as character references in court cases (Marland, 2005; Rutherford, 2010). Midwives have held very complex, heterogeneous roles, and throughout history most communities have had a version of the midwife as part of their story (Carroll & Benoit, 2004; Fleming, 1998; Marland, 2005).

Women would usually give birth with the assistance of someone, most often a woman (mothers, grandmothers, friends, cousins), who had either attended several births in the past, or been apprenticed in the art of assisting in giving birth (Bourgeault, Luce, & MacDonald, 2006; MacDonald, 2006; Marland, 2005; Rutherford, 2010).

During the mid-nineteenth century and in the midst of the scientific revolution, medicine became a professionalized, male-dominated occupation. Porter (1999), in his book *The Greatest Benefit to Mankind: A Medical History of Humanity*, argues that prior to the mid-nineteenth century, modern medicine had not made much progress since the Greeks first began their practice. Much of the development of modern medicine emerged out of a specific approach to mapping the human body. Successes in these scientific approaches, he argues, started the professionalization of modern medicine. Around the same time Florence Nightingale founded the Nightingale Home and Training School for
Nurses in 1860 and is credited with professionalizing and humanizing nursing. She was also regarded as a social reformer who was very interested in health-care access for all (Marland, 2005). These two developments are most often given as explanations for the professionalization of medicine.

As medical practitioners became professionals, they needed a place to practice, and hospitals emerged as the place where they did their work. I think of medical care as having moved into hospitals filled with a cradle of services and practices, and consequently, birth moved into the hospital along with all the others (Conrad, 1992; Vernon, 2015).

It is important to acknowledge that various ethnic and class groups participated in hospitalized medical care at different rates. But over time, the dominant narrative became that birth and medicine are best practiced in the hospital. Although medicalization brought decreased mortality rates, it also changed the way society thought about the practice of medicine.

McIntosh (2013, p.109), in her book *A Social History of Maternity and Childbirth*, highlighted a very influential 1970 Peel Report. Although there were others that greatly influenced the changing trend of where medicine was practiced, McIntosh cites this as the report that cemented the fate of maternity care as being safest in hospitals.

“We consider that the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100% hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective.” (*The Peel Report*, as cited in McIntosh, 2013, p.109.)
McIntosh (2013) credits this report with reinforcing the belief that hospital births were safer than home births. She believes that very little evidence supported the claims made in the report, and much of it was the opinion of the doctors who wrote it. It was damning to midwifery care and set in motion a series of policies that almost led to the disappearance of midwifery in the United Kingdom (McIntosh, 2013).

It is not surprising that there was a prevailing assumption that hospital births were safer than home births. At the time, hospitals were—and continue to be—one of the most important innovations in human history (Hughes & Rog, 2008; Porter, 1999). Moving into the twentieth century, we see a combination of midwives who were formally trained, while others were lay midwives or neighbourhood midwives (Marland, 2005; Porter, 1999). Midwives who were not formally trained gained their skills by apprenticing with other women (Bourgeault et al., 2004; Rutherford, 2010).

Klein et al. (2011) claim that eighty-one percent of obstetricians in Canada under the age of forty are female, compared to forty percent over the age of forty. At the start of the twentieth century, female birth practitioners became increasingly marginalized as male practitioners deliberately tried to control their profession (Bourgeault et al., 2004; McIntosh 2013; Rutherford, 2010).

Today attitudes toward natural birth are determined by prior training rather than age or gender. In a recent study that compared the attitudes of new-generation Canadian obstetricians with those of their predecessors, researchers found that younger obstetricians were more likely to view medical intervention as a solution to complications during birth (Klein et al., 2011): younger obstetricians were less favourable to natural birth and more likely to favour medical interventions.
Before the medicalization of birth, many women would give birth in their homes; sometimes they would be alone because their partners had gone to fetch assistance, but by the time help arrived, the baby had already been born (Bourgeault et al., 2004; Rutherford, 2010). Some, owing to financial constraints, would rely solely on their husbands to assist with birth (Bourgeault et al., 2004; Rutherford, 2010). Other women would barter or pay a version of a midwife to assist with their birth (Bourgeault et al., 2004; Marland, 2005). In some communities an experienced birth assistant would provide care without the expectation of being paid (Bourgeault et al., 2004; Marland, 2005; Rutherford, 2010). Women in the community would participate in washing, cooking food, and other chores that needed to be completed in preparation for the arrival of a newborn. It was part of the social fabric that held that community together (Bourgeault et al., 2004; Marland, 2005; Rutherford, 2010). Midwifery has always been a socially-minded, community-oriented profession.

Midwives are passionate about assisting mothers with birth. There are many examples of midwives who would not charge those who were in desperate circumstances for their services (Bourgeault et al., 2004; Rutherford, 2010). There are heroic stories of midwives like Manitoba midwife Aganetha Reimer, who attended a birth just three days after giving birth herself (Rutherford, 2010, p.61). Frieda Isaak, a Ukrainian nurse who moved to Northern Ontario, was known as the “angel of mercy” and would load a dog sled and, with supplies on her back, would go to assist at births during the long Northern Ontario winters. Her first delivery was a pair of twins. With today’s procedures and perceptions of risk, it is unlikely that a mother would be able to have a home birth if she were expecting twins: it would be considered too high-risk.
Midwives have always been committed to ensuring that mothers have access to safe birth. What is considered safe is very different from what it used to be, but midwifery has always been in tension with medicine. Midwives need to constantly guard their scope of practice; otherwise they risk losing their patient-centred approach. The herstory of birth is contentious, to say the least.

Here I have attempted to give a brief overview of the herstory of birth and midwifery. If one were to tell a single story of the history of midwifery, it could be recalled as births mainly occurring in the home with the help of a skilled birth assistant, then moving into the hospitals, while today we are witnessing a hybrid combination of hospital births, home births and birthing centres (Better Outcomes Registry Network, 2015, 2014; UNFPA, 2014). This trend will be explored in more detail in the following section.

Contemporary midwifery

In some parts of the world, midwifery includes indigenous cultures and traditions, while elsewhere it has become increasingly medicalized—controlled by hospitals and doctors. With the rise of medicalized birth, midwifery saw a decline in many parts of the world (Coe, 2008; Marland, 2005; Relyea, 1992; Thomas, 2009; Weitz & Sullivan, 1984). As births moved into hospitals, in some countries this development pushed fathers and families out of the birthing experience (Biggs, 2004). During the 1960s, and with the rise of the “Back to Earth Movement,” North American women began to reclaim birth, as a response to the rise in medical interventions (caesarean sections, epidurals, and episiotomies) that occurred under male-dominated obstetric care (Bourgeault, 2006;
Starks & Trinidad, 2007; Villar et al., 2006). They argued that birth was a natural, woman-centred activity and many of them did not need medical interventions: they called it “obstetric violence” (Belousova, 2002; Bourgeault, 2006; MacDonald, 2006; 2008).

When midwifery was moved into the hospital, it profoundly changed the social relations or interactions people had with the experience of birth. It became an activity that did not include the family or community. The website Our World in Data (OWID) draws on a variety of data sources to show various world trends. Using data from Gapminder, another data-aggregating website, it demonstrates that global maternal mortality rates have fallen dramatically since the 1900s. From data from the United States, it estimates that maternal mortality fell from eight hundred and fifty per 100,000 to twelve per 100,000 in 2003.

The unintended consequence of these impressive medical advances was that women lost the right to choose where they gave birth. Communities lost their ability to participate at a birth. The paradigm shift that a hospital was the most appropriate and safe place to deliver a baby denigrated the role of the midwife to assistant, onlooker or absence (Bourgeault, 2006; Bourgeault et al., 2004; Vernon, 2015; Marland, 2005).

Today the number of women seeking home births or midwife-led births is slowly beginning to rise. Women, and health practitioners, are demanding choice in how and where women give birth. The best indicator of this shift comes from the UK’s National Health Service (NHS) December 2014 report Intrapartum care of Healthy Women and their Babies (Nunes, Gholitabar, Sims, & Bewley, 2014). The report suggested new guidelines for the care of healthy women and their babies (Nunes et al., 2014). It outlined some surprising facts. For example: in England and Wales nine out of ten babies are
delivered in hospitals under the care of an obstetrician, while only 2.3 percent of births are home births. They state that for low-risk women, it is safer to give birth in a midwife-led unit than under the care of an obstetrician, or physician. The most radical suggestion to emerge from the report is that forty-five percent of all births should be attended to by midwife-led units. These recommendations are a result of the dramatic increase in the rates of unnecessary medical interventions seen under the care of obstetricians. The ICM, in collaboration with the World Health Organization (WHO), published a recent report on the state of midwifery in seventy-five countries around the world. The report found that eighty-seven percent of essential care for women and newborns can be delivered by midwives (FCI, 2014). They argue that investing in midwifery could yield a sixteen-fold return in investment with respect to lives saved, medical interventions avoided, freeing-up of doctors and nurses, and the reduction of infectious diseases and mortality rates among mothers and babies. Other evidence offered by Sandall et al. (2014) suggests that the midwifery model of care produces lower rates of medical interventions and improved outcomes for low-risk mothers and newborns in contexts where midwifery services are adequately resourced and well integrated into existing medical systems.

In data retrieved from the National Centre for Health Statistics in the United States, between 1996 and 2007 there was a fifty-three percent increase in the rate of caesarean sections (Cho & Norman, 2013). One Canadian study found that midwife-led units were also considerably cheaper than obstetric-led care (Sandall et al., 2014) and produced better outcomes for both the mother and baby. Mothers reported an overall better experience under midwifery-care models (Sandall et al., 2014; Sandall et al., 2015). In the United Kingdom, a study by the National Institute for Health and Care
Excellence found that midwife-led units produce better outcomes for mother and baby. In Canada similar findings have been reported (Hutton et al., 2010; Sandall et al., 2014; Sandall et al., 2015). One of the key findings of the Canadian research suggests that using professional scope appropriately—the range within which midwives and obstetricians are permitted to practice—will likely yield the best outcomes (Hutton et al., 2010; Sandall et al., 2014). When appropriate use of healthcare professionals can be paired with healthy relationships between all maternity professionals, outcomes are most favourable for mother and child (Hutton et al., 2010; Sandall et al., 2014; Sandall et al., 2015).

The evidence that midwives as primary caregivers produce improved outcomes for community, mothers, and newborns is overwhelming. Many health-care systems are beginning to take steps to ensure midwives care for low-risk mothers (UNFPA, 2014). If this trend towards more midwife-led units—within health systems like the NHS—continues, then we might be on the front end of another transition phase in midwifery, except that this time births are likely to move from control by obstetricians to midwife-led units.

Midwifery is a complex diverse global practice with a long, contested herstory. It will continue to be a contested space. Not all midwifery communities around the world followed similar paths or were influenced by similar policies. Some parts of the world have never had adequate midwifery care, while others managed to hold onto to their indigenous midwifery practices. The herstory of midwifery is far from homogenous, and we have a lot to learn from its diversity.
Snapshot of the data in Ontario and Trinidad and Tobago

The WHO argues that below ten percent caesarean rates, maternal mortality seems to increase (WHO, 2013). It recommends that reasonable rates for caesareans should be between ten and fifteen percent (WHO, 2013). In Ontario this rate is approximately thirty percent (Dunn et al., 2011). In Ontario six percent of births are seen by midwives (Dunn et al., 2011).

The numbers in Trinidad and Tobago are harder to ascertain, but it is thought anecdotally to be between thirty and forty percent (the annual number of births is between 17,000 and 20,000). The birthing centre is the only health facility in Trinidad that allows women to choose how they would like to give birth. Since the traffic on the island is unpredictable, the birthing centre does not assist at home births, as the risks associated with being transferred to the hospital during birth because of traffic congestion are too great.

Herstory of midwifery in Ontario and Trinidad

I have provided some historical context of the evolution of midwifery in Ontario, Canada, and Trinidad. Within the context of Trinidad and Tobago, very little herstory of the practice has been documented; therefore the account provided here is mainly informed by the interviews conducted, and the study focused on two case studies, a small birthing centre in Trinidad, and the regulation of midwifery in Ontario. Specifically, I investigated critical incidents that zoomed in on how the innovations within the context of Trinidad were able to generate micro-scale social innovation, while the Ontario midwives were able to generate social innovation at a system-wide level.
Herstory of birth and midwifery in Trinidad and Tobago

The herstory of Trinidad and Tobago midwifery is not very well documented, and extant historical accounts are very Trinidad-centric. The herstory I recount applies to the island, not the country of Trinidad and Tobago. In my interviews, midwives claimed that midwifery did not have a strong tradition in Tobago. Trinidad and Tobago is one country, but under colonial rule, the two islands had very different histories. It is unlikely that midwifery did not exist in some form, but to uncover its herstory in Tobago is beyond the scope of this thesis. The limited existing documentation focuses on midwives with formal training and pays little attention to the herstory of “middies”—midwives without formal training.

A document given to me during interviews, which is about two pages long, outlines a herstory of formal midwifery in Trinidad (see Appendix E). It is believed that midwifery first came to the island in the early 1800s, when plantation owners grew increasingly concerned about the high child and maternal mortality rates during the births of enslaved people of African descent. Concerned with their profit margins, plantation owners sent to England for well-trained midwives to help secure their “capital” (see Appendix F). In 1826, after an appeal to the Medical Board by the then Governor Sir Ralph James Woodford, the board began registering midwives and regulating midwifery. The board required midwives to pass a short oral exam before being issued a ticket indicating that they had passed and were legally allowed to practice midwifery (see Appendix F). A midwife could also be certified if two doctors verified that she could assist women with birth. Between 1826 and 1879, twenty names were added to the
register of licensed midwives. In 1897, another medical board changed the requirements. Prior to obtaining a license, midwives had to be under supervision in a hospital for no less than three months and were required to attend a minimum of ten births. The board also implemented a penalty of twenty-four cents for the unlawful practice of midwifery (see Appendix F). It is believed that Ada Fricker was the first British-trained nurse-midwife to arrive on the island, in 1908 (see Appendix F). She was based at the Colonial Hospital in the capital, Port of Spain, and worked on improving the standard of midwifery.

In 1916, the requirements changed to a written and oral exam in addition to which potential midwives were required to undergo six months of training. In 1917, domiciliary services were introduced for the care of mothers and infants. The next few years would see considerable changes to practice and regulation, and by 1924 midwives were required to take two years of training (see Appendix F). Sister Irene Mitchell and Dr. James A. Waterman established the Midwives Association in 1932. Dr. Waterman took a deep interest in midwifery and found that there were gaps in the training programme. He and Sister Mitchell implemented the rule that only trained nurses were allowed to participate in the one-year midwifery programme.

Until 1960, midwifery in Trinidad and Tobago was controlled by the Medical Board, after which the national Nursing Council took responsibility for the registration, licensing and training of nurses and midwives. Today midwives can enter into the midwifery stream directly, or they can first become nurses, and then qualify to practice midwifery (see Appendix F).
It is important to note that, although this may be the formal account of the herstory of midwifery on the island, all the interviewees spoke about “middies.” These were lay midwives who learned to attend at births by apprenticing with other middies (Trinidad interviewee 3; Trinidad interviewee 4; Trinidad interviewee 11). These women were knowledgeable about natural medicines and would give women various teas, herbs, and remedies to aid with birth. Many interviewees used the term “rubbing the belly,” which referred to the practice of middies massaging the stomach of an expectant mother to ease the pain (Trinidad interviewee 3). Middies were also known to turn babies if they thought the baby was in a position that would not be ideal for birth (Trinidad interviewee 3; Trinidad interviewee 11).

Contrary to the official narrative of midwifery on the island, it is clear that each community had a woman whom they would call when needed. It is unclear if these women learned from early British-trained midwives, or if their practices were derived from traditions brought by the enslaved or Indian indentured labourers. It is likely that middies learnt some of their skills from British-trained midwives and incorporated traditional practices brought to the island by enslaved women, free Africans and Indian indentured labourers.

The important things to note about the herstory of midwifery in Trinidad are that midwifery has been under the purview of the Medical Board since 1826; and additionally, many of the midwives interviewed reported that at one time, each community had a domiciliary unit. These were primary-care units where many people would go to deliver babies. As birth became medicalized, women began to choose to give birth in hospitals, because it was perceived to be safer. The government eventually closed all the
domiciliary units because they were being underutilized and the cost of keeping them open could no longer be justified (Trinidad interviewee 2; Trinidad interviewee 3; Trinidad interviewee 4; Trinidad interviewee 5; Trinidad interviewee 11). When I visited many of these domiciliary units they still existed, but had been converted into community health facilities, which means that the capacity to reopen these domiciliary units is still there.

**How the Trinidad and Tobago Birthing Centre was born**

“The four of us, we were a little group together and we used to meet and just share and talk, and really I guess we were unhappy about the system in Trinidad,” (Trinidad interviewee 9). Frustrated by the existing approaches to assisting with birth, a group of Trinidad midwives initially got together as a community of practice.

When we met, we would bitch about the fact that midwifery was just being dragged through the mud, that clients were so dissatisfied, so scared to go to the public hospitals. They pray, if they are unable to afford to go privately, that they would be able to go in and come out quickly.

The new Mount Hope Hospital would send clients home if they were not ready to give birth. A lot of clients lived far, so they didn’t go home. They would stay in the car park. A lot of babies were born in Mount Hope car park. (Trinidad midwife 4.)

When the midwives would meet up,
[...] it would be at somebody’s house, either Sarah’s house—her husband would cook and feed us; or we met here; or at another midwife’s house. There was always food. There was always drink. We would drown our sorrows.

It was cathartic because it would give us the will to go on, because we were all committed to staying here. That was the other common denominator. I think, in talking with each other, we all gave each other the courage that we had made the right decision to be here and to try in our own little ways to change it. (Trinidad midwife 4).

Until this point these women were operating informally, outside the public and private health-care system. Midwifery was legalized and they were allowed to practice as independent practitioners, but they were the only four midwives in the country trying to deliver care differently. They were the perfect ecosystem of midwifery-led care. Between them they gave lactation classes, prenatal classes, and birthing classes. One informant stated,

I guess when we do birth classes, the clients tend to question their doctors a bit more, and definitely in Trinidad and Tobago doctors don’t like being questioned. It’s just something that I think most people know. The minute they start questioning doctors, they are met with a coldness and they just don’t answer appropriately. (Trinidad midwife 2).

If they did not need to be transferred to a hospital, mothers were extremely satisfied. Legally hospitals could not refuse transfers, but there was considerable tension
between midwives, hospitals, and doctors. Some doctors were supportive of the midwives, so they would work with these doctors. When they knew when a mother was likely to go into labour, they would try to have supportive doctors on call, in case they needed backup. Midwives’ scope of practice as independent practitioners is births that do not require medical intervention. If midwives identified a birth as being outside their scope, they would transfer to their backup doctor. They would mitigate this risk by only accepting low-risk mothers as clients.

These midwives were operating as best as they could, until one day a young woman walked into one of their birthing classes. She would come to encourage these midwives to open a birthing centre. When she was having her baby, “She started out seeing an obstetrician and just felt that she wasn’t getting the right answers when she asked questions about the birth,” (Trinidad interviewee 3).

This young mother

…just absorbed all the information, and when she realized that she didn’t have to go the medical route and told her doctor that she was changing her route, I want to tell you, the doctor was very angry, was very raved, very angry, and said some things to her that were quite out of place, quite frankly. (Trinidad interviewee 3).

When [this young single mother] entered in the picture, I mean, she was a game-changer, because she brought along her friend. She brought hope that we could do more than we were doing. When she had a birth with [one of our midwives], she kept hammering us even after she had the birth. She could have
gone away, but she kept hammering us, hammering at us that we should try and that there were ways. (Trinidad interviewee 9).

The busy lives of these midwives had convinced them that they did not have the time, couldn’t get the money, or that opening a birthing centre was too big a task to pursue. The young mother felt strongly that more women needed access to the services that these midwives could offer, because women did not have many options. To this young mother, they had to find a way to open the birthing centre. For her it served a higher purpose, a calling. “What we want to do and what we are going to do is God’s work. This is God’s work for God’s people. I am not crazy. We have to do this for our country,” (Trinidad interviewee 10).

This mother had a friend who worked with the United Nations, and who had convinced her that the midwives had a strong case to get funding, from a variety of sources, to start a birthing centre. Her friend helped them write a proposal and they began the journey of bringing the birthing centre to fruition. The young mother “had a friend who had a baby in the hospital. When she went to visit her friend, the difference in the care and the experience is what made her really come back to us and say, ‘You have to do something.’ That’s where the switch happened,” (Trinidad interviewee 3). These midwives felt they did not have any choice but to start a birthing centre. They had all worked at a private birthing centre before, but it had closed, and there was great need for better care.

There were many reasons that these women felt mothers needed better care. For one, in the public hospitals, there was a policy that all women gave birth on their backs.
Several studies have found that giving birth in this position does not produce the best outcomes for the mother in labour (Chan, 1963; Dundes, 1987; Gupta & Nikodem, 1996; Gupta, Hofmeyr, & Smyth, 2004; Priddis, Dahlen, & Schmied, 2012). Through anecdotal evidence they knew that the rates of intervention were higher than necessary.

Anecdotally, the national caesarean rate is believed to be about fifteen percent, as reported by the interviewees who she knew the numbers through word of mouth (Trinidad interviewee 3; Trinidad interviewee 11). Private hospitals did not release their data, but women who were attending birthing classes were returning with horrific stories of abuse and interventions against the mother’s wishes. At the time of the research the Central Statistical Office in Trinidad and Tobago was closed, so despite my best efforts I was unable to corroborate these claims with data. If you compare the anaecdotally reported statistics with those in the United States, Canada, and the United Kingdom, then the rates in Trinidad and Tobago are not surprising. We can only assume there is merit to these claims.

A report developed by the Trinidad and Tobago Birthing Centre estimates that over the a three year period 9,050 people have benefited from its services. These include orientation tours, childbirth education classes, admissions for birth, postnatal support groups and a miscarriage-and-stillbirth support group. On average the centre does about forty deliveries annually, and the birthing centre is the only place where women can choose how they would like to give birth (Personal communication with the centre, 2015).
Birth in Trinidad and Tobago, as in many parts of the world, is a highly contentious topic. The following excerpt from one of the midwives gives a sense of the climate in the country.

Well, that’s probably not well documented, because in Trinidad and Tobago we don’t collect good statistics. For example, the public institutions have to report, so the Central Statistical Office has that data, but it’s quite often four or five years old, because the ministry collects it and sends it. Ours would be as well.

The private institutions, though, are not obligated to report their data, so we don’t know what is happening in the private institutions. The last data we have from them was when the Midwives Association was doing a conference in 1997, and we sent out a questionnaire and got the information. It would be caesarean rate, intervention rate, that type of thing[…]

Then, when the guy, who was a doctor, Marsden Wagner—who worked for WHO—he took that information and included it in his presentation, there was a scene. They were going to deport him, because they felt he was bad-speaking the medical establishment, because what he was saying is that there is a difference in the clientele in the private institution and a public institution; nothing different [other] than [the former] have money, and so caesarean rates are higher, rates of intervention are higher—why? Because the clientele in the public institutions are the ones that are at higher risk to have pre-existing health problems. So the reverse should be true.
The first time he said that, it blew up. The Minister of Health, the National Security [Minister] came to the conference and they said he didn’t have a permit to speak. It was a real scene.

Since then, we haven’t been able to get the information, because they know what it’s going to show, and they’re not obligated to report. That is something that I’ve been lobbying for as well. So for the private institutions, we don’t know. We know anecdotally, because we know people that work there. We’d be like, “For the month of January, how many births you had, and how many caesareans you had?” We know through that their rate is close to forty [percent]; it’s in the thirties in private institutions. (Trinidad interviewee 3).

This tension between the midwives and physicians suggests that the quality of care, between these two approaches, can likely be improved if midwives are formally integrated into these obstetric units. If both groups of practitioners are encouraged to practice within their scope with clear communication and integration, it could result in increased savings within the system and in improved quality of service delivered.

How the first Toronto Birthing Centre came to be built in Trinidad and Tobago

This study was originally intended to follow a single-case design focusing on a small birthing centre in Trinidad and Tobago. During the interviews it was revealed that the centre had adopted a Canadian model of midwifery care. When I probed, I learned that two midwives had met at the ICM Conference. They were talking about the challenges of midwifery in their respective countries, when one—the Trinidadian—
explained that her group had just received funding to build a birthing centre, but did not have the money for the research needed to design a building to international specifications (Trinidad interviewee 3). The Canadian midwife explained that their government had just removed the funding for the Toronto Birthing Centre, but they had already completed all the research.

The Canadian midwife recounted the story as follows:

We are given initial funds to find a place, hire a consultant, hire architects, and there’s a group that has been meeting for two or three years to determine what this birth centre will look like, down to the size of the rooms, the equipment needed in each room, the protocols, the policies. Like a thick book...

She was talking about doing a birth centre and I said, “Well, I don’t know if this is going to help her or not,” and I went to Kinko’s and I had the whole thing copied and bound and sent it down to her...

They built the Toronto Birth Centre in Port of Spain. The original Toronto Birth Centre. Not that the building is exactly the same, but so much of it was informed by the Toronto Birth Centre. (Canadian interviewee 2.)

While I was interviewing the Trinidad midwives, one said, “We got all this information and we actually followed their thing: what do you need, what should the size of the rooms be, etc.,” (Trinidad interviewee 3).

When I encountered this unique relationship between the birthing centre in Trinidad and the Toronto Birthing Centre, I decided to pursue both case studies. A lot had already been published on the Ontario midwifery movement, so there was enough
secondary data to complete the case study, even if I was unable to secure in-person interviews. This changed the design from a single-case design to a multiple-case design (Yin, 2012). When I interviewed Ivy Lynn Bourgeault, author of two of the most prominent books on midwifery in Ontario, she responded:

I was involved in that proposal. That’s a great story. That’s a wonderful story about how things shift. Now, the International Confederation of Midwives does exactly what they should be doing. They’re a hub for the spread of ideas for social networking, so it’s not surprising that it ended like that, that this type of spread of innovation happened. That’s a great news story.

The herstory of birth and midwifery in Canada and Ontario

The story of Canadian midwifery can be understood as a patchwork of connected histories. Midwifery in Canada has been documented with considerable care and intentionality. (One author, Lesley Biggs, notes, however that in reflecting on her early writing on the herstory of midwifery, she has become increasingly concerned about what she didn’t say (Biggs, 2004). She admits that in her early telling the voices of Aboriginal midwives were notably absent.)

Prior to the Second World War, home births were the norm in Canada (Mitchinson, 2002; Rutherford, 2010). In some parts of Canada, midwives were well-respected members of the community, while in others they were either marginalized or not recognized as professionals. Biggs (2004) points out that there was no universal form of midwifery, but rather there were diverse understandings, histories and practices of
assist in birth. Midwifery was an occupation for some women, while for others it was part of community life. Benoit (1991) identifies four types of professional midwives: the granny midwife or traditional lay midwife, who had been informally trained and provided at-home care; rural-clinic midwives, usually British-trained nurse-midwives who worked in clinics that were in isolated coastal Canadian communities, usually in Newfoundland; cottage-hospital midwives, usually local women who had formal training and worked in regionalized hospitals; and nurses who worked in hospitals. Within Aboriginal communities in British Columbia, both men and women were seen as being able to provide skilled midwifery care. Women usually served as the primary attendant, but in Aboriginal communities, birth and death were considered part of a sacred, natural, and creative process (Benoit & Carroll, 1995). Therefore, it was considered natural for loved ones to assist at births, regardless of gender. It is important to note that different Aboriginal communities would have had different perspectives on birth, and around Canada, women who assisted at births varied in their level of formal training and incorporated different spiritual or religious practices, depending on their country of origin or the community they served (Bourgeault et al., 2004; Plummer, 2000; Relyea, 1992).

This herstory of Canadian midwifery “reminds us that many models of midwifery have existed pre- and post-Confederation Canada. Their demise was intimately tied to particular discourse that can be connected to configurations of professional interests, race, colonialism, class, industrial development, and regional politics. Thus no singular history of midwifery exists but rather many,” (Biggs, 2004, p.19). For example, evidence suggests that ethnic and religious communities, such as first-generation Japanese-Canadians in lower British Columbia; Mennonite communities; communities that were
predominantly black or coloured; orthodox Jewish communities; Roman Catholics or Jehovah’s Witnesses, were more often served by women who had acquired their midwifery skills through apprenticeship versus formal training (Biggs, 2004; Bourgeault, 2006). These examples serve as both a counter-narrative and confirming narrative to the common motif or dominant image of the Canadian midwife as the neighbourhood midwife, either a formally trained midwife or one who had gained experience through apprenticeship. The common theme was that she was acknowledged by the community as having the skills to assist with birth (Bourgeault, 2006; Bourgeault et al., 2004; Sharpe, 2004).

Birth in Canada, or in Ontario specifically, was far from homogeneous, yet the image of the neighbourhood midwife became a dominant motif within the cultural landscape (Biggs, 2004). This motif reflected “the image of reciprocity, denoting equality in status between the midwife and client,” (Biggs, 2004, p.22). The image became so dominant that when midwives struggled for autonomy versus professional status, the folklore of the neighbourhood midwife served as a political symbol and historical resource for advancing the professionalizing project of midwifery (Biggs, 2004). Eventually, this motif would also serve to inform and constrain how midwifery would come to be developed and who would be allowed to practice midwifery (Bourgeault, 2006; Nestel, 2004).

In Canada, midwifery saw a decline between 1795 and 1900 (Biggs, 2004; Bourgeault, 2006) and childbirth in Ontario became increasingly medicalized (Biggs, 2004; Rutherford, 2010). “The available evidence suggests that the uneven decline of midwifery across Canada is intimately tied to the level of industrialization in each
province/region and to colonial and nationalist agendas,” (Biggs, 2004, p. 30). Despite this, women began to get trained as midwives. They formed professional and advocacy groups to further their cause in advocating for the right to the birth of their choice (Bourgeault, 2006). Today in Ontario, midwifery is part of the public health-care system. Canada’s midwifery care is considered among the best in the world. Although it is imperfect, and women still have limited access to midwives, the Ontario model is held in very high esteem. Karen Kaufman, a member of the 1986 task force that the ministry appointed to make recommendations about the way midwifery should be implemented in Ontario, reflects on a recent visit to the Netherlands:

The Dutch model was very much held up as the kind of premier model of autonomous midwifery back in the days of the task force. And we visited the Netherlands and spoke to a lot of people there about how it worked and what people liked about it and how it operated.

They now are saying, “We have something to learn from what’s happened here.” They are having discussions within the Netherlands association about the continuity-of-care component of practice here, and how can they implement that better. They are considering limiting the number of people that any given client might meet during the course of her pregnancy care, so that she’s not seeing this person, that person, this person, that person. Would they have two midwives come to a birth? They have this whole other cadre of worker that comes to the home and stays and does post-natal care. Then the midwife just checks in basically with the [midwife assistant].
Anyway, it’s very interesting that there is now this reciprocity happening, and their education model is changing also to incorporate much more of a broad-based university preparation and the possibility of graduate degrees. (Canadian interviewee 5).

Ontario midwives obtained their current status from the ground up, through activity. These women were also highly organized: they formed associations, maintained communities of practice, and some groups even wrote weekly publications. They focused on building a midwifery model of care that allowed women to choose how they wished to give birth (Bourgeault, 2006). Ontario midwives managed to develop a truly unique and world-renowned midwifery model of care, within the existing public health-care system (Bourgeault, 2006). The model of care that these midwives were able to achieve was truly admirable. They were autonomous, self-regulated (not regulated by other health-care practitioners), and integrated into the Ontario public health-care system (Bourgeault, 2006). Their most impressive achievement was that they were able to convince the state to cover the insurance bills that paid the salaries of these recently legalized midwives (Bourgeault, 2000; 2006; Bourgeault & Fynes, 1997; Gotts, 2013). Midwifery became the first profession to gain privileges in the hospitals in almost a century (Bourgeault, 2006; Bourgeault et al., 2004). One of the major contributing factors was that until “the 1990s, Canada held the dubious distinction of being the only industrialized nation without formal provisions for midwifery practice,” (Bourgeault et al., 2004, p.3).

In many ways Canada benefited from this late start, since the proactive, intentional, and politically astute midwives at the core of the movement could look at examples around the world and advocate for a midwifery model that best served women.
They had the benefit of observing prototypes without having to implement any of them. Unlike Trinidad and many other countries around the world, midwifery in Canada did not need to unravel existing regulation. Midwives saw an opportunity and decided to define, defend, and implement the profession as they saw it before others did it for them (Bourgeault, 2006). This was a labour of love and intentionality.

**Summary of midwifery in Trinidad versus Ontario**

The Medical Board has regulated midwifery in Trinidad since 1826. The island has a strong history of informal neighbourhood midwives called middies. Until the mid-1990s, much of the country was serviced by midwife-led units called domiciliary units, many of which have been repurposed as community hospitals. The country has a two-tier system of both public and private health care. Midwives I interviewed, however, referred to midwives in the public and private medical systems as being more akin to obstetric nurses than midwives.

Contrastingly, midwifery was not regulated in Canada until 1994: at the time there were fifty-three registered midwives in Ontario, while today those numbers have increased almost fifteen-fold (Better Outcomes Registry Network, 2015; Bourgeault, 2000; 2006). Midwifery in Ontario had a unique opportunity: as midwifery was unregulated, midwives started with something of a blank slate.

By contrast, Trinidad midwives are in a scenario where regulation has been predetermined by historically being under the control of the Medical Board. In Canada, midwives needed to be regulated, so there was an opportunity for them to work to define their own future (Bourgeault, 2000; 2006). In Trinidad, there is not this sense of urgency,
since midwifery is largely seen as regulated, and this works for the Medical Board. In Canada, in the early 1990s everyone saw, the need to regulate midwifery, while in Trinidad only a small group of women see the need for new regulation. Both contexts need further regulation, but since Canada and no regulation, it was easier to push for midwives to define how they wished to be regulated.

When midwifery was regulated in Canada, three colleges were set up to train midwives. They were also integrated into the public health-care system. The most important change was that midwives were granted privileges in hospitals. This is not true in the case of Trinidad, and as a result midwifery on the island is medically led.

In both contexts there is considerable tension between the medical profession and midwives. In Canada the relationship is a lot better, since midwives are well integrated into the medical system.

**Discussion**

I have defined midwifery as an activity that profoundly changes social relations or interactions, deeply challenges or changes our existing paradigms, and significantly changes resource flows within an existing social system. The preceding chapter outlines the history of midwifery as a way of demonstrating how it qualifies as a social innovation.

From the historical accounts presented, the social relationships and interactions around birth have greatly influenced by the medicalization of birth. Historically birth has been a family and community activity, but with medicalization much of the family and community involvement was slowly eroded.
The medicalization of birth did have considerable benefits. Over the last century mortality rates associated with birth have dramatically decreased (UNFPA 2014; WHO, 2014). The rates of medical interventions have also increased (Dunn et al., 2011; Joyca, Hamilton, Osterman, & Curtin, 2015). The paradigms associated with birth have also shifted throughout history. Prior to World War II women would usually give birth assisted by women and community (Mitchinson, 2002; Rutherford, 2010). Women also prepared for death at the same time they were preparing for birth. Today, deaths during and surrounding birth have dramatically decreased (WHO, 2015). Additionally our dominant paradigm has shifted to a perception that it is safest to give birth in a hospital.

The final node in the proposed triad for identifying social innovation refers to a change in the flow of resources. In Ontario, between 1995 and 2015 the number of registered midwives increased from fifty-three to seven hundred and fifty. The government has committed to paying midwives through insurance plans, so that women do not need to pay out of their own pockets for midwifery services. The Ontario government has also committed to three educational institutions to train ninety midwives annually.

In Trinidad, the change in the flow of resources is very different. The birthing centre is set up as a social enterprise with a tiered payment system under which families pay for midwifery services depending on their income. These midwives were able to shift resources that would have otherwise been locked up in either the private or public hospitals. They have opened the first and only non-profit hospital on the island that operates as a social enterprise. These women have been able to reallocate resources to serve a small ecosystem of women in a way that would not have been possible otherwise.
Birth and midwifery are an incredibly complex topic. In this section, I provided additional rationale for why I chose midwifery as a case study for social innovation. The majority was dedicated to giving an historical overview of midwifery and some of its tensions and contradictions. I have also provided an overview of each case study and how they came to be examples of social innovations on very different scales. Readers should be mindful that each case should be viewed as a sub-movement of the international midwifery movement. In both cases, too, the examples used are outliers within the international context, and it is precisely these characteristics that make them the ideal case studies for theorizing social innovation.

The Trinidad and Canadian midwives were at very different stages of generating social innovation. The major difference is that prior to 1990, Ontario midwives were neither legal nor illegal, but alegal (Allemang, 2013; Bourgeault, 2006). Knowing that regulation was imminent, midwives defined “themselves before they were defined,” (Bourgeault, 2006, p.149). They took a proactive approach to ensuring they were part of the regulation process. In Trinidad, however, midwives have been under the control of the Medical Board since 1826, which makes their journey one of unravelling existing structures. They first need to redefine themselves within the context in which they are situated. It is thus difficult for them to transform an entire medical system to include their approach to assisting with birth. Instead they have created a model that exists partially outside the system.

These case studies offer us unique insight into how small groups of citizens have been able to generate social innovation within their communities. The thesis began by problematizing current social innovation literature and developed a framework for
identifying social innovation. The study began by using a social innovation frame to explore how in 1998, a small group of Caribbean midwives were able to open and operate a birthing centre. This exploration led to the revelation of a unique connection with the Ontario midwives and their connection to the international midwifery governing body, the ICM, which helps give both groups credibility, legitimacy, and access to resources.

For example, without the ICM conference, it is unlikely that these two midwifery communities would have been able to connect and support each other. Being connected to the Ontario midwives, who were also in the midst of striving to develop their own birthing centres, provided the Caribbean midwives with access to knowledge and resources they would not have normally had (Bourgeault, 2006; Bourgeault et al., 2004).

The herstory of these midwives is a story of social justice, sisterhood, perseverance, and determination. Against the odds, these midwives have been able to provide women in their communities with the opportunity to have the birth of their choice. They were able to generate social innovation at a micro-scale and the macro-scale.

It is easy to become focused on the interesting aspects of midwifery as a movement, but the objective of the thesis is to explore midwifery through the lens of social innovation. Midwifery as a practice has gone through several phases of changes in paradigm, changes in resource flow, and changes in social interactions or practice.

This section was intended to provide the reader with some context. We can now begin the discussion on midwifery within the context of social innovation.
Chapter 5: Generating space for social innovation:
Preparing the soil for the seeds of social innovation

“The need for a pre-existing communications network or infrastructure within the social base of a movement is a primary prerequisite for ‘spontaneous’ activity.”

Freeman (1999, p.7.)

Figure 5.1. Two-dimensional framework of making space for social innovation.
One of the major aims of this thesis is to formulate a framework for generating the conditions for social innovation. The framework above, Figure 5.1, presents a three-tiered framework for social innovation. The outer blue layer identifies what counts as a social innovation. The middle layer represents the process of that layer: it answers how we generate social innovation. The centre of the model represents why we need social innovation and how we prepare for our social innovation journey. This chapter focuses on the centre of the framework, setting the stage for social innovation. It looks at how citizens are able to develop relationships and networks that both inform and inspire them to proceed to the second layer, the process layer. The process layer answers how social innovation is generated, while the final, outer layer presents the solution citizens have developed after travelling through the various layers—the “what.” The following three chapters slowly develop this two-dimensional framework of social innovation and eventually present a three-dimensional approach. The first layer, the focus of this chapter, is the types of relationships that are developed in these spaces.

In any stratified society […] there is a set of limits on what both rulers and subjects, dominant and subordinate groups can do. There is also a set of mutual obligation that bind the two together. […] What takes place, however, is a kind of continual probing to find out what they can get away with and discover the limits of obedience and disobedience. No one knows exactly where the limits are until he finds out by experience. (Barrington, 1978, p.18.)
Where do actors learn to push the limits that challenge the mutual obligations that bind the rulers and the subjects? How do they develop collective identities that inspire them to step beyond the limits of their experience?

Free space is a subset of social-movement studies that accounts for the educational spaces where actors learn to push the limits of their social contexts. Making space for social innovation emerged as a complex theme in the exploration of how midwives have reclaimed birth. The right of a woman to be able to choose how and where she can give birth has framed much of the contemporary de-medicalized era of the midwifery movement (Bourgeault, 2006; Bourgeault et al., 2004). Mothers have struggled for the right to a medical-intervention-free birth (Bourgeault, 2006; Bourgeault et al., 2004). Midwives in Trinidad and Ontario were most concerned about women being able to choose where and how they would like to give birth. Although their motivations varied considerably, midwives in both contexts were primarily concerned with a woman being able to have a birth of her choosing. For some, natural birth might have been important, while for others being able to give birth with loved ones present was important. The impetus for generating social innovation was derived from women’s wanting to be able to choose how and where they gave birth. If hospitals were not the place that provided them with the choice, then where was that space?

Space and place became the most salient theme in the interviews, and served as the starting point for developing a framework for generating the conditions for social innovation. This chapter provides an analysis of the data and theory that informed my choice to use space as the central theoretical concept in the substantive theory of social innovation.
Conceptualizing space within the context of social innovation

Many case-study approaches to social movements are very good at answering what happened; fewer give full descriptions of how some social phenomena emerge; and most take for granted where the phenomena emerged (Freeman & Johnson, 1999; Goodwin & Jasper, 2009). In conceptualizing space within the context of social innovation, I zoom in on the “where” of social innovation, using three theoretical perspectives, and examine the themes that emerged from the data. I argue that social innovations change the flow of resources, shift existing paradigms, and change our social interactions. In this section I shift focus to understanding the dynamics of generating the preconditions for social innovation.

These days, I think we are getting a lot better because of the fact that the woman has companionship, support. She has a little better idea of what to expect during labour. The actual physical space doesn’t matter, but just the fact that the woman can squat if she wants, stoop if she wants, stand up if she wants, move around, hold on to somebody if she wants, instead of being confined to a bed—that makes all the difference. It is reflected in the kind of outcome and the kind of mental state that a woman is in after birth. It’s something that always remains with that woman. (Trinidad interviewee 2.)

Social innovation, I argue, is about transforming our social relationships and social interactions. This quote highlights my emphasis that social innovations should
change our everyday doings and sayings, our practices. Prior to hearing this insight from a Trinidad midwife. I had only made cursory notes on space. The quote above deepened my interest in space because it seemed contradictory. The interviewee describes the physical space as not being important, but what the woman was permitted to do in the space was very important. One interpretation of the space was that it was the rules within the space that prevented midwives from practicing to the full extent of their scope. Another interpretation might be that the physical space also influenced the way these women were able to practice.

Later I demonstrate how both the physical space and the rules within particular contexts determined what a woman was allowed to do and her practice. So for example, in all public hospital in Trinidad, women were required to give birth on their backs, while at the birthing centre women were allowed to do whatever they felt most helpful. The quote above encouraged me to dive deeper into the concept of space. In exploring the literature, it is important to make a distinction between rules that create social space, and physical spaces that influence our behaviour. I expand on this distinction in Chapter 6. For example, midwives in Trinidad designed the physical layout of their birthing centre so that families could be part of the birthing experience. Similarly, the birthing centre in Toronto was designed so family and friends could comfortably attend births. Midwives, as the designers of the space, knew that the rules would allow mothers to choose who could be present at their birth. Consequently they needed to design a space that was conducive to their plans.

Since midwives were primarily concerned with reducing a perceived sense of the over-medicalization of birth ("obstetric violence"), many of their conversations referred
to a need for non-medical spaces for birth (Thachuk, 2007). In Ontario midwives pursued home births, since they perceived them as a way of circumventing unnecessary obstetric interventions (Bourgeault, 2006). In Trinidad, midwives were fighting for the development of a birthing centre because they perceived this as their best hope of avoiding the over-medicalization of births. In both contexts, their motivation came from mothers’ negative experiences of birth (Bourgeault, 2006; Thachuk, 2007). For these women, where a mother gave birth significantly influenced the rates of potential medical interventions and her qualitative experience. During the early 1990s research suggested that the chances of medical intervention for low-risk mothers increased under obstetric-led care (Bourgeault, 2006). These findings only further supported midwives’ perception that mothers needed an alternative space for birth (Bourgeault, 2006; Thachuk, 2007).

Today, there is still considerable evidence to suggest that rates of medical intervention during birth are significantly higher under obstetric-led care than under midwife-led care (Dunn et al., 2011; Joyca, Hamilton, Osterman, & Curtin, 2013; WHO, 2013; 2015). Although there are several reasons for these higher rates of medical intervention, one reason could be that midwives only assist with low-risk births, which are are less likely to need medical interventions. However, the WHO (2013) data suggests that even with this discrepancy, current rates of intervention do not account for the thirty to forty percent rate of interventions reported in many hospitals (Dunn et al., 2011; Joyca et al., 2013; WHO, 2013). In Ontario, twenty-eight percent of all births are caesarean deliveries (CIHI, 2015). Globally, the evidence suggests that for low-risk births, rates of medical intervention rates are considerably lower in contexts with integrated midwife-led care than under obstetric care (UNFPA, 2014).
The innovation within the context of Trinidad was a birthing centre, which allowed families and communities to choose how they would like to participate in birth. Similarly, in Ontario, home births empowered mothers to choose how they gave birth and who could participate in their birthing experience. These alternative spaces provided midwives with an autonomous space where they could provide women with choice as to how they gave birth and who participated in birth. In both contexts midwives initially generated social innovation by fostering alternative spaces that changed how birth was practiced. These spaces existed outside the existing institutions.

“Free space” refers to a subfield of social-movement theory that focuses on the role “offstage” spaces play in political and social action. Each perspective is discussed in more detail in the following section and is compared with the emerging data. In exploring space as a theoretical concept, I compared data (quotes, insights and stories) that emerged from the research with the literature related to space. In this chapter, I emphasize free space as the prefigurative space for generating the conditions of social innovation.

**Free space and social innovation**

James C. Scott (1990), in his book *Domination and the Arts of Resistance: Hidden Transcripts*, outlines an engaging account of how slaves, serfs, peasants and untouchables were not free to speak their truth in the presence of power, arguing that “offstage” understandings or interpretations of the world often could not be spoken in that setting. Both the powerful and the powerless host offstage conversations that they would never say in the face of the other. Scott (1990, p.14) argues that both elites and subordinates engage in such “hidden transcripts.” Subordinates might engage in
“activities such as poaching, pilfering…” These and “clandestine tax evasion [and] intentionally shabby work for landlords are part and parcel of the hidden transcript.” Meanwhile, elite practices “might include clandestine luxury and privilege, surreptitious use of hired thugs, bribery, and tampering with land titles. Both have private, offstage conversations that are well known among their peers, but are often not revealed on the public stage,” (Scott, 1990, p.5). Polletta (1999) argues that these offstage conversations prepare the ground for co-creating collective identity in social movements. Building on Polletta’s (1999) work, I argue that hidden transcripts similarly set the stage for generating the conditions for social innovation. These offstage spaces serve to co-create collective identity in the early stages of generating social innovation. They act as a mechanism for fostering a collective identity that helps prefigure the conditions for generating social innovation.

Scott has often been critiqued because his writing refers to a time of extreme oppression. Critics argue that Scott does not propose a theory of power; but his focus on offstage and onstage transcripts between the powerful and the subordinate bring novel insights to understanding notions of power. Scott’s (1990) major contribution is that hidden transcripts are not only speech acts, they are a range of practices. These practices, I argue, help prefigure the conditions for generating social innovation. Scott’s examples include pilfering, stealing, gossiping, use of euphemisms, disguise, playing dumb, bribery, and tampering. Midwives use comparable practices to resist domination by physicians. For example, savvy midwives resisted domination by constructing their own free space(s), which simultaneously served as a way of building collective identity and transferring practices to their clients. These free spaces serve as the prefigurative
condition for social innovation. For example, when midwives in Trinidad could not go into the hospital with their clients, they would tell their patients, “‘Go to the bathroom a lot. Tell them you need to pee. Plenty!’ You try to do little things, because it’s interfering,” (Trinidad interviewee 3). They also advised mothers to stay home as long as possible. They told them to walk as much as possible when they were in the hospital—all practices in the form of hidden transcripts for avoiding or delaying medical interventions during birth. Midwives thus taught their clients practices for delaying medical interventions. These practices evolve in free spaces where they can be repeated, coded, or transferred to other actors in the system.

The Jamaican proverb “Play fool to catch the wise” aptly captures Scott’s (1990) argument that those in disempowered roles need to pretend to be fools as a form of survival and resistance. This game-playing is part of the prefiguring process of social innovation. Midwives in disempowered contexts, like that in Trinidad, played games to bring about the future they desired. For example, one midwife explained, “You’re sitting in front of a doctor in a hospital, you kind of sit there, meek and mild and humble, and you don’t want to ask questions because you might rock the boat,” (Trinidad interviewee 9). The midwives knew that the power resided with the hospital, so they developed various practices to subvert the formal system. For example, “We’re not allowed in the public-sector hospitals, [but] even now, some of us sneak into various wards, pretending that we’re doing something else, like helping with breastfeeding or something which we’re allowed to do,” (Trinidad interviewee 9). These collective narratives helped unite mothers around a similar story. This notion of playing foolish is extended in later chapters when I discuss Bourdieu’s notion of game-play.
In Trinidad the hidden transcripts of midwives were disguised from nurses and obstetricians, yet they are well known among mothers and midwives. The Trinidad midwives would meet regularly and talk about the challenges they had as midwives. These spaces were bonding spaces where midwives formed a collective identity, different from public-sector midwives. They would meet in each others’ homes, where they would share stories and strategies for improving their practice.

Evans and Boyte (1992) draw on Scott’s (1990) notion of hidden transcripts to conceptualize free spaces. An example of a free space can be found in the civil-rights movement, when activists would organize meetings in the basements of churches, schools, and universities, beyond the eye of authority. It was here that they would discuss, debate, plan, or exchange ideas and strategies. These were educational spaces where citizens could teach each other what to do if they were arrested, how to respond if they were hit during a sit-in, or how to protect themselves if police were beating them. These were rich educational spaces. Another example of a free space can also be found in the formative years of the movement, a time when it was illegal for blacks to read and write. Free spaces acted as the offstage setting in which people taught each other to read and write. Citizens who were literate could also read the amendment that explained their civil rights (Evans & Boyte, 1992). In these settings free spaces operated as citizen schools, social spaces where citizens could collectively envision the future they wished to create.

The most famous free space occurred on Robben Island (Goodwin & Jasper). It was on this island, off the coast of Cape Town, where black South African political leaders would spend a considerable amount of time plotting, planning, and strategizing
what they were going to do when they got out of prison. This group included Nelson Mandela. Anthony Sampson, Mandela’s biographer, described it as being “a protracted course in a remote left-wing university,” (as cited in Goodwin & Jasper, 2009, p.253).

Free spaces are “places relatively free from surveillance where oppositional ideas and tactics can develop,” (Goodwin & Jasper, 2009, p.253).

Similarly to Scott (1990), Evan & Boyte (1992) argue that critical theorists often view those who are marginalized as innocent victims of power. Free spaces honour the idea that “people in society are never simply or completely ‘powerless’; there are always resources, stratagems, and social and cultural manoeuvres [that are] available to them, and can be used by even those who seem at first appearance most unambiguously victimized,” (Evans & Boyte, 1992, p.xvii). In leveraging various forms of power midwives used free spaces to set the stage for social innovation. Free spaces are transformative social spaces where ordinary people can dream about and imagine a better future. It is where they set the stage for their social-innovation journey. Free spaces are “settings between private lives and large-scale institutions where ordinary citizens can act with dignity, independence and vision,” (Evans & Boyte, 1992, p.17).

Another key component of free spaces is that because they are community-focused, they depend heavily on vast networks of ordinary citizens. For example, during the civil-rights movement, black churches were able to leverage their far-reaching, highly trusted networks to organize sit-ins, protests, and marches without alerting authorities. These networks were highly organized, well-connected offstage spaces. These vast networks were citizen-inspired and citizen-led, complex networks of ordinary people

The midwifery movements in both Ontario and in Trinidad were preconfigured by citizen-led free spaces where midwives educated each other and strengthened their relationships by discussing, debating, planning, or exchanging ideas and strategies. They were unwittingly preparing to challenge existing large-scale institutions. For example, in Ontario, prior to legislation, a small group of midwives learned their craft by apprenticing with other midwives and physicians (Allemang, 2013; Bourgeault, 2006; Sharpe, 2001). Some would travel to the United States or the United Kingdom to be trained and would return to their community of midwives. At the time midwifery was alegal, neither legal or illegal (Benoit & Carroll, 1995). These midwives knew they were taking a risk. One interviewee recalled:

We knew at that time that in the United States, midwives were being arrested for practicing medicine without a license. We knew there were women in prison for doing what we were agreeing to do.

What we didn’t know was how Canada would respond. We didn’t know how the police in Toronto would respond, how the government would respond, if we could be arrested for practicing medicine without a license.

We didn’t believe we were practicing medicine, we were practicing midwifery. It was on that stance that we moved forward. (Canadian interviewee 2).
These midwives already knew what they would do if they were asked about their medical training. They used their free spaces to prepare for potential arrest scenarios, which also helped foster a sense of collective identity, not unlike the civil-rights activists.

I personally had a level of discomfort with the fact that at any moment I could be stopped by the police. They could go through my car. They could find syringes, Pitocin [a drug that causes contractions of the uterus], which wasn’t illegal to carry, but it would have been an interesting explanation.

At any point a birth could go bad, and you could lose everything. You can lose your house, you could lose everything in a court case, maybe [be] thrown in jail. (Canadian interviewee 2.)

We knew, because of the network then of midwifery across North America, we knew what midwives were doing in California, in the Midwest, arrests that were taking place, midwives in prison; [in] this state it’s okay, [in] that state it’s against the law. How the pieces fell was very much based on the individual jurisdiction…hiding the drugs was illegal…We didn’t want the police coming in and finding drugs and turn it into something to be arrested for. What right did we have to have the drugs? We didn’t know what right we had or didn’t have. It was a grey area. No lawyer could have told us what was right. Nobody could have said, “Well, here is the law in Canada: if you attend a woman in birth it’s practicing medicine without a license.” There was no law. It was grey. We weren’t illegal, we were alegal, and that’s the grey area we hung out in, and as it
happens, that was the approach the government took as well. (Canadian interviewee 2.)

Both groups of midwives had places and spaces where they could self-define the future they wished to create, their free space. They were co-creating their collective identity and building relationships and trust. Freeman & Johnson (1999, p.8) argue that “if a co-optable communications network is already established, a crisis is all that is necessary to galvanize it. If it is rudimentary, an organizing cadre of one or more persons is necessary.” What they are arguing is that movements do not start spontaneously; rather, pre-existing communication networks are needed for groups to be able to organize for effective social action.

Midwives in Ontario, when they were apprenticing with one another, were developing communications networks. In hosting regular meetings to discuss the state of midwifery on the island, midwives in Trinidad were also building communications networks. Intentionally or not, they were preparing for either a crisis or a window of opportunity. They were setting the stage for social innovation.

Polletta (1999) in her widely cited critique of free space, identifies several problems with the way the term “free space” has been adopted. She admits that free space is a compelling metaphor, but argues that although metaphors can act as powerful explanatory tools, in the case of free space, she has found that many authors invoke it without explaining key questions such as: “How ubiquitous are free spaces? How necessary are they to mobilization, and are they necessary to all movements? What makes them free?” (Polletta, 1999, p.2). Similar questions can be asked of free spaces and their
relation to social innovation. How ubiquitous are free spaces within the context of social innovation? How necessary are they to social innovation? Are they necessary for all social innovations? What makes them free? Nevertheless, as a metaphor, free spaces are very appealing and can offer a significant contribution to social innovation.

But Polletta (1999) outlines further contentions over the use of the free-space metaphor. She argues that the free-space concept holds the potential to “integrate culture into structuralist models of collective action” (1999, p.25). For her, many theorists have conflated culture with structure. She argues that the conflicting and diverse applications of free space place insufficient emphasis on the diverse forms and functions of the “associated ties” in these varied contexts: too much emphasis is placed on the physical space rather than the character of the ties. She points out that free space holds great promise in integrating culture and structure, but with the wide, uncritical application of the term to concepts like “protected spaces,” “safe spaces,” “spatial spaces,” “havens,” “sequestered social sites,” “cultural laboratories,” “spheres of cultural autonomy,” and “free social spaces,” the concept of free space has a tendency to reduce culture to structure. This reduction does little to help our understanding of the potential for free spaces. She writes:

For all these writers, free spaces and their analogues refer to small-scale settings within a community or movement that are removed from the direct control of dominant groups, are voluntarily participated in, and generate the cultural challenge that precedes or accompanies political mobilization.

The term’s appeal is considerable. Not only does it discredit a view of the powerless as deludedly acquiescent to their domination, since in free spaces they
are able to penetrate and overturn hegemonic beliefs, but it promises to restore culture to structuralist analyses without slipping into idealism. Counterhegemonic ideas and identities come neither from outside the system nor from some free-floating oppositional consciousness, but from long-standing community institutions. Free spaces seem to provide institutional anchors for the cultural challenge that explodes structural arrangements. Yet the analytic force of the concept has been blunted by inconsistencies in its definition and usage and by a deeper failure to grasp the more complex dynamics of mobilization (Polletta, 1999, p.1).

Polletta (1999) argues that instead of using the term “free spaces,” it is helpful to use the term “structures of association.” I argue that it is the appeal of the metaphor of free spaces that gives it its initial value. If combined or adapted to include Polletta’s rigour, then free space has the potential both to attract and transform lived spaces. The term “structures of association” is academically precise, but loses appeal for those working in the social innovation space.

But Polletta’s focus on structure and the relationships within the spaces is a valuable addition, and should be primary in discussions of free space. Her main thesis is that the free-space concept needs to be reconceptualised. Her proposal is to disaggregate the structures and the tasks of mobilization into three concepts—transmovement, indigenous, and prefigurative—so that free spaces can be understood along several dimensions. For her, “transmovement free space” refers to movements with extensive connections that are well equipped to identify opportunities, but not able to supply
leaders, mobilise frames or recruit participants. Some examples include: Highlander Folk School, the National Woman’s Party, and radical pacifists.

Indigenous free spaces are characterised by strong local networks, dense ties, or isolated networks. They are well suited to supply leaders, mobilise frames, or recruit new participants, but tend to be poorly positioned to identify opportunities or recruit participants outside their local networks. Examples include Southern black churches, German Turner halls, Estonian literary circles, or craft guilds.

Finally, prefigurative free spaces “are formed in order to prefigure the society the movement is seeking to build by modelling relationships that differ from those characterizing mainstream society,” (Polletta, 1999, p.11). Prefigurative free spaces, according to Polletta (1999), tend to be characterised by symmetry, where groups strive for reciprocity in power, influence and attention. Some examples include “women-only’’ spaces, new social movements, “autonomous zones,” or “alternative’’ services (Polletta, 1999, p.9).

Many theorists have found the free-space literature useful (Glass, 2010; Lowe, 2009; Melucci & Avritzer, 2000; Rao & Dutta, 2012; Simi & Futrell, 2006). Polletta (1999) argues that as a metaphor it has little analytical value, but considerable appeal. Her focus on free spaces as having diverse associated ties contributes greatly to theorizing social innovation. Polletta’s (1999) reconceptualization of free space, as structures of association that include transmovement, indigenous, and prefigurative spaces, holds significant promise and provides an analytical framework from which to begin to understand the role of free spaces in social innovation.
Free spaces set the stage for social innovation in the midwifery movement

Similarly to free spaces, the origins of social innovations can be transformative, indigenous or prefigurative. Social innovations change our everyday practice. They change our social relations. Polletta (1999) argues that authors who use the free-space metaphor often overemphasize the role of physical space. So although physical spaces are important, it is important not to overemphasize their value, as discussed in later passages that draw on the work of Henri Lefebvre (1992, 2014). For Polletta (1999), it is the character and diversity of the associated ties that produce, reproduce, or reinforce practice in these spaces. It is the characteristics of the social relationships that generate the preconditions for social innovation. Polletta acknowledges the importance of physical space as being able to show people “that issues they thought taboo [could] be discussed, [thus] strengthening collective identity by providing tangible evidence of the existence of a group,” (Polletta, 1999, p.25).

Polletta’s typologies can be used to analyze both groups of midwives and to a lesser extent the international network of midwives. Transmovement structures refer to movements with extensive connections that are well equipped to identify opportunities, but are not able to supply leaders, mobilize frames, or recruit participants. Midwifery, as I have explained previously, is a worldwide network of midwives. Both the Trinidad and Ontario midwives were able to use their networks to mobilize resources. Neither group would appear to have had trouble supplying leaders, mobilizing frames, or recruiting participants. These midwives were part of a large network. It is the nature of these relationships that is most important. Neither of the midwifery groups would fit the idealised version of the transmovement typology.
In analyzing the two cases, Polletta’s typology is challenged by the dynamics of the midwifery movement, but it does provide insight into how we can conceptualize free spaces within the context of social innovation. Additionally, Polletta’s typologies can highlight where midwives were successful and where they were unsuccessful. What is most important in her analysis is that “it is the relationships themselves rather than the physical sites that are important in explaining their role in mobilization,” (Polletta, 1999, p.11). Her transmovement typology privileges weak relationship across expansive geographical locations and varied organizations. Transmovements are networked groups.

Midwives, I argue, are perhaps one of the most networked movements in the world. The ICM is connected to at least one hundred midwife associations around the world, and the mothers these midwives serve. The story of how the first Toronto birthing centre came to be built in Trinidad and Tobago is an example of how midwives are able to use their networks to mobilize resources and transfer knowledge through their networks.

In my interviews with one Canadian midwife, who was on the Task Force for the Implementation of Midwifery in Ontario, she noted that the task force visited some of the best midwifery models in the world to see what they could learn from them (Eberts, 1987). She told a story of how Dutch midwives served as the most renowned model in the early 1990s. These Dutch midwives were now returning to Canada to see what they could learn from the Ontario midwives—who had originally built a midwifery model that was informed by the Dutch model. The Trinidad midwives modelled their approach on the Ontario midwives.
Additionally, a report titled *The State of the World’s Midwifery 2014. A Universal Pathway. A Woman’s Right to Health (SoWMy)*, is a collaborative project between the ICM, the UNFPA and the WHO (UNFPA, 2014). The report examines the state of midwifery in seventy-three low-middle-income countries (UNFPA, 2014). The project was done in collaboration with ICM, which was able to leverage its network to help with data collection and ultimately improve health outcomes and training in each of these countries. For Polletta (1999), transmovements are rarely able to supply leaders, mobilize frames, or recruit participants. But both groups had midwives who were internationally trained and accredited by the ICM. Midwives used these networks to point to examples of where midwifery had been successful in other parts of the world. So although midwives may be a transmovement, they do not fit the typology, since they were able to recruit and supply leaders within their local contexts.

One reason for this lack of fit might be that midwives also fit Polletta’s (1999) second type of structure: indigenous movements, which are characterized by the density of their associational ties. Generally when indigenous movements are established, they are not being established as an oppositional group. As one of the oldest professions in the world, and with the herstory of the ICM, midwifery was not originally established in an oppositional context (McIntosh, 2013; Porter, 1999).

Within the context of Trinidad and Tobago, it is easier to make this argument, as midwives were regulated in 1826 and were once a part of normal community life, as one interviewee notes:

At one point, I mean, births were done at home. It was a normal process that women went through and most of the babies were born at home. I was born at
home. It was nine of us in our family and only one member of our family was born in the hospital. Everybody else was born at home.

When it was time for the woman to give birth, you just sent for the person who was in the so-called midwifery profession and they came home and did the births. (Trinidad interviewee 14.)

Traditionally we had what we call middies or a traditional midwife, so people would deliver in their homes and midwifery was passed on from generation to generation. When a woman would be doing that, generally she would have learned it from someone else and she would pass it on to her daughter so that the daughter would now do the midwifery. (Trinidad interviewee 8.)

Midwifery did not always emerge in formal opposition to something. Women in these groups had strong associational ties and were usually from nearby geographical areas. The midwives who started the birthing centre had strong associational ties, but they began to come together to talk about what their profession had become. Prior to the formation of their group, middies were part of the dominant culture on the island.

In Ontario there is a common misconception that midwifery disappeared for some time. Benoit (1991) and Biggs (2004) challenge this by outlining the herstory of midwifery in Ontario (see p.136).

Polletta (1999, p.11) argues that: “The concentration of ties in indigenous institutions may make it difficult to mobilize beyond the bounds of the locality; hence the importance of formal movement organizations in mass recruitment.” This was not true of
the midwifery movement in Trinidad. There, a small group of midwives were able to build a birthing centre by applying for funding and working with various foundations and private donations so they could purchase a building. Most of their funds came from international donors. In Trinidad these women were able to bring the future they envisioned into being by working beyond their immediate networks.

Midwifery in Ontario has a very different herstory. Until the 1990s midwifery in Ontario was an unregulated profession. Midwives had been advocating for regulation and recognition prior to 1985, but when an inquest was launched into the death of a baby, Daniel McLaughlin, midwifery became a public debate (Bourgeault, 2006). Despite their best efforts, attending midwives Sue Rose and Viki Van Wagner (both members of the Midwives Collective) were caught in a race against time as they tried to transfer the baby to the Hospital for Sick Children (Bourgeault, 2006). McLaughlin died two days later as a result of asphyxiation that he had suffered during birth (Bourgeault, 2006). Although the inquest brought considerable media and public attention to midwifery, Bourgeault (2006) points out that midwives used the crisis as an opportunity to educate the public about midwifery:11

Although midwives had a sense that this was going to be yet another attempt to end midwifery and home births, they also regarded it, the inquest, as an opportunity to make a public statement about the benefits and legitimacy of midwifery. (Bourgeault, 2006, p.108.)

11 During my research I was given a series of news interviews that were aired during the time of the inquest. The interviews also cover many of the debates around midwifery at the time. They have been uploaded to YouTube and can be found at this link: https://youtu.be/hig6SzTt1WM
The inquest into the death of baby Daniel concluded that if the midwives had been better supported, regulated, and incorporated into the medical system, his death could have been avoided (Bourgeault, 2006; Demming, 2015). Several academics and historians point to the inquest as the main focusing event that brought midwifery onto the public stage (Bourgeault, 2006; Bourgeault et al., 2004; Paterson & Marshall, 2011; Sharpe, 2001). Holliday Tyson, director of the International Midwifery Pre-registration Program at the Chang School, Ryerson University, and of the Chang School Simulation Lab for Health Professionals, stated, “The inquest summarized in a lot of ways the opportunity and the threat that happened, and as these things always happen together,” (see also Appendix G). She recalled that it was described in the media as a “trial that’s not a trial in a courtroom that’s not a courtroom, and that it was a witch-hunt. That was really pretty accurate.” For her,

What happened is that you had this ragtag group of people, sixty-five of us, out there doing home births, with all different kinds of backgrounds, with a death on Toronto Island, and the leadership in nursing saying, “We’re not that. We’re not that. Nursing is professional. Midwifery is a subsection of nursing. We would always be doing this under the supervision of physicians. We would be in birth centres and hospitals, never at home.” They basically were setting out their own claim on midwifery. The way it was set up was, it was going to be one or the other.

That’s the environment that was happening around the time of the inquest. The inquest actually suggested that midwifery be legalized, but under the aegis of nursing, at least...what they said is, for the first year or two, leaving it like that.
Ivy Bourgeault’s (2006) chapter titled “Defining themselves before being defined” outlines how midwives took control of their narrative before others imposed one onto them. They were afraid that midwives would be defined as non-autonomous practitioners who would be regulated by a medical board who did not see birth as natural or did not agree that a woman should be able to choose where she gives birth. These midwives had seen that in countries where midwives were not self-regulated, they operated more like obstetric nurses than midwives. The midwifery stance is different from the physician stance, so the struggle for autonomy and self-regulation was a key focusing event in their struggle. Midwives were able to mobilize to define themselves because they had strong existing ties. In their free spaces, they had developed dense networks that provided them with the capacity to supply leaders, mobilise resources, recruit new members, and identify opportunities.

But at the time, midwives were convinced that the task force was not going to allow midwives to be self-regulated. Holliday Tyson argued that:

The nurses didn’t actually have anybody practicing midwifery. That was the key difference, and so you had this groundswell of public support for the people who supported midwifery. They supported the people who had actually been practicing midwifery, not the people who said, “In the future we would like to have this as a subsection of nursing, and we should control it and we’ll do it under doctors’ supervision,” because basically a critique of medicalization was absolutely critical and central to why midwives were asking to be given the privilege of looking after people for public funding.
The government at the time had appointed a task force to determine how midwifery should be regulated and implemented and which, after looking at various models around the world, concluded that midwifery should be a self-regulated profession (Bourgeault, 2006; Eberts et al., 1987). The task force produced its report in 1987, but it was not until 1991 that midwives began to see traction. Much of the success of these movements was because midwives were able to leverage their networks to supply the information the task force needed to make its recommendations.

Midwives were setting the stage for social innovation

Midwives in Ontario have had to fight for their profession in a very different way from the midwives in Trinidad. These groups can be considered indigenous institutions because of their strong associated ties. Polletta’s (1999) notion is that indigenous movements often struggle to mobilize beyond the bounds of their locality; hence the importance of formal movement organizations in mass recruitment. Ontario midwives were able to garner wide public support beyond their local networks, while the Trinidad midwives were able to access support from international donors. Both groups were well organized. In Ontario the inquest into the death of a baby in 1982 spurred midwives to get politically organized, so that when a second inquest in 1985 occurred they were prepared (Bourgeault, 2006). In Trinidad, the mother who insisted that they build a birthing centre brought a friend who helped access funding from granting agencies (Trinidad interviewee 3). Midwives fitted with Polletta’s (1999) indigenous-movements
typology, but did manage to move beyond their bounds of locality to secure resources, despite her observations that these organizations rarely do so.

In Polletta’s (1999, p.11) final typology, prefigurative movements are formed in order to prefigure the society the movement is seeking to build by modelling relationships that differ from those characterizing mainstream society. Examples of these groups may include credit unions, health clinics, food co-ops, women-only spaces, or radical feminist groups. In these groups members are able to foster interpersonal ties and help sustain membership. These prefigurative structures are usually created within existing movements and serve to strengthen relationships and ideas within these movements. These groups are difficult to maintain because they often adhere to egalitarian or democratic principles, which may make decision-making difficult, when quick responses are often needed. Polletta does write that there are sometimes exceptions: if groups “can provide services (healthcare, food, education) that successfully compete with mainstream service providers, they may become enduring indigenous institutions and may supply leaders and participants for later mobilizations,” (Polletta, 1999, p.65).

The four of us, we were a little group together and we used to meet and just share and talk, and really I guess we were unhappy about the system in Trinidad [...] We just kind of found each other, and because we had the same ideas—not a vision, because we didn’t have a vision, we just had similarities; we just felt that women should have choice, and women should be empowered.

(Trinidad interviewee 9.)
Midwives who were designing their local organizations were doing so within the context of existing within a larger movement. They had the support of midwives globally and were strongly connected to the ICM. What is important in Polletta’s (1999) analysis is that although these organizations were created within existing movements, it is the relationships within these associated structures that were important. Polletta argues that free spaces and associated ties are not the same thing. I agree with her analytical distinction but prefer to maintain the use of “free spaces,” because of its metaphorical appeal, the very reason Polletta (1999) sees the need to introduce a new term, “structures of association.” Polletta’s typologies focus on the socialization that is occurring within the movements and how these groups develop a common identity and common message.

In the case of the Ontario midwives, when you analyze the interviews around the inquest, each midwife had a consistent message. The most important messages came from the mother whose child had died. Her messaging was consistent with and supported what midwives were saying in their interviews. I was able to obtain recorded versions of these interviews which I subsequently posted YouTube (Demming, 2015). So although free space as a metaphor is important, what is most important within the context of social innovation is to note that these are social spaces where movements prefigure the future they hope to create. It is within free spaces we develop associated ties and it is these ties that prepare you to fight for and stick with a cause that you might be prepared to be arrested for (see also Biggs, 2004; Bourgeault, 2006; Nestel, 2000a).

One of the most powerful examples of what I refer to as free spaces is presented by Evans & Boyte (1992), when they explain the role citizens’ schools played in the civil-rights movement. It is in these spaces that the members developed what Polletta
(1999) refers to as associated ties. These spaces are important socio-political sites where offstage conversations are refined for the day of their reveal. Free spaces act as incubators for strengthening and developing associated ties. They also act as social spaces where actors rehearse for the main show where everyone knows their lines and is prepared for both the reveal and the struggle. Free space serves as the mechanism by which we prepare the soil for social innovation.

One day you will be called upon to break a big law in the name of justice and rationality. Everything will depend on it. You have to be ready. How are you going to prepare for that day when it really matters? You have to stay “in shape” so that when the big day comes you will be ready. What you need is “anarchist calisthenics.” Every day or so break some trivial law that makes no sense, even if it’s only jaywalking. Use your own head to judge whether a law is just or reasonable. That way, you’ll keep trim; and when the big day comes, you’ll be ready. (Scott, 2012, p.4.)
Discussion: What free spaces contribute to the conversation

- **The why**: Setting the stage for social innovation
  - Free Spaces: Associated ties
    - Prefigurative
    - Indigenous
    - Transformative
  - Game play

**Figure 5.1. Two-dimensional framework of making space for social innovation.**

This chapter focused on the inner layer of the model (see Figure 5.1). In this first phase midwives generated free spaces. They used their networks to supply leaders, share knowledge, mobilise frames or resources, recruit new supporters, and identify opportunities. In her conceptualization of prefigurative, indigenous, and transformative associated ties, Polletta (1990) places emphasis on the types of relationships that characterize free spaces.

In this section I have drawn on existing literature to help conceptualize the preconditions for making space for social innovation. The subtext of this chapter also addresses why midwives embarked on a social innovation struggle. Part of the subtext of
this chapter implies that coincidence played a role in the social innovations that emerged. In many ways both groups of midwives had the right conditions, and the right people, come to the table at the right time. For example, one interviewee stated,

Some people say, “Well, it was bound to happen. It was its time,” but they weren’t there and they don’t really understand all the variables that were happening. The Health Disciplines Act just really happened to open at that time. That was not because of midwifery. The Health Disciplines Act opens every 15 years or so, to say, “

One category that emerged from the data was the theme of a perfect storm. Perfect storm referred to these things windows of opportunity that were a matter of circumstance. The Health Disciplines Act just happened to be up for review, so midwives seized the opportunity. These Canadian midwives were well networked and well prepared. In Trinidad, a group of midwives had been building their network for some time when a mother came along who happened to have a friend who knew how to get funding (Trinidad interviewee 3; Trinidad interviewee 4; Trinidad interviewee 10).

The following chapters address the “how,” or the process, of social innovation, as it pertains to selected case studies. Each chapter expands on the various components of the social innovation framework to propose a substantive theory of social innovation. Free spaces are social sites where citizens can plan or exchange ideas, debate, and strategize the future they want. These spaces can be characterized by the type and density of social relationships that exist within them. Ultimately, these are citizen-led educational spaces where actors can prepare for the future they are working for. Free spaces are empowering places where citizens leverage networks to co-create their collective
identity, and strengthen the relationships that will provide them with the support for disrupting existing relationships and institutions.

I use examples from the midwifery case studies to demonstrate the role relationships played in setting the stage for social innovation. Midwives were able to use their networks to realise the future they imagined. Their pre-existing networks and relationships provided them with the capacity to co-opt those relationships and networks for social action (Freeman & Victoria, 1999). Free spaces serve as a foundational framework for developing and conceptualizing a relational approach to generating the conditions for social innovation. This redirects attention to the associated ties within spaces, and away from a focus on physical space. These pre-existing relationships and networks act as the soil for the seeds of social innovation.

In choosing to use the concept of free space we are able to leverage the notion of hidden transcripts as a form of practice. This manoeuvre allows us to introduce thorny concepts like game-play (discussed in Chapter 6), the co-construction of collective identity, and the importance of the relationships or networks within these spaces so we can further develop a framework for generating social innovation.
Chapter 6: The social and spatial practice of social innovation

“A revolution that does not produce a new space has not realized its full potential.”

Lefebvre (1991, p.51.)

In earlier chapters, I drew on Dolwick (2009) to propose a broad conceptualization of the word “social” to include human and non-human actors. This approach proposed a conceptualization of the term “social” to include socio-material actors and artefacts. Space then emerged as a major theme from my interviews with midwives, and in returning to the literature it seemed only plausible to explore a notion of space that also included a socio-material understanding. This chapter builds on the previous free-space conceptualization to include insights from Henri Lefebvre (1992) to propose an approach to generating the conditions for social innovation. In Chapter 7 I begin to synthesize these themes into one conceptual framework (Figure 6.1).
In the previous section I argued that free spaces set the stage for social innovation by fostering social ties within social space where actors can exchange ideas, debate, and strategize about the world they wish to create. These spaces set the stage for actors to co-create how they might generate social innovation. Space is a complex topic with many implications for conceptualizing a framework of social innovation. I argue that social innovations should at a minimum change our social relations. Free spaces prefigure the conditions for social innovation, by preparing citizens for transformative perspectives of social and spatial practices. This section draws on Henri Lefebvre to conceptualize a social-material transformative perspective of space as a way of strengthening a theory for

**Figure 6.1. Two-dimensional framework of making space for social innovation.**

- **The how:** Exploring how midwives were able to generate social innovation: the process
  - What did they do to generate social innovation
  - Social and spatial practice of social innovation
  - Stance
generating social innovation. It is important to remember that the activities within free spaces are themselves practices, which can be co-opted for social innovation.

**Henri Lefebvre’s production of space and social innovation**

There is a cliché which with a certain degree of justification compares creative moments to the mountaintops and everyday time to the plain, or to the marshes[...] Here everyday life is compared to fertile soil. A landscape without flowers or magnificent woods may be depressing to the passerby; but flowers and trees should not make us forget the earth beneath. (Lefebvre, 2014, p.87.)

The previous conceptualization of space also builds on this idea of paying attention to the earth beneath. Lefebvre (1992) brings a very valuable analysis of how we make use of, conceive of, and attribute meaning to space to the conversation of social innovation. In free spaces midwives were able to conceptualize the futures they imagined. Drawing on Lefebvre (1992), I demonstrate how midwives were able to influence their socio-spatial practice. Considered one of the most eminent Marxist scholars (Gottdiener, 1993), Lefebvre (1992; 2014) is best known for his books *The Critique of Everyday Life* and *The Production of Space*. Considerable emphasis has been placed on Lefebvre’s concepts in *The Production of Space*. Elden (2004) and others (Gottdiener, 1993; Morton, 2011) have pointed out that there is some inconsistency in the way Lefebvre has been interpreted (Elden, 2004; Gottdiener, 1993). Some of this can be attributed to his work having been originally written in French, and only later translated into English. For non-French-readers, like myself, it leaves us dependent on others’ interpretations in the course
of these translations. Similarly, because his work was only published in English in 1991, many readers were often unable to access the full breadth of his work until additional translations were made available (Elden, 2004; Gottdiener, 1993; Kipfer et al., 2013; Ritzer & Stepnisky, 2011). Many early applications of Lefebvre’s work have been criticized for taking too narrow a perspective or ignoring how his previous work led to the development of *The Production of Space* (Elden, 2004; Gottdiener, 1993; Kipfer et al., 2013; Ritzer & Stepnisky, 2011).

Much of Lefebvre’s popularity can be attributed to the influential publications of Edward Soja (1989) and David Harvey (Harvey, 1992; 2000). As early Lefebvre scholars, both authors have been criticized for appropriating, under-representing, focusing too narrowly, or idealizing Lefebvre’s work (Elden, 2004; Kipfer et al., 2013; Milgrom, 2008; Ritzer & Stepnisky, 2011; Unwin, 2000). Several authors have suggested that Lefebvre should be understood within the context of his wider writings, not just his most popular (Elden, 2004; Kipfer et al., 2013; Milgrom, 2008; Ritzer & Stepnisky, 2011).

It would be limiting not to include Lefebvre’s ideas in a conversation on generating space for social innovation. His idea that physical space is more than a background to social happenings makes a major contribution to thinking about how we generate the conditions for social innovation. Here I choose to use specific insights as a way of adding depth to the conceptualization of space within the context of social innovation.
Lefebvre’s notion of spatial practice

Lefebvre’s work is often described as being nonlinear, complex, and difficult to grasp, but it is this nonlinearity and complexity that are also the strength of his ideas (Unwin, 2000). Lefebvre has been described as offering multiple representations of his work, and perceptions about it vary considerably. For example, Lefebvre has been described in the following ways:

The complexity of Lefebvre’s arguments is closely related to the elusiveness with which he develops them. Reading *The Production of Space* can be compared to walking across quicksand, or trying to find the end of a rainbow. No sooner does one think that one has understood what he is trying to say, than he shifts his position, so that what was once thought to be acceptable is now shown to be problematic. (Unwin, 2000.)

Whenever I read Lefebvre I am reminded of Barthes’ phrase “the pleasures of the text,” because he is a joy to read. In a virtuoso display of dialectical reasoning, for example, he discusses how the advance of capitalist industrialization superimposes abstract space, the quantified space, everywhere. (Gottdiener, 1993.)

I lean more towards Unwin’s (2000) approach to thinking about reading and understanding Lefebvre’s work. Despite the somewhat inaccessible nature of Lefebvre’s writing, the main concepts presented in his two major works, *The Critique of Everyday*
Life and The Production of Space, have been considerably influential in the conceptualization of space, in fields including architecture, geography, planning, urban sociology, and cultural studies (Gottdiener, 1993). I draw on his work to propose a conceptualization of social innovation.

Wilson (2013, p. 373) argues that:

[A] broader reading of Lefebvre beyond The Production of Space...

provides the concept of differential space with substantive content: territorial autogestion, the politics of difference, and the transformation of everyday life, in opposition to alienation, homogenization, and the domination of lived experience by technocratic abstractions.

For Lefebvre, space was socially contested, constructed and constituted. “Rather than portraying it [space] as a neutral, passive, and fixed backdrop to history, he [Lefebvre] is determined that we shall acknowledge that spaces/places are localized, particular, and changing—both producing, and produced by, social relations,” (Morton, 2011, p.607). He thought that revolution and transformation lay in transforming everyday life. Lefebvre provides “an essential condition of possibility for the reproduction of late capitalism—which cannot be transcended without revolutionizing space, by claiming the right to the city, or the right to difference,” (Ritzer & Stepnisky, 2011). In thinking about social innovation, if we are to change the everyday practice of social space, Lefebvre’s ideas about right to difference and revolutionizing space have considerable relevance, especially within the context of midwifery as a case study for social innovation.

The story of midwifery as I presented it in Chapter 4 outlines how midwives were able to influence their everyday social practices. Midwives fought for a right to difference
in the sense that they were fighting for the right to the birth of women’s choosing.

Similarly, midwives in Trinidad and Ontario co-opted spaces external to the existing institutions to revolutionize space. During the 1980s, in Ontario, the decision to assist births at home—home births—was a revolutionary act. It revolutionized a specific type of space. In Trinidad, the midwives built a space, both social and physical, that was outside the existing health-care system as a way of claiming their right to difference—women’s right to a birth of their choosing.

“Henri Lefebvre argues against the abstract space of capitalism, space that tends toward homogeneity and suppresses difference rather than attempting to accommodate the representational spaces and spatial practices of diverse populations,” (Milgrom, 2002, p.1). This abstraction of space standardizes and formalizes spaces in a way that marginalizes difference. It ignores diversity and produces homogeneity in the everyday lives of those inhabiting these spaces (Milgrom, 2005; Penny, 2011). Capitalism or abstract spaces therefore limit what is possible by standardizing these social structures and spaces through rules and regulations, all in the name of neighbourhood management. Lefebvre argues that “inasmuch as abstract space tends towards homogeneity, towards the elimination of differences or peculiarities, a new space cannot be born (produced) unless it accentuates differences,” (Milgrom, 2008, p.6). This difference is referred to as the “right to the city” or “right to difference.” It is a critique of urbanization and its tendency towards the homogenization of space. I draw on these insights to demonstrate how midwives created a new space to avoid standardized spaces dominated by obstetric rules and regulations.
Lefebvre’s work has mostly been applied to theorizing urban space, but his insights are extremely helpful for theorizing about how we might generate social innovation. Lefebvre argues that homogeneous spaces are the outcome of what is possible. As a result, the city that is possible becomes the city that is almost predetermined by existing rules, regulations, or preconceptions of the city. Those living in these spaces rarely determine these rules and preconceptions. Space becomes a social phenomenon that is imposed on those living in it, who have little agency, but significant stake in the outcome (Elden, 2004; Lefebvre, 1992; Milgrom, 2005). It is this notion that is of particular importance to social innovation and its conceptualization. For example, current funding models where foundations determine what gets funding and what is worthy of being funded fall into the category of space being imposed. So those who hold the purse strings ultimately shape the practice of those working in NGOs. In the previous section I proposed that free spaces are a way of setting the stage for social innovation. It is in free spaces where citizens are able to co-create the future that seeds of social innovation are sown. In these free spaces, citizens can begin to plan how they can claim their right to difference; their right to space. A medicalized approach to birth assumes a homogeneous experience of birth. It is not uncommon for hospitals to have pre-existing rules that women who are in labour for a particular length of time will be induced to speed up the process. This assumes that birth can be mechanized, when every birth is different.

The struggle for the right to choose how a mother gives birth is analogous to the “right to the city” concept. Midwives were interested in the right to different kinds of birth, while theories related to urban planning are referring to the right to different built
environments. Lefebvre was largely criticizing urbanization. His notions of possibility, the right to the city/right to difference, and his triadic representation of space all play important roles in articulating his potential contribution to theorizing social innovation.

Lefebvre argued that there is no revolution without changing everyday life, without changing our space. “Henri Lefebvre argues against the abstract space of capitalism, space that tends toward homogeneity and suppresses difference rather than attempting to accommodate the representational spaces and spatial practices of diverse populations,” (Milgrom, 2008, p.1). One of his main arguments is that “everyday life is the native soil in which the moment germinates and takes root,” (Ritzer & Stepnisky, 2011, p.13). If we are to change society, we need to change what we do in our spatial practices. Lefebvre had a deep interest in everyday life, and thought that it was through a radical critique of everyday life that you could transform it (Lefebvre, 2014).

Similarly to the free-space literature and Scott’s (1990) conceptualization of hidden transcripts as practice, Lefebvre (1992) also places considerable emphasis on his conceptualization of practice. For these authors everyday life acts as the proxy for generating change. The free-space literature theorized about how associated ties within offstage spaces can be a counter-response to the dominant discourse. These theoretical dispositions echo Lefebvre’s ideas about spaces of difference. He fits very well into the previous presentations of space for social innovation. What Lefebvre adds to the discussion is a conceptualization that refers to space as being a “vigorous concept in a perpetual state of flux; influencing, and being influenced by, subjectivities[;] it is deeply political, politicised, and is no longer assumed as static, homogeneous, apolitical,” (Morton, 2011, p.605). His triadic representation of how space is produced provides an
empirical framework for understanding and analyzing space. For Lefebvre, space emerges out of a triadic relationship between: **spatial practice** (perceived space)—how space is used; **representations of space** (conceived space)—how space is produced by designers; and **space of representation** (lived space)—the way meaning is attributed to space or the symbolic value produced by inhabitants (Kipfer *et al.*, 2013; Lefebvre, 1992; Milgrom, 2008). Each element of the triad exists simultaneously in a dialectic relationship with the other. No element can be analyzed on its own, nor can they be reconciled or conflated with each other. In using this dialectical approach, Lefebvre was trying to avoid a reductionist approach to understanding space.

In his triadic proposal (Figure 6.2), what he presents is “a unitary theory of space that ties together the physical, the mental, and the social,” (Gottdiener, 1993, p.605). It is the interaction of these spaces that produces space, in space. Morton (2010), in her thesis, *The Relevance of Judith Butler and Henri Lefebvre to the Theories and Practice of Law: The Production of Bodies and Spaces through Law,* provides an example of how women’s health clinics in British Columbia became highly politicized sites of the struggle for abortion rights as sites of contention between pro-choice and pro-life supporters, so much so that zoning regulations needed to be implemented to allow women access to the space, so they were not hassled by “pro-life” supporters who might try to stop them from entering these clinics.

These spaces held a specific history and consequently held symbolic meaning. These spaces were used for abortions; this was the spatial practice that occurred in these spaces. This is what Lefebvre (1992) referred to perceived space. They were designed to be medical clinics; this is what he referred to conceived space. They provide women with
control over their reproduction, which carries significant meaning and symbolic value. This is what Lefebvre (1992) called lived spaces or spaces of representation. They were by no means neutral backdrops to the struggle for the right to abortion.

![Figure 6.2. Lefebvre’s conceptualization of space. Adapted from Milgrom, 2008.](image)

In his own words Lefebvre (1992) described his triad as being:

Spatial practice, which embraces production and reproduction, and the particular locations of spatial sets characteristic of each formation. Spatial practice ensures continuity and some degree of cohesion. In terms of social space, and of each member of a given society’s relationship to that space, this cohesion implies a guaranteed level of competence and a specific level of performance.

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Representations of space, which are tied to the relations of production and to the “order” which those relations improve, and hence to knowledge, to signs, to codes, and to “frontal” relations.

Representational spaces, embodying complex symbolism, sometimes coded, sometimes not, linked to the clandestine or underground side of social life, as also to art (which may come eventually to be defined less as a code of space than as a code of representational spaces) (Lefebvre, 1992, p.33.)

**Using Lefebvre’s triad as a tool for analysis**

In qualitative research, the inquirer often bounces between theory and data. Lefebvre (1992) provides a framework for demonstrating how the social and the material interact to influence practice. Each node in Lefebvre’s (1992) theory represents a different interpretation of space.

**Spatial practice (Perceived space)**

“Spatial practice” refers to everyday practices which are largely un-thought and the environments which result from them or develop in relation to them. Lefebvre refers to this as perceived space, meaning that space is always an aspect of our experiences of the world but, most of the time, it is apprehended without conscious attention. (Jeyasingham, 2014, p.1883.)
Lefebvre’s (1991) first node, spatial practice, refers to how the space is used, the everyday practices of space. Space within the context of midwifery is used to ensure women have the birth of their choice. Midwives produced a caring environment that was largely informed by their thought and unthought practices. They produced spaces where mothers could maintain their right to an intervention-free birth. For example, the midwives in this study held the pre-existing belief that women should be able to choose how and where they can give birth. For example, when mothers would go to the hospital, they would advise mothers to “go to the bathroom a lot” (Trinidad interviewee 3). It was a way of using the physical space to influence the way the mother experienced birth. They used the space to support their resistance strategy.

In some hospitals...I will say, “Okay, if you feel like squatting you can get out of the bed and squat on the floor, and when it’s time we can bring you back up on the bed.” There are some midwives who will facilitate that. As well as—in the majority, though—you will get most midwives saying, “No, you have to stay on the bed and you have to do as I am directing you to do.” The client doesn’t really have a lot of say. (Trinidad interviewee 2.)

Women were not allowed to use the full extent of the room to ease their birthing experience because the rules within the hospital limited what they could do. If you contrast this with the birthing centre, the midwives used the spaces in the birthing centre however they thought it would be helpful to the mother. Within the context of the hospital, the unthought practices of birth practitioners influenced how women experienced birth. For example, depending on the perspective a midwife held, she might
allow a mother to stand or squat during birth. Depending on the rules or existing practices of the hospital, a midwife might or might not allow a mother to stand during labour.

The obstetricians, they were doctors, so they learned the medical way. It is all about the doctor delivering the baby. It’s about the doctor, not about the mother. It’s about the doctor having ease of access, easy access to the birth canal.

(Trinidad interviewee 11.)

From the quote above, what does the midwife mean by “the medical way”? She is referring to midwives and obstetricians having different perspectives on birth, and it is these perspectives that influence how the space is used or not used. Here the physician-centric approach is believed to contribute to the high rates of caesareans.

There was one doctor who said, “I have a lot of respect for [midwives, they] will go down on the ground, and oiling up and thing, you know.” He said, “I cutting you one time.” […] When he [says] “cut” he means he’s giving you an episiotomy. So he respects midwifery training and he says, “Respect mine. And this is what I do: I’m an obstetrician, I cut—end of story.” He supported us because it was very important for us to have [support]. (Trinidad interviewee 10.)

The midwife supports the mother and would change her position to make the mother comfortable. The obstetricians, however, insist that the mother is lying on the bed, because it easier for them. These daily activities influence the kinds of practice that emerged in these spaces. The one obstetrician I was able to interview stated:
I have patients who really want vaginal deliveries, so my goal is to try to get you a vaginal delivery.

There are other doctors who are like, “I’m only going to do a C-section, so if you don’t want a C-section, don’t come here.” There are doctors who just strictly do caesareans because the caesareans, in this environment—and your patients don’t understand it—but in this environment, you get paid more money to do less work if you do a C-section. You go in for an hour, you get paid double the money, you go home. Why would you want to do a vaginal delivery if now you have to spend eight to ten hours to make half the amount of money you would make, for a normal delivery?

Midwives “go where the woman goes because her body is naturally going to assume the position of birth at that time,” (Trinidad interviewee 10). From the free-space literature, midwives used spaces to define the future they wished for; they knew they wanted their spatial practice to be woman-centred. They focused on the space, but they knew the rules of the space and space itself influenced the spatial practice. The practices of these midwives produced an environment that was intended to empower and inform women of their choices. In drawing on Lefebvre (1992) it is important to recognize that each node is mediated by the other, so if spatial practice refers to how the space is used, and midwives were clear on how they intended to use their spaces, then in building the birthing centre, these midwives were creating a space where the practice of birth could be woman-centred. These spaces were understood as places for physical and emotional
support. One surprising interpretation of how their understanding mediated their social
spaces was one midwife’s description of how she designs emotional space.

You can give birth in a hovel, and it can be a lovely experience. You can
give birth in five-star whatever, and feel traumatized by it.

I would define space in emotional terms, especially, for birth. It would be
the level of support, the level of attention. One of my doula friends talks about
“holding space,” and that’s about holding emotional space, and sometimes that’s
more about sitting back, and I guess not interfering, however you would say that.
(Canadian interviewee 9.)

This midwife held the ideal that birth should be woman-centric. This idea
influenced her practice and the mothers’ experience. In the quote above, the midwife
described how she fostered emotional and interpersonal space as being just as important
as physical space. Her practice focused on keeping the mother comfortable. Lefebvre
(1991) argues that space is socially produced and is mediated by the interactions of
perceived, conceived, and lived experiences. For midwives, the woman in labour is the
centre of care. It is her needs and desires that matter most. One interviewee put it:

Just think about the phrase, “The doctor delivers the baby,” or “The
midwife delivers the baby,” as opposed to, “The woman gives birth.” That’s just a
whole different way of thinking about things. Just even that grammatical
construction—in the first, the woman is not even present. [In] the second, the
woman is in the position of the agency. She’s taking the space of the—she’s the
active one, and maybe, if a woman gives birth, there might not even be any
caregivers there. That’s the important function that I’m interested in. (Canadian interviewee 1.)

In quote above it is clear that midwife’s perception of how birth should be experienced mediated her practice. When I asked the Canadian midwife who spoke about emotional space, she described how her doula friend once described holding space. She further explained,

One of the first things I learned in my midwifery training was how to enter a room. I thought I knew how to enter a room. You open the door, you walk in. But it was all about if somebody is in labour, and you walk into a room, and go, “Hi, how you doing? Awesome! That’s great! You’re having a baby, huh?”

That’s so invasive. You not only have to enter a room quietly, but you have to pull your energy back, so you have to be able to come into a room so that her energy doesn’t feel you.

It’s really interesting. I’ve had situations when I was a midwife, and she calls me, and I’m on the phone with her, and she says, “Yeah, I’m in active labour,” and as we chat the contractions space out. It’s like, wow, interesting. You can feel my energy halfway across the city, and your body is going, “Who’s that?” And as I sit with her, and as I chat with her on the phone, and just pull my energy back, then she can kind of go, “Okay, I will come forward, and I will meet you.” (Canadian interview 22.)
During the interview I found her notion of entering a room interesting, so I asked this midwife to tell me more about what she meant by learning to enter a room. She explained,

It means being respectful. It means putting yourself aside, because I am not important in that moment. If I’ve got any ego, then that’s a problem. I’m here to serve, and I’m here to help you in whatever way you need. In order for me to know what you need, I need to be clear, be observing, be noticing, and in order to do that, my entrance—it’s like you can jump into a pool, or you can just, like, slip in, and you want the ripples to be as minimal as possible…

Not everybody maybe has that kind of training, or that understanding of things. There are people who just have really big energy, and so that person can walk into a room quietly, but their energy precedes them by twenty-eight feet, and everybody else in the room feels that. I know people like that. Not necessarily midwives, but just people in general.

Being very…“invisible” is not the right word. Being very respectful, observant, thoughtful, aware, just like, not disturbing. (Canadian interviewee 22.)

Another midwife stated, “There’s an old saying, the best midwife is when a woman has her baby and she says, ‘I did it myself,”’ (Canadian interviewee 2).

The space these midwives designed was not only physical, but profoundly social. When entering a physical space one can open the door loudly or one can slowly and gently enter so as not to disturb what is happening in the room. Space is not just a backdrop to the work midwives do. It informs their approach to care.
Midwives serve as advocates for women in birth. Part of the midwifery approach is to develop a birth plan. Each expectant mother will discuss what kind of birth she wants to have, prior to being in labour, and as much as possible the midwife will try to ensure this happens. Often midwives act as an advocate against unnecessary medical interventions. For example, one midwife described her experience after assisting with birth:

For the most part my experience was, I would just take the hit from staff, so that women would be protected, so I would walk out feeling like something the cat had dragged in, but women would have probably had a better experience from me being there. (Canadian interviewee 22.)

This notion of advocating for women was echoed by many of the midwives I interviewed, because “nothing happens without asking the woman first—ever.” (Canadian interviewee 2.)

Women and midwives want to have:

a place where women can walk in with their families and have educational sessions and then come in and have their babies with support, in whatever position they wanted to deliver their babies. I think that it would be so nice, I mean, we had started talking in some of the hospitals...If we were to put a place aside, a space aside, and let midwives manage the centres in the government institutions, I think that government could derive so much from that. (Trinidad interviewee 1.)

Trinidadian midwives spent a lot of time cultivating the culture of the birthing centre; the way they practiced in the space meant that every woman who walked through
the door, no matter their circumstance, was treated well. One midwife recalled people in the neighbourhood commenting on how they never heard screams or cries from the centre, located in a neighbourhood just on the outskirts of the capital. She recalled:

I remember some remarks from around here, at Belmont, when we first opened, it was like, “But we never hear anybody bawling.” Well, no, because they come in here and we keep them calm. To them it’s a place where serenity is there, and that’s not something you’ll find in a hospital. It’s bustling it’s hassle-y, it’s noisy, it’s trolleys coming along in the middle of the night and that kind of thing.

So here is very serene, very calm. Even physical things, we make sure that we have nice décor, we have everything pristine and clean, that everything smells nice. We have, not incense, but nice-smelling candles and things like that, so that the experience when they come in, no matter who they are, they’re treated with kid gloves. They are the reason that we’re here, they’re important, and they’re having a baby, which is one of the most important things you can do in your life.

(Trinidad interviewee 7.)

The birthing centre is a free space that allows midwives to practice their craft without interference from medical practitioners. Within the walls of the physical space, these Trinidadian midwives were changing the everyday experience, their spatial practice, and the experience of birth for a small group of women.

In Toronto, space was being used in a similar way. Although Toronto now has a birthing centre, until recently, midwives assisted with home births as way of providing a space where women could give birth as she would choose. These spaces were used to
provide women with an alternative birth experience. This perceived space, how the space would and should be used, influenced the design of the space, how the space should be conceived.

Representations of space (Conceived space)

“Representations of space,” or conceived space, refers to the ways in which space is represented, reduced, and rendered measurable when it is the focus of conscious attention, such as in maps, plans, and verbal accounts of spaces (Jeyasingham, 2014, p.1883). The second node in Lefebvre’s framework refers to representations of space, how the spaces are designed. In home births, space is designed to be a place where the mother feels comfortable. It is the familiarity of this space that allows the mother to feel relaxed during birth. For the Trinidadian midwives, the space was designed with the mother in mind. They paid attention to the colours of the walls, they made sure there were no white bedsheets, and hid all metallic-looking equipment, so the space felt nothing like a hospital.

When I visited the Toronto birthing centre you also got the sense that this space was designed for birth. Nothing about its aesthetics reflected the medical profession. In both centres, there were spaces for families and children to wait and play. The Toronto, the centre can even accommodate indigenous births that at times include a variety of ceremonies.

One of the critiques of midwives is that we come into the hospital, go into a room, shut a door, and none of the staff knows what’s going on. It’s interesting
in terms of how we use space or what we do when we create space—and it really bothered them, because all the nurses are going in and out of different rooms and the doctors and the residents are going in and out, and everybody’s going in and out and chatting at the nursing station—and then the midwife is in there, down the hall, she’s in the room and she doesn’t come out for hours. We’re creating a space in there. I have never kind of understood it, or you’ve just helped me to understand it a little bit better and how it doesn’t jive with the rest of the floor.

(Canadian Interviewee 2).

In trying to create that familiarity within a hospital setting, the midwife closes the door consciously to create space for the mother. This conscious focus simultaneously creates focus outside the room for the nurses in the hall who are physically excluded from the practice. These midwives who come in with mothers, to the hospital where these nurses work on a daily basis, are so focused on the mothers, as they should be, that they exclude the rest of the floor. The physical form of the space is not designed to be a space for midwives, it is a hospital. It was never designed to feel like a comfortable home; yet that is what the midwife is trying to do.

The way space is designed influences the practice within that space. For example, one midwife described how hospitals prefer to use physical devices to monitor the baby so that if something goes wrong they can catch it early.

Well, most institutions these days, when the woman is admitted they will attach the fetal monitor to get a tracing of the baby’s heart rate, just to have something documented that when the woman came in, well, everything appeared to be normal, or whatever. If the woman is in labour for any length of time, they
might opt to do intermittent fetal heart recordings. Yes, there are instruments that you can just put her on and listen without needing the woman to be lying down for any long periods of time, but [in] most of the institutions these days, if the woman is in active labour they are probably going to have her attached to a fetal monitor for most of the time (Trinidad interviewee 2).

Once the monitor is attached, nurses do not like mothers to stand up and walk around, because they will then have to reattach the monitors. So the physical equipment encourages some nurses to insist that mothers stay lying in bed. The problem with this that “gravity helps during labour. If you’re in the upright position, the baby will descend quicker and you probably will have a quicker and easier birth. It’s better for the woman to be in an upright position (Trinidad interviewee 2).

One Canadian midwife describes how:

I always felt that the birth centre was a very important intervention, because it was visible. You could drive down the street, as we do now, as I do now, and say, “There’s the birth centre. People would say, ‘Well, what’s that?’” You could explain to them why there’s a need for a birth centre...That’s why I was for the birth centre, because I thought, this is something that people can actually see, identify with a certain kind of change, and then maybe learn more about it, just because it’s there.

Midwifery was confined to home births for a large period of the time, and therefore was sort of a secret, private thing. It didn’t really have the kind of social intervention into the rest of the system. The change was that midwives got to
practice, and that’s great, because it offered a choice to people (Canadian interviewee 6).

At the birthing centre, midwives are not as focused on the fetal monitor as the nurse-midwives are in the hospital. The way midwives understand or perceive birth frames how they both think about and design physical and emotional spaces. For them, birth is woman-centred, not practitioner-centred.

Spaces of representation (Lived spaces)

“Spaces of representation” occur when space is directly lived and experienced bodily. Lived spaces may be instances which defy official representations of space or when events occur in ways which fail to be reflected in routine practices (Jeyasingham, 2014, p.1890). Lived space is a combination of perceived and conceived space and refers to the invisible structure that influences what happens in these spaces. In the midwifery example there is a unique scenario where midwives, from their experience and the conversation they had had in their free space, knew how they wished to use the space (perceived space), and how they wished to design the space (conceived space). In this final node, lived space is understood as “the complex combination of perceived and conceived space. It represents a person’s actual experience of space in everyday life,” (Purcell, 2002). It refers to what Sawchuk (2013) describes as the “seen but unnoticed material operations within activity, and the tacit features of occupational learning”—the un-self-conscious. These activities are not always reflected in everyday practice, and are
often felt and imagined (Lefebvre, 1991). For example, when I interviewed the midwives in Trinidad, they explained how the size of the tub they used for water birth influences which room a mother might give birth in.

We have two tubs. This one is the smaller tub, so we use it for smaller women, or people who only want to use water for labour, because it has the massage jets like a Jacuzzi. We had to bring the tubs in from the USA, because with the water-birth tubs, the important thing is the depth, because they must be under far enough that the baby is completely submerged when they come out. One of the things that stimulates breathing is when the air hits their wet skin they, “Huh.” So when they come out they have to be completely submerged, and then bring their head okay, so they don’t breathe under water. (Interviewee 3.)

It took a long time and a lot of trouble to get the tubs, because they were specially ordered and there was some trouble getting them through Customs. Yet the size of the tub slips into the domain of the un-self-conscious, and the size of the mother then begins to determine which room she gives birth in. Space in this context, then, influences the social practice. These hidden thoughts arise out of the dialectic relationship between perceived and conceived space, to generate lived space (Lefebvre, 1992). These almost unnoticed materials within the practice of birth influence the experience of the mother and the options that midwives deem possible.

In a second example a midwife explained, “We couldn’t commit to doing…home births; we don’t have enough of us,” (Trinidad interviewee 3). In a conversation with Trinidad interviewee 4, she explained that many of the midwives who started the birthing
centre also worked a private hospital that operated like a birthing centre. It closed when a mother and baby died. After almost 15 years of no deaths there was one death and, she recalled,

…nobody wants to know about what the circumstances were. The fact was that the OB/GYN was not there. She was stuck in traffic. There was one midwife.

People don’t want to know that. The client did not survive. That is the fact. That is something that we have always…this was something that we always put at the fore about the care for the client. We put certain things in place. We have protocols written as to when to transfer, etc...

Then we have our own private ambulance. They didn’t have a private ambulance. [Where the old birthing centre was] has terrible traffic if you don’t have a private ambulance to transfer a client who’s bleeding. That’s a problem. You have to make certain cost decisions if you want to minimize as much as possible. Then you have to have set protocols and the staff [have] to know to move. You see, at this stage here, you do not keep this client here. You transfer. You see, in their case, they had a theatre.

When the midwives were deciding where their centre would be, they chose a location that was near to a hospital, so the risk of being caught in traffic influenced the geographic location of the centre. Yet when one midwife explained that they always had a private ambulance on call, she mentioned nothing about the past experience of the previous birthing centre. Having an ambulance on call, visiting the centre in a particular neighbourhood, driving a particular route when mothers need to be transferred, all become routine practices that are mediated by the perception and conception of space.
“Lived space evades verbal description but holds the potential for new ways of experiencing the social and material world,” (Jeyasingham, 2014, p.1883). It refers to the way meaning is attributed to space or the symbolic value produced by inhabitants (Kipfer et al., 2013; Lefebvre, 1992; Milgrom, 2008).

For mothers and midwives, the meaning attributed to a space that allows them to have the birth of their choice is complex and has many hidden socio-material consequences. In Trinidad, the very existence of the birthing centre was a statement of resistance. It is a space that demonstrates that women can choose how they can give birth, and it can be a memorable experience. Birth does not have to be in a medicalized setting, with medical interventions, where mothers are forced to give birth on their backs. One midwife said, “I believe to be a midwife in the world today, it’s a political act to be a midwife. Choosing midwifery is more than just choosing a profession,” (Canadian interviewee 1). In Ontario one interviewee described the Toronto Birthing Centre in this way:

I think that it did not take us that long to achieve what we set out to achieve and we were able to buy the building and then we did the resource centre first, and then what does it represent to women: finally, at last, wow! Change.

(Canadian interviewee 6.)

**Discussion: social and spatial practice of social innovation**

Spaces where midwives are allowed to practice their craft carry significant meaning. These spaces where mothers are allowed to give birth as they choose can be very powerful spaces. “Just to see, it’s a very emotional thing to actually see parents who
have maybe had babies in hospitals before, coming here and they just can’t believe that they can do whatever they want to do,” (Trinidad interviewee 7). For another midwife, the birthing centre represented: “A place that [women] can do what they were born to do. I think they have finally done what they were put and sent on this earth to do and I think it represents freedom,” (Trinidad interviewee 10). Midwifery-friendly spaces carry significant meaning for these midwives.

It means the realization of a dream. I tell you something: when I was in Belize and in Africa, I had a book, a notebook like this. In it, I had already set up all the rooms for a birth centre, the equipment that was going to be needed and everything. When we had that birth centre, I knew exactly where everything was going to go and how the space was going to be set up. It’s part of my DNA, I think, that space. I mean, I’m not actively practicing, for health reasons, but to this day I could tell you where everything is and where everything should be. The setting up of the birth centre, well, it brought back all my memories from commissioning hospitals in the Middle East and so on. (Trinidad interviewee 4).

Lefebvre’s conceptualization of space adds significant meaning to the literature on social innovation. He had many interests: among them were alienation, praxis, revolution, everyday life, dialectics, and the right to the city (Gottdiener, 1993; Kipfer et al., 2013; Milgrom, 2008; Morton, 2011; Unwin, 2000; Wilson, 2013). His conceptualization of space provides a dialectic framework from which we can begin to examine social innovation case studies.

What is unique about midwifery is that both in Ontario and in Trinidad, midwives had a good understanding of what they wished their lived space and perceived would
look like. They also had significant input, especially with birthing centres, about how they could conceive their space. They were able to transform their social practices because they had control of the perceived, conceived and lived spaces. In being able to transform each of these spaces that they had envisioned while they were in their free space, midwives were able to generate social innovation.

Lefebvre (1992) argues that space is “not a neutral container, but plays a role in shaping the social processes that determine representations of space, spatial practice, and representational space,” (Milgrom, 2008, p.7). My critique of the social innovation literature is that too often, space is presented as being neutral, is not presented, or is assumed to be a backdrop to the social innovation process, when:

[D]espite—or rather because of—its negativity, abstract space carries within itself the seeds of a new kind of space. I shall call that new space “differential space,” because, inasmuch as abstract space tends towards homogeneity, towards the elimination of existing differences or peculiarities, a new space cannot be born (produced) unless it accentuates differences. (Mun, 2012, p.52.)

In the preceding section I explored space within the context of social innovation. As the exploration emerged, so too did our understanding of space. The conceptualization I have presented positions space as a social and spatial practice. Free space, and Lefebvre’s triadic approach to space, all provided theoretical insight into a conceptualization of space for social innovation. From the free-space literature, I emphasized two main themes: hidden transcripts as practice (or offstage conversations)
being brought on stage, and the importance of understanding the associated ties within these free spaces.

Lefebvre makes a unique contribution to social innovation with his understanding of how space is produced and reproduced. For him, space is produced through social relations and can be analyzed using his triad. Each element exists in dialectical relationship with the others, and cannot be analyzed individually. Lefebvre outlines three interpretations of space: how space is used, spatial practice; how space is produced by designers, representations of space (conceived space); and the way meaning is attributed to space or the symbolic value produced by inhabitants, space of representation (Kipfer et al., 2013; Lefebvre, 1992; Milgrom, 2008). Midwives were able to influence each of these spaces in both “places” and consequently were able to transform their social practice.

These three conceptualizations of space have provided an analytical framework for understanding the role of space within social innovation. I initially labelled this category “space” during the coding process, but in exploring the literature on space, the theme needed to be reconceptualised to include a more nuanced representation. In the next chapter, I refer to space as “social and spatial practices” as a way of representing the complex interpretations of space, which have a strong connection to theories of practice. The following chapter builds on the exploration of space for social innovation to propose a substantive conceptual framework of social innovation.
Chapter 7: How stance and autonomy versus interdependence contribute to generating social innovation

“Prosperity in human society is misunderstood. The difference between a rich and poor society is the number of problems that society solves for its citizens. That means technological innovation is the source of all prosperity, but with every tech innovation, you also get disruption—ultimately, social and civic disruption.” – Nick Hanauer

(As cited by Brown 2015 p.1).

As themes emerged from the data, I returned to existing literature. In the previous sections, I explored the theme of space from two theoretical frameworks. Free space provided a framework for exploring the preconditions for social innovation, while the theme “social and spatial practices” explored a socio-material approach to space. As a reminder, three dominant themes emerged from the data: social and spatial practice, stance, and autonomy versus interdependence. In Chapter 5, I demonstrated the overlap between these themes, which exist in tension with each other to form a triadic relationship, which I explore in this chapter. It begins by exploring conceptualizations of stance, followed by an exploration of the theme of autonomy versus interdependence.

Roger Martin (2009), in his book The Opposable Mind, argues that stance, the lens you bring to a context, strongly influences the types of strategy you develop. For example, a common way of describing social innovation is that it crosses the traditional boundaries of public, private, and non-profit sectors. Social innovation encourages actors to collaborate with unlikely partners and in sectors they may not traditionally play in (Westley et al., 2009). Social innovators’ willingness to cross traditional boundaries
makes it difficult to identify where potential innovators may need to play. In Chapter 6 we explored how space can be social, or how midwives’ use of space generated social innovation. In this chapter, I will explore how stance inhibits or enables our potential for social innovation.

**Complexity as a stance of social innovation**

The previous chapter conceptualized the notion of space and how it can contribute to the conceptual framework being developed. Here I continue the conversation by expanding on three notions of stance and how they relate to social innovation. I explore the complexity stance as a way of framing our approach to addressing complex social problems; secondly, stance as an enabling and constraining cognitive construct, as informed by Pierre Bourdieu; and finally, the empathic stance as an approach to designing practice.

Several complexity theorists have developed heuristics for helping groups make decisions under conditions of uncertainty (Patton, 2010; Stacey, 1996; Westley *et al.*, 2009). These authors argue that it is important for groups to be able to identify the type of problems they are working with as a way of helping with decision-making in complex scenarios. One branch of complexity theory classifies challenges or problems as being simple, complicated, complex, or chaotic (Patton, 2010; Stacey, 1996; Westley *et al.*, 2009). In Chapter 2, I explained that simple problems were analogous to baking a cake, while complicated problems were analogous to launching a rocket. For complex problems, I used the analogy of raising a child (see Westley *et al.*, 2009, p.9). These
analogies are helpful for identifying the type of problems actors may be working with when they are working on social innovation.

Table 7.1. Categories of Complexity

<table>
<thead>
<tr>
<th>Simple</th>
<th>Complicated</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baking a cake</td>
<td>Sending a rocket to the moon</td>
<td>Raising a child</td>
</tr>
<tr>
<td>The recipe is essential</td>
<td>Rigid protocols or formulas are needed</td>
<td>Rigid protocols have a limited application or are counter-productive</td>
</tr>
<tr>
<td>Recipes are tested to assure easy replication</td>
<td>Sending one rocket increases the likelihood that the next will also be a success</td>
<td>Raising one child provides experience but is no guarantee of success with the next</td>
</tr>
<tr>
<td>No particular expertise is required, but experience increases success rate</td>
<td>High levels of expertise and training in a variety of fields are necessary for success</td>
<td>Expertise helps but only when balanced with responsiveness to the particular child</td>
</tr>
<tr>
<td>A good recipe produces nearly the same cake every time</td>
<td>Key elements of each rocket MUST be identical to succeed</td>
<td>Every child is unique and must be understood as an individual</td>
</tr>
<tr>
<td>The best recipes give good results every time</td>
<td>There is high degree of certainty of outcome</td>
<td>Uncertainty of outcome remains</td>
</tr>
<tr>
<td>A good recipe notes the quantity and nature of “parts” needed and specifies the order in which to combine them, but there is room for experimentation</td>
<td>Success depends on a blueprint that directs both the development of separate parts and specifies the exact relationship in which to assemble them</td>
<td>Can’t separate the parts from the whole: essence exists in the relationship between different people, different experiences, different moments in time</td>
</tr>
</tbody>
</table>

Source: adapted from Westley, Zimmerman, Patton (2009, p.9).

Complexity within the context of midwifery

If we zoom in on the analogy of raising a child, we can see similarities with midwifery practice and the complexity stance. Midwives never know if a birth plan is
going to work until a woman goes into labour, but they always work with women to develop one. They understand that birth is emergent and their approach needs to respond to what is emerging, that they cannot force the scenario and can never have rigid plans. Midwives consistently work with ambiguity. No two births are ever alike, and it is difficult to predict how births might unfold.

In the midwifery model of care, you are given a birth plan. You are able to say who you want in your room with you, what you want, and I’m like, “Oh my God! It’s like going to a restaurant and choosing things off of a menu,” and I’m like, “This is revolutionary. Nobody ... I’ve never seen that on TV; a woman getting a birth plan.” You know what I mean? And a birthing ball, and I can choose how I want to sit and everything. (Trinidad interviewee 10.)

The research on planned midwifery births suggest mothers experience considerably fewer interventions with midwifery care than with hospital care (Fullerton, Navarro, & Young, 2007; Hutton et al., 2010; Janssen et al., 2009; K.C. Johnson & Daviss, 2005; Lindgren, Christensson et al., 2009). Midwives adhere to an agile or responsive approach to managing care. Although they may have a plan, they understand that the context is always emerging and midwives cannot adhere to strict, preconceived plans. They have matched their midwifery style to the type of challenge they face.
Table 7.2. Categories of complexity as compared with midwifery practice

<table>
<thead>
<tr>
<th>Complexity in midwifery</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparing midwifery to the raising a child analogy</strong></td>
<td><strong>Raising a child</strong></td>
</tr>
<tr>
<td>Midwives have protocols, but they are not rigid, since they need to be appropriate to</td>
<td>Rigid protocols have a limited application or are counter-productive</td>
</tr>
<tr>
<td>each birth</td>
<td></td>
</tr>
<tr>
<td>No births are ever the same</td>
<td>Raising one child provides experience but is no guarantee of success</td>
</tr>
<tr>
<td></td>
<td>with the next</td>
</tr>
<tr>
<td>The experience and expertise of midwives helps when the midwife responds to a</td>
<td>Expertise helps, but only when balanced with responsiveness to the</td>
</tr>
<tr>
<td>particular mother</td>
<td>particular child</td>
</tr>
<tr>
<td>Every birth is unique and must be understood individually</td>
<td>Every child is unique and must be understood as an individual</td>
</tr>
<tr>
<td>Even with low-risk births the outcomes are never certain</td>
<td>Uncertainty of outcome remains</td>
</tr>
<tr>
<td>Midwives take a holistic approach to assisting with birth. For them everything,</td>
<td>Can’t separate the parts from the whole: essence exists in the</td>
</tr>
<tr>
<td>from emotions to smells, can affect birth.</td>
<td>relationship between different people, different experiences,</td>
</tr>
<tr>
<td></td>
<td>different moments in time</td>
</tr>
</tbody>
</table>

Returning to the literature, the complexity stance helps decision-makers think about their approach to addressing complex challenges. The framework helps decision-makers think about how they might develop strategies or techniques for resolving complex social problems. Zimmerman and her co-authors have an excellent way of contextualizing the utility of the complexity stance. In their book *Edgeware: Insights from Complexity Science for Health Care Leaders*, Zimmerman and her colleagues draw on Stacey’s (1996) complexity matrix to develop a decision-making framework for working within complex social systems (Zimmerman *et al.*, 2001, p.136).

The Stacey Matrix places decision-making along two dimensions: the degree of certainty and the level of agreement (Stacey, 1996). Once outlined, the matrix quickly...
becomes a heuristic for decision-making (for more see Zimmerman et al., 2001, p. 136).

Along the vertical axis, Stacey presents “close to certainty” and “far from certainty.”

Along the horizontal axis he presents “close to agreement” and “far from agreement.”

**Table 7.3. Levels of agreement as quoted by Zimmerman (2001, p. 136).**

<table>
<thead>
<tr>
<th>Axis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close to Certainty</td>
<td>Issues or decisions are close to certainty when cause-and-effect linkages can be determined. This is usually the case when a very similar issue or decision has been made in the past. One can then extrapolate from past experience to predict the outcome of an action with a good degree of certainty.</td>
</tr>
<tr>
<td>Far from Certainty</td>
<td>At the other end of the certainty continuum are decisions that are far from certainty. These situations are often unique or at least new to the decision-makers. The cause-and-effect linkages are not clear. Extrapolating from past experience is not a good method to predict outcomes in the far-from-certainty range</td>
</tr>
<tr>
<td>Level of Agreement</td>
<td>The vertical axis measures the level of agreement about an issue or decision within the group, team or organization. As you would expect, the management or leadership function varies depending on the level of agreement surrounding an issue.</td>
</tr>
</tbody>
</table>

*Quoted from Zimmerman et al., 2001, p.136.*

**The complexity lens and social innovation**

There is a distinction to be made between a stance that affects a strategic approach to social innovation and one that influences everyday practice. Stances that influence daily practice could be the different ways midwives and obstetricians understand birth. Midwives understand birth to be a natural process, while obstetricians see it as an activity to be controlled or managed. A stance that affects a social innovation strategy can be understood within the context of a decision-making framework.
In earlier chapters I argued that social innovations are often an attempt to address wicked problems or complex social problems. These are nonlinear, messy problems whose solutions are neither true nor false, right nor wrong, but are instead better or worse (see p. 14 and Rittel & Webber, 1973, p.155).

Research on the outcome of birth suggests that those assisting with birth are caught in what I refer to as the uncertainty trap. This refers to a set of conditions that ensure practitioners who assist with birth will always face uncertainty. Several studies, including those published in *The Lancet*, draw conclusions about birth that guarantee these conditions of uncertainty (see Bergenhenegouwen *et al.*, 2014; Buist, 2007; Daskalakis *et al.*, 2007; Durik *et al.*, 2000; Golffier *et al.*, 2001; Hannah *et al.*, 2000; Herbst & Källén, 2007; Huang *et al.*, 2011; Lobel & DeLuca, 2007; Mutryn, 1993; Roman *et al.*, 2008; Villar *et al.*, 2006; Whyte *et al.*, 2004). From these studies, the research suggests several contradictory findings that bind birth assistants to conditions of uncertainty. For findings from the studies above suggest:

2. Planned caesarean sections for complicated births produce the best outcomes for mother and newborn (Lobel & DeLuca, 2007; Mutryn, 1993; Villar *et al.*, 2006).
4. There is no way of predicting if a mother will have a complicated birth (Buist, 2007; Lobel & DeLuca, 2007; Mutryn, 1993; Villar *et al.*, 2006).
These parameters suggest that decision-making within the context of assisting with birth is usually under conditions of uncertainty. Birth assistants are always managing in an agile manner rather than with a predetermined plan, and always working under conditions of uncertainty. They begin the delivery with a plan knowing that the outcome should be a healthy baby and mother. How they get there is unknowable. With each birth, they are knowingly walking into an uncertainty trap, a context where they know the outcome they hope to achieve, but they cannot know the journey to get there.

Why does a complexity stance matter?

The uncertainty trap demonstrates how midwives live with uncertainty each time they attend a birth.

Mowles (2010) argues that complexity theory should be understood in interpretative terms. For him social arrangements emerge through the local iterative interactions between agents. Complexity theory cannot be utilized or applied to social phenomena, but should be understood as an interpretive framework, a way of understanding social phenomena. Complexity is a stance from which we interpret the world. I propose that for social innovation, it is helpful to adopt a complexity stance as a lens for understanding the problems we wish to address.

R. Young (personal communication, March 7, 2017) visiting Professor of Social Innovation at Ryerson University, describes social innovation as being analogous to growing a garden. He makes the distinction between this and building a house. If you were doing the latter, you would need to get all the materials, the approvals, and the work crews to co-ordinate around building a house in a relatively predictable fashion. Contrast
this metaphor with growing a garden. Firstly you need to have the right conditions before you can begin to plant. Secondly, you need to choose plants that are an appropriate fit for the environment: you can’t grow tropical plants in the middle of Canada. Not only would it be a mistake, it would be destined for failure.

Finally, and perhaps most importantly, you need to let go of control. If you are growing a garden, you need to tend to what is emerging. If a house behaved like a garden, you would have a very different approach to the way you built it. This way of understanding social phenomena influences the strategies we develop and the ways we approach developing social innovations. Consequently, the stance of social innovation assumes that world is complex and that social arrangements emerge through the local interactions of agents within these social systems.

Under the best of circumstances, social innovation is more likely to be like growing a garden, since it tends to reside within the complexity domain. Adopting a complexity stance and engaging in research that explores how midwives cope with the uncertainty of birth can likely lead to deeper insights into how we might develop an approach to managing uncertainty. I discuss this in Chapter 8 under the section on further research.

**Bourdieu on stance**

Bourdieu (1990) conceptualizes “social space” as a social phenomenon that is not passive, but instead contributes to the social construction of reality. For him, social space is relational and is mediated by his key concepts of capital, *habitus*, and field. For Bourdieu, his three concepts exist as a co-constructed trio (Thomson, 2014). None of
them is dominant, and none stands alone. Each is a component of the social world that, if deconstructed on a case-by-case basis, provides a deeper understanding of social innovation.

Bourdieu “nominated four forms of capital: economic (money and assets); cultural (e.g. forms of knowledge; taste, aesthetic and cultural preference; language, narrative and voice); social (e.g. affiliations and networks; family, religious and cultural heritage) and symbolic (things which stand for all of the other forms of capital and can be ‘exchanged’ in other fields, e.g. credentials),” (Thomson, 2014, p.67). It is the combination of these different forms that Bourdieu argues determines the space an agent is able to occupy (Lovell, 2001; Thomson, 2014). Symbolic capital is immediately evoked when agents enter into a space, which then influences the agents’ perceived position within that space. Position is determined by the amount of capital that is “recognized in society at the time, and by the relative values placed on different configurations and volumes of those capital,” (Hardy, 2014, p.230). For Bourdieu, space is positional and positions in space can be available, recognized, or occupied (Bourdieu, 1989).

Capital therefore contributes to social space, but it is only one part of the explanation. It is our stance or predisposition that determines how we decide what space is available, recognized, or occupied.

Bourdieu’s major contribution is that he problematizes structure. He introduces a subjective and objective structure. Habitus helps inform various stances or dispositions, while field provides insight into objective social positions. Within the context of social
innovation, it implies that innovators would need to design initiatives that address *habitus* and field (Crossley, 2003; Hardy, 2014; Nash, 1999).

What Bourdieu is alluding to is that many things, conscious and unconscious, determine social reality, and those interested in activity that involves changing social order would need to be able to address these unconscious-influencing forces. As an example, midwives in both contexts held very little economic capital (money and assets). They were, however, able to leverage their social capital to mobilize resources. In my interviews in Trinidad, midwives would often tell stories of having delivered a baby for someone with considerable economic capital, and because they had a good experience, that person usually then became an advocate for the birth centre.

It is important to note that all the midwives in Trinidad were trained in other countries or had lived in other countries. Several midwives interviewed pointed out that they found it interesting that: “We are all foreign-trained: we’re all Trinis, but all foreign-trained. We were just out-of-the-box midwives, because we didn’t follow the system, we were not trained in the system,” (Interviewee 9). These midwives understood that another reality was possible. Being foreign-trained gave them credibility as a form of capital. Though they did not have a lot of economic capital, their other forms of it provided enough symbolic capital for them to be deemed trustworthy by potential funders. Symbolic capital refers to things which stand for all of the other forms of capital and can be “exchanged” in other fields, e.g. credentials. Each Trinidadian midwife I interviewed was an extremely good communicator, appeared to be middle class and had what could be interpreted as a middle-class Trinidadian accent. This could be interpreted as their also possessing considerable cultural capital. They could also point to their foreign training
and to examples elsewhere of how midwifery could be practiced. “Well, as you appreciate, all of us have trained abroad, been abroad, and lived abroad. So we come with an understanding of what we want to actually achieve, and all of us are very strong-minded women,” (Interviewee 7).

Bourdieu’s conceptualization of capital helps to reinforce Polletta’s (1999) notion of associated structures. Here space is not about the physical space, but about the relationships and socialization that occur in spaces/fields that play a significant role in the production of space. In evoking Bourdieu’s concepts of field and \textit{habitus}, we are able to further the conversation on space within the context of social innovation. Bourdieu draws on these concepts to explain how humans make choices. For Bourdieu, an agent’s activity, stance, or disposition is influenced by their embodied \textit{habitus}:

\begin{quote}
“an active residue or sediment of [the agent’s] past that functions within [the agent’s] present, shaping [the agent’s] perception, thought, and action and thereby molding social practice in a regular way. It consists in dispositions, schemas, forms of know-how and competence, all of which function below the threshold of consciousness: the schemes of the \textit{habitus}, the primary forms of classification, owe their specific efficacy to the fact that they function below the level of consciousness and language, beyond the reach of introspective scrutiny or control by the will.’’ (Crossley, 2001, p.82).
\end{quote}

\textit{Habitus} refers to the “structuring structure, which organises practices and the perception of practices,” (Bourdieu, 1984, p.170). \textit{Habitus} is the unconscious structure that statistically determines the choices actors make as they navigate the social world. It
“is ‘structured’ by one’s past and present circumstances such as family upbringing and educational experiences. It is in ‘structuring’ that one’s habitus helps to shape one’s present and future practices,” (Maton, 2008, p.50). These predispositions, tendencies or inclinations generate what Bourdieu refers to as structured and structuring structures (Bourdieu, 1977; 1990).

Midwives’ past and present experiences shaped how they practiced. Many of them could recount powerful past experiences explaining why and how they got into midwifery. They refused to practice as obstetric aides or nurses because their habitus shaped their future practices. In the interviews with one Ontario midwife, she described the experience that solidified her support for midwifery practice.

I went to prenatal classes in Ottawa with the intention of giving birth naturally. I had my first baby at the Grace Hospital in Ottawa. Straightforward labour, and I was in there struggling through contractions and the nurses were coming in and repeatedly asking me didn’t I want something for the pain, and there was no real institutional support at all for my intentions—and my poor husband—we were both twenty-two years old—as the contractions got worse he was overwhelmed, the anaesthetist was in the hallway and basically yelled outside my door, “If that woman doesn’t take an epidural now, I’m going home for dinner and she’s not going to get one at all.”

I had an epidural...I had the epidural, and an hour later I was fully dilated, ready to push, gave birth, forceps, episiotomy, on my back in the operating room, just like everybody was at that time, and it was 7:30 at night—and I can, forty years later, get teary about this—they took her away from me, they bundled her
up, let me hold her for a few minutes on the table, and then I asked when I was
brought to my room if I could see her, and I was basically told no.

And she was fine, there was no problem with her at birth, there was no
problem with my health, we were both absolutely low-risk normal. They took her
away from me and I begged them to bring her in to me, and it was like I was
forcing the rules to be broken and they brought her in to me, and she was bundled
and wrapped and all I could see was her little face and I hadn’t seen her whole real
naked body and hadn’t held her, and my husband had gone home. I just tentatively
unwrapped her and dared to look at her and I was so afraid I’d be caught
unwrapping her, and then I tentatively put her to my breast to try to breastfeed,
terrified and sweating that the nurse would come in and yell at me […]

My husband came in the next day, and I knew there were hippies in
California giving birth to babies, and he came in the next day and I told him if I
ever had a baby again I was having it at home, and the blood drained from his
face. (Canadian interviewee 2).

The cultural capital of this interviewee had shaped her cognitive influencing
structures so that she wanted to have natural birth. In a Trinidad example, one
interviewee recalled that after years of practicing abroad and finally deciding to return to
Trinidad, she found her experience in both the public- and private-sector hospitals to be
obstetric-centred, and not woman-centred. Her cognitive influencing structures drove her
to find a way to improve midwifery care in the country. As she recalled,
After having those experiences, I wasn’t going to stay, but then I thought, “This is my country.”

I’ve been welcomed in foreign countries all over the world, but here I am with my profession and being made to feel unwelcome by the way people were treating me, because I had a degree, because I had post-graduate qualifications they didn’t. There was that prejudice, because I had a very strong British accent because I went to England...Before I started nursing, I wasn’t of age to start nursing. (Interviewee 4)

Each midwife I interviewed held a cognitive frame that was shaped by her prior experiences, which strongly influenced how they practiced their craft. Additionally, because these women were trained as midwives, they perceived birth as something women were born to do. This stance determined how they practiced. One of the major theoretical contributions that habitus provides is an explanation of how human behaviour is regulated through our cognitive influencing structures, which then generates social structures and tendencies without relying on rules or prescriptions (Lehmann, 2007; Maton, 2008; McNay, 1999; Nash, 1999). These perceptions then influence the choices and the kind of risk an agent may be willing to take.

Management theorist Peter Senge (1990) makes a similar argument when he argues that structures influence behaviour, although Senge and Bourdieu are referring to different types of structure. Senge (1990) is usually referring to organizational structure, while Bourdieu is arguing that our experiences and perceptions structure the choices we make. Habitus does not only influence how we perceive or understand various forms of capital within our social world; it also influences our perceptions of these various forms
of capital and the kind of choices we are able or willing to make. For example, the midwives in Trinidad, before meeting their champion mother, did not think they were well positioned to make the birthing centre a reality. Specifically, they did not think they could access enough economic capital. “We thought, ‘Well, we don’t have the time, we don’t have the money, right? We don’t know what to do,’ and we kept saying this—and she just refused to listen. She just kept behind us, kept behind us.” (Interviewee 3.)

When I interviewed the mother, she recalled saying to the Trinidad midwives:

You all know all of this, and why have you all not done anything? And they’re like, “It’s really hard. How do we get funding? We need money,” and this and that. They just saw a big wall up against them, and I said, “You all!”—And this is my point, and this is always my point—“What we want to do and what we are going to do is God’s work. This is God’s work for God’s people. I am not mad...There are women out there right now asking for better...There are people experiencing horrible situations who are wanting more, so this is happening now for a reason...Don’t worry about how, the how is not our part. The how is His part. We need to do the work, we need to figure out who,” and that was my friend who worked at the UN, who knew how to write proposals. (Interviewee 10.)

This mother had blind faith, and believed the birthing centre was possible. Her interactions with midwives served as a sort of educational experience which altered her cultural capital. Social capital refers to her networks—a friend who knew how to write proposals and where to find resources, i.e. economic capital. This mother’s perception of what was possible was different from that of the midwives in the space, since she brought
with her a different combination of capital. She was able to convince the midwives that it was possible.

In Ontario, the stance midwives took was also determined by their context. Arguably, midwives happened to be very well organized at the right time (Bourgeault, 2006). An inquest in 1982 prepared midwives for the inquest in 1985.

They organized so that they would be many hands making light work. They organized to create submissions, they organized to lobby, they really networked very well through people that had proxy power or links with other social networks…some of their clients, new members of the Liberal Party that were in government at the time. (Ivy Lynn Bourgeault.)

Bourgeault (2006) argues that midwives found ways to mobilize resources so they could move their agenda forward:

A resource that they mobilized were midwifery clients, and people who had had midwifery care. They became a really strong and effective lobby effort as well. That’s another resource that midwives mobilized. They also mobilized evidence, international evidence for the safety and efficacy of midwives. There was a currency in resources that midwives mobilized in order to move the midwifery agenda forward. (Canadian interviewee 4.)

They had considerable social capital in the form of strong networks, which they formalized in starting their midwifery association and during the various inquests that had
happened. In many ways, midwives in Ontario took the offensive when it came to regulating their profession. Bourgeault (2006) argues that, at the time, most people agreed that midwives needed to be regulated and midwives knew regulation was coming. For Bourgeault (2006), what doctors and nurses did not predict or see as a possibility was that midwives would be regulated as a self-regulating profession. Consequently, midwives were better prepared for the regulation process. The task force drew on evidence from around the world to make a case for midwifery as a self-regulated profession (Eberts et al., 1987). They drew on their relationships with the ICM, their social capital, to find the best models in the world and used them as examples of the possibilities of midwifery and how midwives could serve women. (Bourgeault, 2006; Demming, 2015; Paterson & Marshall, 2011; Sharpe, 2001).

Capital and *habitus* are therefore intrinsically linked. For Bourdieu, position is determined by the combination of various forms of capital, while *habitus* refers to how we make sense of (interpret) these various forms of capital. From this Bourdieusian perspective, capital, *habitus*, and field operate simultaneously to produce practice. Although Bourdieu represents this relationship in the form of an equation 

\[ ((\text{habitus})(\text{capital})] + \text{field} = \text{practice} \]

(Bourdieu, 1984, p.84), Crossley reminds us that this representation is misleading, since the three bear no mathematical relationship to each other (Crossley, 2003). What Bourdieu is trying to convey is that practice is generated by the combination of actions, interactions and context, namely *habitus*, capital and field.

For Bourdieu, social spaces are relational and generative. *Habitus* and field co-exist with each other in a sort of circular relationship (Crossley, 2001; 2003). Social
reality is always producing new social dynamics through a structured and structuring process. Since *habitus* refers to cognitive structure, which is informed by the agent’s interpretation of capital, *habitus* and capital are thus the subjective elements of practice, while field refers to the objective components of practice (Crossley, 2003; Lehmann, 2007; Maton, 2008).

Bourdieu’s conceptualization of field is complex. In English it is easy to think of a beautiful meadow or field, which in French would be *le pré*. What Bourdieu is referring to is *le champ*, which is closer in meaning to an area of land, a battlefield, or a field of knowledge (Thomson, 2014). Bourdieu evokes several metaphors to explain his notion of field: a football field; the field that is often evoked in science fiction, a force field; or a field of forces, as is often used in physics (Thomson, 2014, p.67). In using the football field as an analogy, Bourdieu points out that players (agents/actors/institutions) are limited by what is allowed on the field, and what is allowed on the field shapes how the game unfolds. Players compete to accumulate the various forms of capital (social, economic, and cultural). In social fields, the field is not always even and well manicured. Players often start with uneven distributions of capital, which they use to their advantage (Thomson, 2014). Each field has its own rules, histories, star players, and legends, which shapes how the game is played out. Players who have more experience have “a feel for the game.” Bourdieu also uses the analogy of “a fish out of water”: players who are new to the game lack the “feel for the game” and “feel like a fish out of water” (Bourdieu, 1977).

Returning to midwifery, both midwife groups can be said to have been caught in a game with an uneven playing field. They were limited by the rules on the field, but used
those rules to move their agenda forward. Midwives in Trinidad registered as a non-profit organization and set up the only non-profit hospital on the island. They were able to mobilise traditional grant funding to purchase a building and start their birthing centre. Much of their work involves the game-playing Bourdieu refers to, as is evident in the comments of one midwife:

My approach is gentle...If I go to a meeting, I try to identify beforehand what they’re looking for. I don’t push any buttons, but I am very firm. I’ve gone to a meeting at the public institution with the doctors who said we could no longer send patients there.

Now, legally, they can’t do that. As a public institution, they have to accept whoever shows up. They’ve tried many different things, but I have really sat and thought through what they could try. (Trinidad interviewee 3.)

One Canadian interviewee stated that the midwives were skilled at game-play. Sheryl Nestel (2000a) argues in her book that Ontario midwives were extremely successful at game-playing. Her book questions the ethics of this game-playing, and the unintended outcome it had on immigrant women and women of colour. In her interview she stated:

The way midwives had to groom themselves, and present themselves, and the image that was necessary in order to get buy-in from the doctors, buy-in from the government—they had to present themselves as very, very reliable, educated, intelligent, bourgeois, if I may. There’s a certain way of presenting themselves that was very important. That was absolutely necessary. It was a trade-off. The
people who actually became most—what’s the word I’m looking for?—most influential were those who were leaning more toward looking like doctors. In other words, professional.

They wanted to weed out people who were too hippy. There were all kinds of white people that were not welcome on the voyage...the number of women of colour who were excluded and not allowed to go through the process was so massive. There were just so many of them. Then you ask yourself, is that really worth it?

In the quote above, the midwives were using their social and cultural capital to appear more professional. Bourdieu’s various forms of capital help us to see how the midwives were using them to play into existing social structures, deliberately performing professionalism as a game-playing strategy that moved their agenda forward. Nestel (2000b) convincingly argues that this game-play came with a trade-off. Midwives successfully advocated for a self-regulated, publicly funded midwifery model of care and were able to integrate midwifery into the existing public health-care system. But many who were excluded happened to be immigrants and people of colour. Nestel (2000b) attributes this to the requirement that midwives needed to have been practicing during the years when midwifery was alegal. The group who were least likely to be practicing under these precarious circumstances were immigrants and midwives, thus implementing a system that gave women choice of birth, but did not include immigrants and women of colour in the first round of midwives who were regulated.
For Bourdieu, in these game-playing sites, or sites of struggle, both groups were competing for power. How these midwives improved their social position was by playing the system.

Bourdieu’s second metaphor for “field” refers to the science-fiction notion of forcefields. Forcefields create boundaries as barriers for those who are inside versus outside their lines. They are designed to protect those inside the field from events, dangers, or threats outside the field (Thomson, 2014). Each field has its own “logic of practice,” its own set of beliefs, where some people are dominant, while others are dominated. These fields are not controlled by an authority figure, as they would be on a spaceship; instead they emerge through processes of co-construction and influence. They help agents rationalize their assumptions—what Bourdieu refers to as the doxa, the rules of the game. These assumptions allow agents to explain away the oppression of others, or the social reality in the field, as being normal or natural.

It is important to note that agents may simultaneously occupy more than one social field. These different fields generate “fields of power” that tend to include or exclude various actors similar to the way in which a force field might include some while excluding others. These social spaces often emerge based on agents’ capital, where agents with similar capital combinations tend to belong to similar fields of power.

Returning to Sheryl Nestel’s (2000a; 2000b) argument, for the midwives who were at the centre of the decision-making, their doxa helped them rationalize the choices they made, which ultimately secured the fate of midwifery as part of the public health-care system. The new registration system would include a requirement for midwives that had been practicing in Canada for a specified number of years. This meant that only
women who could take the risk of being arrested could practice. Not only were immigrant midwives risking jail time, they were also risking deportation, if they were charged with illegally practicing medicine. Immigrant midwives could not take that risk. Nestel argues that some of these midwives were well qualified and had significant experience as nurses and midwives (Nestel, 2000b). It is important to note that different midwives would have different conclusions about this particular history of the Ontario midwifery movement. Ivy Lynn Bourgeault, in her documentation of how midwifery emerged within Ontario, presents a story that seem to support Nestel’s interpretation of how immigrant midwives were marginalized (Bourgeault, 2006; Bourgeault et al., 2004; Bourgeault & Fynes, 1997; Bourgeault, 2006).

When I interviewed Sheryl Nestel, she stated:

In retrospect, after thinking about it for all these years, I absolutely believe that midwifery would not be where it is today had they not employed those strategies, for better or for worse. Those strategies were necessary for them to get to where they are today.

Were they the most ethical strategies? Absolutely not.

A counter-narrative that emerged in my own research came from my conversation with Holliday Tyson, the director of the International Midwifery Pre-registration Program at the Chang School, Ryerson University and of the Chang School Simulation Lab for Health Professionals.

If you look at the people who were the internationally educated midwives who were rejected, ninety-nine per cent of them were nurses who hadn’t practiced here, and who didn’t want to do home births. At the time, and to this day, one of
the issues, fundamentally [...] we want to have people fifty years out or even five years out, people who we don’t think we’ll have problems with...you had a group of people who identified as nurses and professional midwives, who if anything really looked down on that group, they were totally ragtag. Some of those people did apprenticeships with doctors. Some of those people...they’re not nurses, they’re not all of those things, and so they were outraged that they couldn’t just go, “I have a license for midwifery from England. I should just be in.”

Instead, we said, “There’ll be a path for you to be in, but you’re going to have to do home births like everybody else.” They were saying, ‘What? I don’t want to do home births. I want to do shifts in a hospital like I do now.’

And—and this is a really important thing to understand—they were good union nurses, every one of them. Not a few, pretty much every one of them. One of the things, quite rightly, was they wanted to be guaranteed that whatever process they did, they could stay at at least their pay grade, and there was no system for any of that.

[...It is] especially interesting to me to find how hard it is amongst groups of people talking about access to find people who actually support doing things like letting people in who don’t have degrees—and yet that is the single most important thing if you want to provide access for people all around the world. That simple thing, do you know what I mean? To not punish people who don’t have money and who don’t have access.

That’s why I look always two or three times at those kinds of claims, because it’s understandable when people are angry and they talk about their
stories, to take that at face value and then go, “Oh, well, that’s obvious. There was a clash. A group of white people invented this, and then, blah, blah.”

But honestly, it was a ragtag group of people who were looked down on mostly by the people who wanted to come in, who had no commitment to doing things like home births or anything, and in fact, many wanted to work directly under a physician’s supervision. (Canadian interviewee 4.)

This interviewee paints a very different picture from Nestel. Midwifery had made a commitment to multiple routes of entry, which meant people with and without degrees could participate in a bridging program that allowed them to become licensed practitioners. *Doxa* allows people to explain social realities they see in the field, and both Tyson and Nestel have an internal logic that have led them to their personal conclusions.

Bourdieu’s theory of social spaces positions agents as being interdependent and non-autonomous, while allowing for the possibility of change by individuals and institutions. Through these various sites of struggle, change is both possible and unpredictable, as agents game-play on the basis of their various combinations of capital (Bourdieu, 1984; Hardy, 2014). This conceptualization still provides the “possibility of ‘free play’ in fields, or that are events in adjacent fields (demographic change, new technologies, global crises, natural disasters and so on) could also provide change within them.” (Thomson, 2014, p.72).

Bourdieu makes a distinction between subjective spaces and objective spaces. For Bourdieu, subjective spaces refer to the *habitus*—an individual’s stance or dispositions. Subjective space refers to the cognitive influencing structures that affect everyday
choices or practice. Stance also provides individuals with the capacity to understand and interpret their objective spaces. Objective space, for Bourdieu, refers to field. Field and *habitus* exist in relation to each other.

Another way to think of field or objective spaces is to think of them as referring to position—“all recognizable and thinkable positions with their varying degrees of legitimacy,” (Hardy, 2014, p.232). Bourdieu describes space as social positioning (Hardy, 2014). For him, “the space of symbolic stance and the space of social positions are two independent, but homologous spaces,” (Bourdieu, 1990, p.323). These spaces coexist in a complex relationship with each other. Changes in one can generate changes in the other. They are simultaneously interrelated and independent. Individuals and institutions are simultaneously interrelated and independent.

This conceptualization of space as being dynamically linked between subjective and objective structures provides Bourdieu with a mechanism for both analyzing and explaining change. Within the context of social innovation, a Bourdieusian perspective provides considerable insight into the theorizing of social innovation. For example, three of Bourdieu’s main contributions add to the theorizing about social innovation: 1) the notion of playing a game or having a feel for the game; 2) the notion of sites of struggle or contest through an understanding of what is at stake; and 3) an understanding of forces as existing within analyzable bounded fields that can be mapped (Hardy, 2014, p.231). Those involved in generating the conditions for social innovation need to develop a feel for a game that is likely to be unfamiliar to them. Social innovation is likely to occur at sites of struggle as agents position themselves to accumulate various combinations of
capital. These combinations provide agents with various social positions or contribute to how others in their context interpret their social positions.

Bourdieu’s major contribution is that he problematizes structure, introducing a subjective and objective structure. *Habitus* helps inform various stances or dispositions, while field provides insight into objective social positions. Within the context of social innovation, it implies that innovators would need to design initiatives that address *habitus* and field. One of the major criticisms of Bourdieu is that he places significant emphasis on *habitus*, which implies an almost deterministic interpretation of it (Crossley, 2003; Hardy, 2014; Nash, 1999). What Bourdieu is alluding to is that many things, conscious and unconscious, determine social reality, and those interested in activity that involves changing social order would need to be able to address these unconscious influencing forces.

Bourdieu’s notion of *habitus* is just one of the many he proposed. He offered his concepts as a relational theory, with each contributing to an overall theory of practice. Bourdieu’s concept of *habitus* provides great insight into the conceptualization of stance within a substantive framework of social innovation. For example, from the conceptualization of social innovation, I propose that social innovations arise when we observe a change in paradigm (*habitus*), resource flow (capital), and social interaction or agency within a social context (practice).

Practice, for Bourdieu, is an effect of actions and interactions which are shaped, simultaneously and in equal measure, by the *habitus* and capital of agents, as well as the context and dynamism constituted by their shared participation in a common “game” or “market” (field) (Crossley, 2003, p.44). Practice is also influenced by two additional
Bourdieusian concepts: *illusio*, belief in the game, and *doxa*, the rules of the game, or “the assumed and unquestioned postulates or axioms taken for granted by all the players of the field,” (Hurtado, 2010, p.55). These three concepts, *habitus*, *doxa*, and *illusio*, help to conceptualize the role of stance in the substantive conceptual framework that emerged. For example, midwives within both contexts understood the rules of the game, the *doxa*, and played the game very successfully to transform their practice (see p.140). They believed that there was a game to be played (*illusio*) and if they were to transform their practice, they would need to be able to influence the rules of the game.

Midwives in Trinidad, after being nudged by a mother, embarked on their own journey to create a space where they could make the rules. They understood that because they are not as protected by the rules and policies, they need to be gentle yet firm.

We have to do the “softly, softly” thing very much with the medical profession here, because we need to maintain good relationships with them. […] other members of the board spent quite a bit of time making sure that people understand what we do, how we do, why we’re doing it. And even ten years on, we still have to do that, because of staff changes, and you’re dealing with different people all the time. (Trinidad interviewee 7.)

In Chapter 5, I explained hidden transcripts and referred to a Jamaican proverb, “Play fool to catch the wise” (Scott, 1990) to refer to the games midwives play in free spaces. Similarly, the Bourdieusian concept of *illusio* refers to a belief in the game. In the quotation, the midwife states, “We need to maintain good relationships with [the doctors]” (Trinidad interviewee 7). What she means is that for midwives to have a
successful birth centre, they need the support of the medical system. When midwives are well integrated into the existing medical system, the outcomes for mother and child improve significantly (Villar et al., 2006). In Trinidad, since the midwives were not officially supported by the medical system and by law hospitals are not allowed to turn away patients, these midwives need to play the system a little. They need to find allies within the existing medical system to get hospitals to co-operate with them when and if they need to transfer a mother to a hospital. The midwives needed to keep the doctors on their side. Hence they needed to push gently. They confronted the medical system while remaining friendly. Since they articulated this gentle pushing, it is clear that they believed in the game; they believed in the illusio.

Similarly, doxa refers to “taken-for-granted, preconscious understandings of the world and our place in it that shape our more conscious awarenesses,” (Ritzer & Stepnisky, 2011, p.373). In Trinidad, midwives are challenging the assumption that all births should happen in a hospital. The Canadian midwives put forward a similar challenge when they moved towards regulating midwifery (Bourgeault, 2006). In Chapter 4, I outlined how these assumptions were challenged.

Both groups of midwives understood and believed in the rules of the game. In conceptualizing stance, one can think of stance as being habitus + (doxa) (illusio). Stance = (cognitive influencing structures) + (the rules of the game) (a belief in the game). Bourdieu (1984; 1990) argued that the social world comprises various spaces or fields, habitus being the dispositions one brings to the game, which are influenced by personal history (Crossley, 2003; Nash, 1999), doxa referring to the rules of the game, and illusio
being a belief in the game. These three subcategories of stance have much to contribute to a conceptual framework of social innovation.

Social innovations attempt to change our social interactions, which means we need to reconfigure existing power relations. In privileging habitus, illusio and doxa, we explicitly ask three questions related to each of these Bourdieusian concepts. Habitus inspires us to ask, what cognitive influencing structures currently enable or disable our practice? Illusio inspires us to ask, what game do we believe in? Does this game exist? Doxa asks us to explore the rules of the game and what new rules would bring forth the world we are hoping to create. These Bourdieusian concepts help inform the emerging substantive conceptual framework of practice, by providing us with practical approaches to addressing the concept of stance.

It is important to note that Bourdieu (1984; 1990) recognized fields as sites of struggle, where agents struggle for the accumulation of capital. Agents make choices about whether to participate and how to participate, based on their perceptions of capital, which then determine their social position (Bourdieu, 1984; 1990). Habitus provides an explanation for both reproduction and transformation of social life. Doxa and illusio provide us with an analytical frame from which we can explore the practice of midwifery (Bourdieu, 1977; Crossley, 2003; Thomson, 2014). Habitus is both structured and structuring, a product and producer of social worlds. It captures both the embodied-performative aspect of social structures, and the mechanism whereby they are transmitted across generations and through historical time. The habitus, to borrow a metaphor Bourdieu himself uses, contains the “genetic information” which both allows and
disposes successive generations to reproduce the world they inherit from their parents’ generation (Crossley, 2003, p.43).

**Exploring the empathic stance**

The third major theme related to stance I labelled as empathy. Throughout the interviews, midwives would frequently make reference to women’s right to choose how, where, and in what position they gave birth. The midwives I interviewed repeatedly make comments similar to this:

> I think the primary thing is choice and respect. Primarily choice: then you have a choice of position for birth. You have a choice of water or not. You have information. We share. We discuss things with you. You’re involved in your decisions. (Trinidad interviewee 3.)

Midwives stated things like, “For me nothing happens without asking the woman first, ever. It’s just drilled through me,” (Canadian interviewee 2). Midwives take the position that “the woman is in control and we are just there to assist,” (Trinidad interviewee 8). One of the most instructive quotes came from the Trinidadian mother I interviewed: she explained that she was asking her doctor at the time how he felt about natural birth, and he responded, “I don’t like to see my women in pain,” (Trinidad interviewee 10). She responded, “Well, doctor, the strange thing is that I am not your woman. This is not about you. This is about me, my body and my child,” (Trinidad interviewee 10).
Midwives adopted a woman-centric view: everything they do is so that the mother has a positive birth experience.

When a woman could look back at that birth as a positive experience, it makes a huge difference with the relationship she has with that child and how she raises that child, and growing up and stuff. (Trinidad interviewee 3)

I labelled a sub-code of the stance theme “a woman’s right to be able to choose.” This was the most common sub-code within the theme. In the proposed social innovation framework, stance serves as a passageway to the change in paradigm that is needed if we are to generate social innovation. The belief that women should be able to choose how and where they can give birth, coupled with the belief that women were born to give birth, greatly influenced the choices women made as they struggled for the right to choose how they wished to give birth.

Stance was immediately visible when midwives described how they understood birth, in contrast to how physicians viewed birth. Midwives saw birth as something women were born to do, while they claimed that physicians saw birth as a medical procedure to be managed. Two quotes from the Trinidad midwives highlight how stance determines practice.

For some reason they seem to feel that we will interfere with their management of the patient. As I said before, a lot of the times they tend to think that you [a mother] are not going to be able to do this vaginally, naturally. That the slightest thing that might appear, they will say, “Okay, no, you are going to have a C-section.”
Whereas, if the client comes to us for classes or so, we will then go through bit by bit what might happen, what should be the response of the obstetrician, in what ways can we deal with the situation, instead of just going straight to say, “C-section.” (Trinidad interviewee 2.)

We look at a pregnant woman and we see “normal,” because it is a normal physiological process... The obstetrician would see, “Well, okay, she’s in early labour. Let us intervene and hasten the delivery,” so they may want to go in now, rupture membranes, put in whatever to hasten the contractions, put up [a] drip until the contractions come quick and they took out the baby quickly.

We will see that there is nothing wrong, she’s quite normal, leave her alone. If she takes a day, then that’s okay. Leave her alone, let her go the normal process.

They would see: “Patient,” and think, “Let us get this out.” We would see a woman in labour. (Trinidad interviewee 8).

An illustrative example of how stance influences practice can be revealed in a story told by a midwife I interviewed. This midwife described how midwives used to do breech births, but because of fear of litigation, there has been a standardization of how breech births are managed. A breech birth is when the baby is born bottom first instead of head first. Prior to birth, practitioners are usually able to tell if a baby is in a breech position or not. In today’s world of litigation, it is common practice for doctors to suggest
a caesarean section if they know a baby is in a breech position. One midwife described how in the past, midwives would be trained to assist with breech births.

We were able to do breech births without it being a problem. These days, midwives are not allowed to do it because we are not doing breech births vaginally. […] There’s something called “hands off the breech” that we say: “So hands off the breech.”

The thing is, in every birth, the baby knows what to do […] With a breech, the danger is that you go and try and help. (Trinidad interviewee 2.)

The story above reflects a practice that is very difficult to adopt. The midwife describes an activity that involves a considerable amount of skill, yet without her belief in natural birth, it is easy to interpret her action as something that involves a considerable amount of risk. She claimed that physicians are not trained to deliver breech births, which implies that they hold a stance that breech births are to be delivered by performing a caesarean section. By contrast, her belief that the baby knows what to do guides her action. Within the context of modern medicine, and in the midst of a dominant narrative that subscribes to evidence-based practice, her faith in the baby could easily be framed as being a radical or reckless approach to birth.

The response adopted by most hospitals is to standardize the response to birth, so that for all breech babies doctors schedule a caesarean section. This homogenizes the experience and reduces the risk of litigation. In our society, we rarely, if ever, regard newborns as the authority. Adults make decisions and are in control, so to propose a process where an adult follows the lead of a newborn, in such a significant activity, is a
radical suggestion. This midwife’s faith that the baby knows what moves to perform during birth, and all the midwife has to do is be there to guide the process, is a radical stance. Something about her past has brought her to believe that she can deliver breech babies.

Framing a birth practitioner as someone who assists with birth is a completely different stance from “delivering a baby.” Stance plays a major role in influencing the kinds of choices birth practitioners make. The way stance influences these choices is evident in many of the comments made by midwives.

There are so many little nuances that happen. You will go to a doctor and tell them, “Okay, I want to do childbirth classes,” and they would say to the client, “Oh, no, you don’t need to do that. When you come in and labour we will tell you what to do.” Just little things like that that really undermines, I think, the client’s confidence. They will come and say, “Oh, well, we went and they said we don’t need to do classes. That you don’t need to go to a midwife.” That kind of thing. It happens all over the place. All over the place. Some worse than others.

There are some doctors that you will go to who will tell you up front, “If you’re going to a [midwife] to have your baby, I am not going to be involved.” I do childbirth classes and I have a lot of clients who will come to me and say, “I come and I told my doctor I wanted to go there, and they would say things like, ‘No, no, no, don’t go there. That place doesn’t have doctors, and babies might die there,’” and that kind of thing. (Trinidad interviewee 2.)
The quotes above from the Trinidad context demonstrate that there are high levels of tension between physicians and the midwives. The midwives viewed the doctors as allies, while the doctors viewed the midwives as unprofessional practitioners.

Midwives in Ontario also had similar experiences when their stance on birth contradicted or contrasted with medical practitioners’. One Ontario midwife recounted an experience she had at one birth.

We were at [the hospital], where the obstetrician was a young gal, really tightly wound, highly interventionist and irritable, new out of school. […] I’m thinking, “Damn, she’s on call.” So I went and I had a chat with her, and I said, “I’m with so and so, she’s having her baby, I might be calling on your services later. Just to let you know everything is going great, but I just thought I’d kind of fill you in a little bit just so you’re not surprised.” I said, “Everything is going great, but my client is feeling blah-blah-blah, blah-blah-blah, emotionally.”

The obstetrician looks at me like I’ve got three heads, like I just landed from some other solar system, and she said, “How do you know that?”

I said, “What? How do I know that? How do I know what?”

She said, “How do you know how she feels emotionally?”

I was completely dumbfounded. I said, “I asked her.” […] The fact that emotions could affect the birth was completely outside the realm of this OB’s understanding, but the fact that I had this connection with my client, and I asked her about her emotions was like a whole other… and I thought, “Okay…”

Thank God, I never had to call on her, but it was like, wow, the divide was really huge. (Canadian interviewee 9.)
Stance influences practice in subtle and profound ways. The quote above suggests that for the medical practitioner, birth is a non-emotional procedure, a routine. “With good medical care, we can ensure a successful delivery.” For the midwife it was, “If I am able to create a safe emotional cradle for the mother, then her birth experience would be greatly improved.” Understanding the complexities of the situation, the midwife decided to help make the obstetrician on call feel comfortable she was creating emotional space for the two people.

This is the same midwife who made the comment about needing to create emotional space by learning to enter a room “quietly.” She described holding emotional space as something that “requires an ability to be mindful, to be present, in the moment, and any emotions that are bubbling up in me, to be okay with that,” (Canadian interviewee 9). She later went on to explain that when she is assisting with birth she holds the stance that:

I’m here to serve, and I’m here to help you in whatever way you need. In order for me to know what you need, I need to be clear, be observing, be noticing, and in order to do that, my entrance—it’s like you can jump into a pool, or you can just, like, slip in, and you want the ripples to be as minimal as possible.

(Canadian interviewee 9).

From my research, this stance is very different from those of medical practitioners. These quotes demonstrate how different stances influence the practice of
birth, and frame the sites of struggle between midwives and the larger medical profession.

It should be noted that around the time of regulation in Ontario, midwives recalled similar tensions between physicians and midwives. In 1981, the College of Physicians and Surgeons of Alberta banned physicians from providing backup to midwives (Bourgeault, 2006). Doctors were not always supportive of midwives in Canada, since they held very different stances on how birth should be practiced (Bourgeault, 2006).

Until 1974 the profession of midwifery was written into the license to practice medicine in Ontario, but doctors, because they didn’t value it, had gotten rid of it. If they had maintained it we would have been in an illegal profession. (Canadian interviewee 4).

Revisiting stance and the data that emerged

In making the observation that stance profoundly influenced practice, I revisited the data. The theme stance comprised twenty-three code members. Of these, the most prominent was “a woman’s right to be able to choose.” There were several other members of that theme that also help to inform the decision to position stance as a dominant theme in the emerging theory of social innovation.
Table 7.4. Categories that comprise the theme stance.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Members of the theme</th>
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<tbody>
<tr>
<td>Stance (gaze or perspective)</td>
<td>- Activism: self-identifies as an activist</td>
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<tr>
<td></td>
<td>- Empathic stance</td>
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<td></td>
<td>- Systems approach to care</td>
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<td></td>
<td>- Professionalization of the field</td>
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<td></td>
<td>- Public perception of midwifery</td>
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<td></td>
<td>- Gaze or perspective</td>
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<td></td>
<td>- Tension between physician/doctor and midwives</td>
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<td></td>
<td>- Education as an intervention strategy</td>
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<td></td>
<td>- Champion for midwifery</td>
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<tr>
<td></td>
<td>- A woman’s right to be able to choose</td>
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<td></td>
<td>- Women are disempowered</td>
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<tr>
<td></td>
<td>- Empowering midwives</td>
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<td></td>
<td>- Physician/doctor-centred</td>
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<td></td>
<td>- Mutual respect between midwife and physician/doctor</td>
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<td></td>
<td>- Disempowering midwives</td>
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<td></td>
<td>- Obstetric violence</td>
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<td>- Social-justice stance</td>
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<td></td>
<td>- Resistance strategies</td>
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<td></td>
<td>- Faith and belief in a better future</td>
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<td></td>
<td>- Obstetrician gaze</td>
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<td></td>
<td>- Midwife gaze or stance</td>
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<td></td>
<td>- Reframing of a stance</td>
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<td></td>
<td>- Fathers can be present at birth</td>
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Somewhere at the core of the midwifery stance was an approach to health care that I labelled as the empathic stance. Krznaric (2014) in his book *Empathy: Why It Matters, and How to Get It*, makes the distinction between the golden rule and the platinum rule. The golden rule refers to doing unto others as you would have them do unto you. The platinum rule, however, refers to doing unto others as they would like done unto them. There is a slight distinction here, and it seems to reflect a component of the
midwifery stance. Midwifery held a deep commitment to doing unto others as they would have done unto them, not as you would have done unto you. Some women would like to have an epidural, while others want to have natural childbirth. Midwives do the work to determine what mothers mean by natural childbirth.

Natural can mean five different things to five different people, which people don’t understand, that their definition is going to be different than everybody else’s definition. “Natural” can mean just vaginal, “natural” can mean no medication, period. “Natural” could mean no medicines to augment delivery, “natural” could mean water birth. “Natural” could mean a million things. (Trinidad interviewee 5.)

MacDonald (2008) outlines in her book how the word “normal” can mean different things to different women. Women who need to have an intervention can at times feel like failures or that their bodies were not strong enough to give birth naturally. The natural-birth discourse, she argues, can be psychologically damaging. The empathic stance, when applied as “do unto others as they would like done unto them,” allows women to choose the option that they feel most appropriate for them. Midwives argue for choice. Interventions should be used appropriately and women should be able to choose if they would like to have an epidural or not. Women who have a vaginal birth, but with an epidural, should not be made to feel as if they had an unsuccessful birth. MacDonald’s (2008) thesis is that women should be able to self-define their own birth.

When the physician stated he “did not like to see his women in pain,” it meant that when he thought a woman was in too much pain, he would intervene to try to
alleviate her pain. Some women want to remember their birth experience and prefer to experience the pain than to have a doctor decide what is appropriate for them. The midwifery stance is that women must be empowered to make decisions that they are comfortable with.

Midwives allow mothers to have a lot more say in how they deliver, the position they deliver in, the room they deliver in, the light level—everything else. They give parents choice.

When you deliver in a hospital, whether private or public, we do not get choice about how you deliver.

They [midwives] empower the mothers. (Trinidad interviewee 8.)

Another Trinidadian midwife stated,

All women in Trinidad and Tobago in hospital deliver on their backs.

Whereas as a midwife, we learn that gravity, change of position, helps a woman deliver faster and sometimes easier in terms of pain control. They have more control, we learn that they have more control, and so we want to get them to walk and to stoop and to bend—and as a midwife in hospital, we don’t have that autonomy. (Trinidad interviewee 2.)

Assuming that the above quotes are reflective of how women are treated throughout the hospitals in Trinidad and Tobago, then the empathic stance that midwives adopt would have an impact on the practice of birth throughout the country. Research in other contexts suggests that giving birth on your back is not optimal for pleasurable
experiences (Donald Chan, 1963; Dundes, 1987; Gupta & Nikodem, 1996; Gupta, Hofmeyr, & Smyth, 2004; Priddis, Dahlen, & Schmied, 2012).

Another observation that emerged in the data, which also informed the empathic stance, is that many midwives were also consumers of birth. They were mothers. I initially labelled this theme as “ethnographic insight”; what I was trying to capture was that when midwives were designing and thinking about how mothers should experience birth, since some of them were once the end users, they were designing from the perspective of the end user. Midwives adopted the stance that what they were developing was for the expecting mother to be as comfortable as possible. Interestingly, their stance included empowering mothers to make the best choice for themselves. Their stance tried not to impose, but to inform. They would provide mothers with the information, and whatever decision the mother made, they had to respect that decision.

What’s the information? You need to make a choice. Your choice might not be to come here [the birthing centre], and that’s okay. That choice must be based on information. It mustn’t be because you think there is no other option, that you have to go to a hospital. You must make that decision consciously and with information: “I understand that this option is available. However, I’m still choosing to go to a hospital.” (Trinidad interviewee 3).

Midwives support a woman’s choice of birth even if it is not to use a midwife. “I don’t sway people away from their choice of medical. If they want to go medical, they get information—but the information very often makes them change their mind about going medical and coming here,” (Trinidad interviewee 9). For midwives, “nothing
happens without asking the woman first, ever” (Canadian interviewee 2), and it is this that informs what I have defined as the empathic stance.

Discussion on stance

The social innovation stance as I have conceptualized it refers to social innovation adopting a complexity stance, exploring various combinations of capital that produce *habitus*, understanding the rules of the game and engaging in empathy with the end user.

If I were to model stance as an equation it would be something like:

\[
\text{stance} = \text{complexity} + \text{habitus} + (\text{doxa}) (\text{illusio}) + \text{empathy}
\]

By definition, usually when we refer to social innovations, we are addressing complex problems. Simple and complicated problems, because they are more knowable, are often easier to address. Problems that reside in the domain of chaos are usually crisis scenarios. So holding a stance of complexity is helpful for generating social innovation. Bringing a complexity stance to social innovation gives us the agency to identify the domain in which the problem resides. Being able to determine which aspects of a problem are complicated and which are complex allows agents the capacity to break problems that look like intractable messes into complicated but more solvable clusters.

For example, midwives in Ontario were able to generate social innovation by accomplishing a series of complicated activities:

- 1985: Toronto island inquest into the death of baby Daniel McLaughlin launched midwifery into the public spotlight. The parents of baby Daniel openly support midwives.
Midwives gain the support of pro-life and pro-choice groups. Health Profession Legislation Review (Ontario) recommends that midwifery be regulated

- 1987: Midwifery Task Force (Ontario) submits its final report
- 1991: Midwifery Act makes the practice of midwifery legal in Ontario
- 1991: Association of Midwives (Ontario) secures liability insurance for practicing midwives
- 1993: Midwifery is publicly funded in Ontario
- 1993: Midwifery Act in Ontario proclaimed
- 1993: Transitional Council of the College of Midwives, Ontario is formed. Midwifery education begins at Ryerson, McMaster, and Laurentian Universities
- 1994: Ontario midwives gain privileges in hospitals

To achieve these goals midwives understood the rules of the game, believed in the game and played it (doxa) (illusio). They leveraged their various forms of capital (habitus) and drew on an empathic stance to help shape how they would design space for mothers to give birth. Stance is a complicated component of the framework, but it is valuable in understanding how we create the conditions that generate social innovation.

**Autonomy and interdependence**

The third major theme that emerged from the data referred to the autonomy versus interdependence of midwifery. From the data, the midwifery model of care proposes appropriate use of scope. In this model midwives work with doctors. Midwives assist with low-risk births, while physicians manage—with the support of midwives—all other
births. During the regulation of midwifery in Ontario, the task force explored how midwifery was practiced around the world. From their extensive research into how other countries practiced midwifery, they concluded:

Midwifery care [was] most effective when midwives can practise autonomously through their full scope of practice and when midwifery is recognized as an independent profession. Midwives must be permitted to take responsibility for the management of their clients’ care; they should not be used as extended-role nurses or physicians’ assistants. (Eberts et al., 1987, p.12).

This finding framed how midwifery would be implemented in Ontario. Midwives in Ontario worked hard to ensure that they were allowed to practice as self-regulated independent practitioners. Today, research continues to suggest that in contexts where midwives are self-regulated, function as independent practitioners, and are allowed to practice autonomously through their full scope, they are most effective (FCI, 2014; Sandall et al., 2015; UNFPA, 2014). A recent report by the National Health Service in the United Kingdom (NHS), “Intrapartum Care of Healthy Women and their Babies,” recommended that forty-five percent of all births should be attended to by midwife-led units (Nunes et al., 2014).

Midwives guard their autonomy closely. The two cases explored in this thesis exhibit a major herstorical differentiator. As a reminder, in Trinidad, the Medical Board had regulated midwives since the early 1800s. Since then, the medical board has regulated midwifery throughout the island.
The herstory in Ontario is very different. “Until 1974 the profession of midwifery was written into the license to practice medicine in Ontario, but doctors, because they didn’t value it, had gotten rid of it. If they had maintained it we would have been in an illegal profession.” (Canadian interviewee 4.)

Until the 1990s, midwifery in Ontario was not regulated. This difference in herstory has in many ways predetermined midwifery practice in both countries. Midwives I interviewed in Trinidad attribute their lack of autonomy to the culture in the hospitals, where midwives are not allowed to take full responsibility for their clients, and operate as obstetric assistants. This dynamic limits their scope of their practice, since the medical practitioners’ perspective on birth is very different from that of midwives. This theme of autonomy versus independence also overlaps with stance. Midwives need their autonomy because their stance informs their practice. Without autonomy midwives often find that their practice becomes that of an obstetric nurse, where they are not allowed to practice within their full scope.

The research suggests that when midwives are autonomous self-regulated practitioners, this produces the best outcomes for the mother and her newborn (FCI, 2014; Sandall et al., 2015; UNFPA, 2014). Midwives interviewed in both contexts acknowledge that they are very dependent on the medical system for support during birth. The midwifery scope ends when births require medical interventions. They were very happy to refer births that were outside their scope of practice to a physician or obstetrician.

At the same time, the themes of autonomy and interdependence exist in tension with each other. Midwives cannot be completely autonomous, yet they require autonomy
to practice. For example, one interviewee stated, “There are clients that we don’t suggest have their babies out of hospital. They need to be in an institution with access to an operating theatre, or an intensive-care nursery for the baby and all of that,” (Trinidad interviewee 3).

Another interviewee suggests that:

The argument is that normal births are the purview of the midwives. When birth goes from the normal to the abnormal, the midwife then calls in the obstetrician. That is the role of the obstetrician, to treat with birth that has gone from the normal to the abnormal. (Trinidad interviewee 4).

Midwives in these interviews were very clear about where their scope ended and where that of the physician or obstetrician began. Midwives were dependent on the medical systems despite practicing autonomously.

Discussion on autonomy versus interdependence

In my master’s-degree work I drew on complexity theorist Ralph Stacey and the work of Norbert Elias and Pierre Bourdieu to argue that agents are only as free to act as their social ties allow (Bourdieu, 1984; 1990; Elias, 2000; Stacey, 2010). I argued that within the organizational-change literature, authors have stated that the success of organizational change depends on empowering agents within these organizations to bring about change (By, 2005; Field, 1997; Schein, 1997). Stacey (2010) argued that our social ties both enable and constrain practice or agency. Humans are never truly free to act as
they like without risking being ostracized. Activity is always moderated by existing norms, rituals and social ties.

Elias (2000), for example, argues that manners first evolved at the individual level. Social elites first adopted control of bodily functions like spitting, urinating, sex, and eating. As elite circles became more civilized by controlling their bodily functions, other groups began to adopt these behaviours. As it became less socially acceptable to belch in the face of company, these social norms or expectations began to both enable and constrain behaviour. If one were to belch when first meeting the parents of a new girlfriend, this would be frowned upon. The history of etiquette demonstrates how, although agents are free to belch in the company of their future in-laws, we are constrained by the social norms within our society. So although we are autonomous, we are interdependent.

Bourdieu (1989) argues that social position or mobility is predetermined by access to economic, cultural and social capital. Agents within a system are usually caught in a game, or struggle for power. These struggles are usually an attempt to access more capital. Our lived history and past experiences (habitus) determine the types of action we are willing to take in the world. Agents with the best access to various forms of capital are most likely to take advantage of them. These perceptions or beliefs, for Bourdieu, both enable and constrain agents within social arrangements. For these authors, human agency is enabled and constrained by our perceived autonomy and interdependence within these social arrangements. In Bourdieu’s notion of free play, Thomson (2014) reminds us that although agents are constrained by their social ties, they are not powerless; they can influence how activities unfold in the field. Thomson (2014) uses the
notion of “free play” to argue that although agents are not always conscious of the structures that influence their choices, they are at times conscious of these forces and can influence their context. They are, however, limited by existing norms, rules or belief in rules. Agents are also constrained by their social ties, but they do not disable them. Agents are only as free to play as their structuring structures allow.

Returning to Scott (1990) and the free-space literature, offstage spaces allow agents the space to plan and strategize around how they make new rules, challenge existing rules, or break those rules in a way that does not ostracize them. Agents are free to do as they wish in their social context. They have the autonomy to do so, but because we exist in a complex network of social ties, these ties limit what we wish to do if we want to remain part of our communities. Consequently, in our struggle for capital and transformation of systems, agents are both enabled and constrained by the status quo.

The theme of autonomy versus interdependence is informed by a unique characteristic related to midwives, but in pursuing insights observed in the literature, the theme seemed to have value beyond the unique observations made within the context of midwifery. This theme highlights the need to focus on the politics of change. Within the context of social innovation, the conversation related to what actors are allowed to do because of existing social norms is rarely acknowledged. Here I have explicitly brought up the notion of game-play within social arrangements to highlight the enabling and constraining aspects of generating the conditions for social innovation.
Discussion

Previously I have explored social and spatial practices related to creating the conditions for social innovation. This conceptualization of social and spatial practices emerged through an exploration of the social construction of space. This section extended this analysis to include stance and autonomy versus interdependence. Stance was conceptualized in this section as comprising three conceptual approaches to stance. I explored the complexity stance and Bourdieu’s *habitus* + *(doxa) (illusio)* notions, and proposed an empathic stance to implementing social innovation.

The complexity stance was positioned as a decision-making framework, while Bourdieu’s *habitus* + *(doxa) (illusio)* introduced three very interesting questions. What are the cognitive influencing structures that we bring to the game? What do we believe about the game? And what are the rules of the game?

Finally, this section introduced an empathic stance as a practice-informing approach. The empathic stance proposes that agents start from the notion of “do unto others as they would have done unto them.”

The following section weaves together the three major themes—social and spatial practice, stance and autonomy versus interdependence—to propose a conceptual framework for generating the conditions of social innovation.
Chapter 8: Discussion: A triadic conceptual framework for generating the conditions for social innovation

“Theory is splendid but until put into practice, it is valueless.”

James Cash Penney.

Bryman (2009) suggests that theory begins with identifying a hypothesis, where a hypothesis refers to a perceived relationship between themes and categories related to a social phenomenon. In the previous chapters, I outlined three major theoretical frames: social and spatial practice, stance, and autonomy versus interdependence. These three themes form the foundation for the proposed conceptual social innovation framework. This hypothesis serves as a starting point for developing a substantive conceptual framework for social innovation (Bryman et al., 2009).

In this section, I refine the proposed themes to develop a substantive conceptual framework for generating the conditions for social innovation (Figure 8.1). Although presented as distinct themes, the hypothesis should be understood as an integrated set of conceptual themes, which when combined have the potential to generate social innovation. The triadic framework of social innovation takes inspiration from Lefebvre’s conceptualization of social space. Each node in the framework is grounded in its own theoretical assumptions. These combine and overlap in many ways to form the proposed framework.

From the interviews, midwives identified space—be it emotional space, home births or birthing centres—as the main activity that allowed them to change their practice.
Consequently, space emerged as the first and major theoretical concept explored. After exploring the existing literature on space, I reframed space as referring to social and spatial practices. Social and spatial practice refers to organized, open-ended, everyday spatial-temporal activity in the form of doings and sayings.

Figure 8.1. A conceptual framework for generating the conditions of social innovation.

The existing literature on space led me to explore three theoretical approaches to space: free space, Bourdieu’s notion of social space, and Lefebvre’s socio-material
representations of space. Each theme contributed uniquely to the emerging theory of social innovation. Each theoretical approach conceptualized space as a form of practice. It is important to note that the free-space literature did not explicitly identify practice, but Scott (1990) does refer to hidden transcripts as a form of practice. Free spaces as I have conceptualized them focus on the associated ties, the everyday relationships within free spaces. Free spaces were those pre-formative periods where midwives developed collective identity. In Ontario that refers to the period before regulation when midwives would develop shared practices and networks of mothers and practitioners. These networks would go on to play a major role in mobilizing resources during the regulation of midwifery. Midwives in Trinidad, prior to building their birthing centre, formed an informal community of practice where they developed strong relationships and networks. It was in this space that these midwives dreamed of the future they wished to bring into being. Within the context of the free-space literature, space was not just a neutral backdrop in the production and transformation of social life, but rather, space is understood as being contested, constructed, and constituted (Evans & Boyte, 1992; Polletta, 1999). They set the stage for creating the conditions for social innovation.

The free-space literature suggests that agents need to foster offstage spaces where citizens envision the future they would like to bring into the world. At the core of these offstage spaces, agents develop relationships with each other to form associated ties (Polletta, 1999). Within these free spaces Polletta emphasizes that it is the relationships between actors that are of importance. She argues that free spaces are predominantly educational settings where ordinary citizens learn, envision and enact their desired futures
In these offstage spaces, agents are removed from the direct control of dominant groups that honour local knowledge.

Polletta makes a distinction between different types of free spaces, which play an important analytical role. She argues that free space should be reconceptualised as a way of disaggregating the structures and the tasks of mobilization. She proposes three categories: transmovement, indigenous, and prefigurative. Transmovement spaces refer to movements with extensive networks; indigenous spaces contain strong local networks, dense ties, or isolated networks; and finally, prefigurative spaces “are formed in order to prefigure the society the movement is seeking to build by modeling relationships that differ from those characterizing mainstream society,” (Polletta, 1999, p.11). The notion of free spaces contributes to social innovation by providing a framework from which we can begin to analyze the role of unmoderated spaces and their ability to mobilize resources or recruit new members. Free spaces privilege the relationships within these spaces to suggest that social ties provide actors with a collective identity and collective vision of the future. The strength and development of relationships in these free spaces then inform the actors’ perceived sense of agency. This perceived agency, in combination with the everyday activities of agents within these free spaces, helps determine their potential success.

Exploring spatial and social practice

In posing the question “Where does social innovation emerge?” I also explore Bourdieu’s notion of social space. Bourdieu introduced three key concepts—habitus,
capital and field—which in combination produce everyday practices that both enable and constrain human behaviour. Each concept contributes to the decisions and activities actors make in their everyday lives. Space for Bourdieu is not determined by any one of his key concepts, but they all simultaneously contribute to how agents perceive their own social position or how others perceive their social position (Thomson, 2014, p.67).

Habitus plays a key role in determining the stance of agents within these social arrangements. In this way Bourdieu contributes a perspective of space that includes cognition, capital and social relations or interactions (Bourdieu, 1984; 1990).

The final approach to understanding space is a socio-material approach presented by Lefebvre (1992; 2014). Lefebvre’s major contribution to the dialogue on space for social innovation is that he argues that space is social, non-neutral, and dynamic. His triadic presentation of the production of space proposes a dialectic approach that includes spatial practice—how space is used; representations of space—how space is produced by designers; and space of representation—the way meaning is attributed to space, or the symbolic value produced by inhabitants (Kipfer et al., 2013; Lefebvre, 1992; Milgrom, 2008).

All these presentations give many more nuanced contributions on space, but the above is intended to be a brief reminder of the main concepts woven together for a conceptualization of social innovation that forefronts space.

One of Lefebvre’s most important contributions is his notion of “right to difference.” Harvey (1992; 2000) extends this notion to forefront Lefebvre’s concept of the “right to the city.” What these theorists are arguing is that capitalism has a tendency to homogenize spaces. They were arguing against the homogeneity of urban space.
(Lefebvre, 1992; Purcell, 2002). It can be argued that free-space literature was arguing for the right of belonging (Evans & Boyte, 1992). Within the context of social innovation, I argue that these theories imply that citizens should have a right to belonging and a right to participation. Just as midwives argue that nothing should be done without a woman’s consent, social innovation should not be implemented without the consent or participation of citizens. A Lefebvre-inspired approach to social innovation suggests that spaces should be diverse, citizen-defined, and citizen-generated. Citizens should have a right to the city. This is an important contribution to the discussion on social and spatial practices for social innovation. The notions of the right to difference and the right to belonging have significant synergy with social innovation, and play an important role in the development of a substantive conceptual framework of social innovation.

A fourth notion of space that emerged from the data came from a powerful story that one midwife told. She spoke of how she entered a room and created emotional space for the mother in labour. She described entering a room as being analogous to entering a pool. The idea was to create as little disturbance as possible. This approach to creating space was mother-centric and not midwife-centric; everything midwives do is to assist the mother in having as memorable and satisfying a birth as possible. This final observation also connects to the second major theme to be explored, stance.

The stance of social innovation

The exploration of social and spatial practice revealed a conceptualization of space that is intensely socio-material. In presenting a stance for social innovation, I propose a conceptualization that includes three major thematic and theoretical
dispositions: a complexity perspective, the empathic stance, and an understanding of stance that includes Bourdieu’s notions of *habitus*, *illusio* and *doxa*. As a reminder, the proposed theory of social innovation first emerged from the data, and as the themes emerged, I returned to the literature to develop insights into the concepts that were emerging.

In exploring the existing literature on social innovation, I retained the emphasis on complexity as a conceptual frame from which we can understand social innovation. In presenting complexity theory, I argue that simple problems should have solutions that are analogous to baking a cake, while complex problems should adopt approaches that are similar to raising children (Westley *et al.*, 2009). Often, interventions chosen do not match the type of problem an organization is trying to solve. A frame that allows us to design and develop solutions that are compatible with the challenge presented should be a starting point for social innovation (Westley *et al.*, 2009).

It is important to note that Bourdieu and Lefebvre both subscribe to the notion of agents changing their context, while simultaneously changing themselves (Bourdieu, 1984; Lefebvre, 1992). They can both be understood as practice theorists. Bourdieu and Lefebvre were very interested in everyday life (Bourdieu, 1990; Lefebvre, 1992; 2014), while complexity theorists Stacey (2010) and Shaw (2009) refer to organizational life as being reproduced or transformed through local interactions or everyday conversations. These three approaches present social life as being emergent, nonlinear, unpredictable, and dynamic, but rooted in practice or everyday activity (Bourdieu, 1984; Lefebvre, 1992; 2014; Stacey, 2010). Similarly, a Bourdieusian perspective and a complexity approach explicitly place emphasis on how stance affects everyday life, so although each
theme is presented separately, the themes should be interpreted as being integrated (Bourdieu, 1990; 1991; Bourdieu & Nice, 1980; Lane, Pumain, & van der Leeuw, 2009; Maton, 2008; Snowden & Boone, 2007; Stacey, 1995).

In outlining a layered triadic approach to social innovation, I am presenting distinct themes that serve as a heuristic for generating social innovation. I am proposing an approach that is interrelated and overlapping. Each theme has its own complex representation and plays a major role in the conceptualization of spaces for social innovation.

From the interviews with midwives, it was clear that the lenses through which midwives viewed the world significantly influenced their practice. Midwives saw birth as something women were born to do. Nothing was supposed to happen during birth that did not involve the mother’s being able to choose. They embodied the golden rule “Do unto others as they would have done unto themselves,” a perspective that informed much of their practice. Midwives have been able to leverage this empathic stance as a way of informing their practice. This observation also overlaps with the frame of social and spatial practices (space). This was most obvious in the notion of emotional space presented in Chapter 6. This idea of emotional space is very much rooted in an empathy-driven approach to practice. It is clear that the stance influenced the choices midwives made, and the world they were willing to struggle for.

I define stance as the socio-cognitive structures that influence the activity of agents and the (social or material) positions they occupy, or perceive they occupy, within social life. This definition is a very Bourdieusian approach to understanding the choices agents make within social systems. It is what Bourdieu referred to as a structuring
structure (Bourdieu, 1984; 1990; Nash, 1999). Habitus and capital represent the subjective interpretations of space, while field represents the object aspects of social space. Bourdieu’s use of habitus refers to the social and physical structures that inform an agent’s choices. For example, midwives in both contexts were driven by the belief that every woman should be able to choose how and where she gives birth. These beliefs were driven by their past experiences, which had convinced them that birth did not have to be a medicalized experience. They saw birth differently from physicians, which is most evident in the following quote:

   Just think about the phrase, “The doctor delivers the baby,” or “The midwife delivers the baby,” as opposed to: “The woman gives birth.” That’s just a whole different way of thinking about things. Just even that grammatical construction—in the first, the woman is not even present. [In] the second, the woman is in the position of the agency. She’s taking the space of the—she’s the active one and maybe, if a woman gives birth, there might not even be any caregivers there. That’s the important function that I’m interested in. (Trinidad interviewee 12).

From the context of stance for social innovation, Bourdieu’s notions of doxa—the rules of the game—and his notion of illusio—a belief in the game—are very informative for theory of social innovation. Bourdieu argues that agents are caught in a type of game where they are consistently struggling for power. Social innovation seeks to identify the rules of the game so agents can then work towards changing them. Agents need first to believe that a game exists and then they need to be very strategic about how they change
the rules. These games unfold within what Bourdieu calls fields. In these fields *habitus* informs actors of the kinds of moves players within these fields are allowed to make, or think they are allowed to make, that set the stage for a change in the flow of resources or the way agents socialize. At the heart of the conversation on social innovation is the realization that changing the rules of the game and the flow of the resource is how we are able to generate social innovation.

To illustrate this example, I draw on the Ontario midwives, since this example involved a whole-system change, while the Trinidad example involved change at a local level. Midwifery in Ontario is believed to be the only profession to be given privileges in a hospital in almost a hundred years (Bourgeault, 2006; MacDonald, 2008). The second major change was that midwifery advocates were able to convince the government that midwifery should be publicly funded (Bourgeault, 2006; Bourgeault & Fynes, 1997). Midwives argued that the way midwifery was funded would influence the way they practiced. Midwives were also able to negotiate being a self-regulated profession and to be integrated into the existing public health-care systems and receive insurance. The Ontario government also allocated funding to train midwives at three universities (Bourgeault, 2006). It is the combination of the changes to the rules of the game and changes in the allocation of capital that were responsible for generating social innovation within the context of Ontario. It is important to note that midwives worked hard to gain legitimacy and credibility by being very strategic about who spoke publicly and how they dressed. Bourgeault (2006, p.132) quotes a midwife, Betty Anne Davis, as stating that:

The problem here is that at some point the image you are presenting, you start to own, and you start to lose the original reasons why you were doing this
birth in the first place—to give the woman what she wants and what is really best for her, instead of what looks good in the eyes of the medical profession, the media, etc., from the medical profession.

The most illustrative aspect of privileging Bourdieu’s notion of game-play is that it reminds us that in the struggle for social change, conflict is inevitable. Midwives managed their conflict well enough to ensure regulation. Not all parties were happy in the end, or felt included, and it is debatable if they could have accomplished the same goals had they been more inclusive (Bourgeault, 2006; Nestel, 2000b). For example, because the core team around regulation was based in Toronto, this sometimes created tension among midwives who did not live in Toronto, which brought on feelings of resentment and alienation. The Association of Midwives addressed the problem by hosting a workshop on the “Dangers of the Professionalization of Midwifery” (Bourgeault, 2006). This workshop helped to focus the process of regulation not on the regulation of midwifery, but on female control of birth. This return to the focusing stance was important to the success of midwifery as a social innovation and helped guide how midwifery was regulated and eventually practiced in Ontario. Midwives understood that they needed to game-play, but they reminded themselves of which rules they were trying to change and avoided getting caught in the existing game.

Autonomy and interdependence

The third major theme of the framework refers to autonomy versus interdependence. This theme explicitly reminds the reader that change is embedded
within a system that already has defined norms and cultures. Agents seeking to change the rules of the game must respect the boundaries of their autonomy versus their interdependence on the system.

Midwives strategically presented themselves as being professional by playing up their credentials and not dressing like the hippies they were perceived to be. Midwifery has a very real tension between needing to be an autonomous, self-regulating profession and one that also works closely with existing medical practitioners. They needed autonomy that allowed them to practice within their scope, but also to work with physicians when births moved outside their scope of practice.

Lefebvre, Bourdieu and complexity theory all adhere to the notion that social life is deeply interconnected and agents are never really autonomous or empowered within a system, but only as empowered as the social context allows. All social activity is both enabled and constrained by social ties, which is precisely why the notion of free spaces is so appealing.

**Weaving it all together**

I have presented a framework for social innovation that includes three major theoretical themes: social and spatial practice (space), stance, and autonomy versus interdependence. The first theoretical frame—social and spatial practice (space)—outlines an exploration of free space, a Bourdieusian perspective of social space and a socio-material approach to space that was informed by Henri Lefebvre. An unexpected theme, emotional space, also emerged in this analysis. In this thesis, I explored three conceptualizations of stance: a complexity perspective, the empathic stance and the
Bourdieu’s concepts of *habitus*, *doxa* and *illusio*. The final theoretical frame explored refers to the notion of autonomy versus interdependence and that agents within a social system are only as autonomous as the context allows.

In weaving together the preceding substantive conceptual framework for creating the conditions for social innovation, I draw on insights from Edelman (2001) to argue that all innovation is social, so the term “social” in social innovation should add something unique to the discourse. “Social” in this thesis refers to changing social structures and the complex socio-material relationships that emerge as actors occupy space.

This thesis was inspired by the perception that social innovation is at risk of devoting disproportionate attention to desirable innovations and ignoring undesirable innovations. Many of the existing definitions privilege a definition of social innovation that adds social benefit. So early in the thesis, I avoided a conceptualization of social innovation that includes a normative requirement. I argue that social innovation should refer to specific instances where communities, groups, organizations, or societies have *profoundly changed social relations or interactions, deeply challenged or changed our existing paradigms, and significantly changed resource flows within existing social systems*.

The model proposed in this thesis suggests a process that leads to changes in social relations, changes in paradigms, and changes in resource flows. Each component informs or influences the others. The proposed model, if represented as three dimensions, might look like Figure 8.2. It is a visual representation of how a practitioner may wish to work through the framework in thinking about generating social innovation.
Discussion on validity and reliability

As far as possible I have tried to be transparent with the research presented. In many cases I used quotes and multiple sources of data to make a case for my theoretical frame of social innovation (Merriam, 2009; Yin, 2013). As with many case studies, this project leans heavily on qualitative rather than quantitative research to validate this finding (Yin, 2013). This is often perceived to be research that is less credible, or
research that lacks rigour when compared with research that is more heavily quantitative (Greene, 2007). This is often because people do not understand qualitative research and have false assumptions that it is somehow less reliable than quantitative research (Greene, 2007; Patton, 1990).

The thesis is intended to serve as a way of framing a conversation on generating the conditions for social innovation. Wherever possible, multiple sources of information were used to substantiate the findings. Much of the data in this study came from peer review of academic sources, which should add to the validity of the research presented.

**Limitations**

The most significant limitation of this study is that the first phase of research that helped frame much of the rest was based on a small case study. I exhausted all options for interviews and consequently could not confirm that I had achieved saturation. This small sample size would be a limitation of the study.

It was also intended to be an illustrative or exemplary case study of social innovation, and from the research presented, it proved to be an illustrative example of the inner workings of social innovation. Where possible I pursued alternative explanations for interpretations I derived (Greene, 2007; Yin, 2013).

Qualitative research is a subjective methodology, and my own mental models would influence the kind of data that stands out to me or that I conclude to be important (Greene, 2007). Another researcher might have chosen to start with another theme than space, and as far as possible I have tried to outline my own predispositions that may lead
to a biased interpretation of the findings. This criticism of case-study research is the norm with most qualitative research (Greene, 2007; Yin, 2013).

A major limitation of this study is its generalizability. Its purpose was theory-building through a combination of conceptual integration and use of evidence. I have sought to be careful not to over-generalize the framework presented (Bryman et al., 2009; Creswell, 2012; Merriam, 2009). The frameworks in this study are still to be tested, so readers should try not to overgeneralize from the claim presented.

**Future research**

This research is a work in progress, and the proposed conceptualizations of social innovation are living propositions that can be updated with additional research. This project has revealed several avenues for further research, some pertaining to social innovation and some specific to the field of midwifery. The first line of further research would be to conduct a larger version of the current study by looking at how social innovation has evolved in a variety of contexts. Since midwifery is governed by the ICM, many of the practices around the world would be similar enough to provide insight into how midwifery has evolved in various contexts.

In this thesis, I have proposed a conceptual framework for social innovation and a conceptual framework for generating the conditions for social innovation. It would be interesting if someone could test the assertions made in this thesis as a way of improving the nuanced distinctions made throughout the paper, or testing whether these frameworks...
share similarities in other contexts, or whether practitioners find them helpful in their work.

One of the most interesting findings was that midwives have a standard practice of working with each mother to develop a birth plan, though they are fully aware that plans rarely go as intended. An ethnographic study that looked at how midwives managed the ambiguity of birth could be beneficial to the management literature. Midwifery could provide insights for contexts where agents are consistently managing uncertainty.

Another line of research could be an exploration of the male experience of birth under midwifery care compared with men whose partners experienced birth with hospital care only. It would be interesting to find men who had had both experiences and examine their stories as a way of examining quality of care. One line of potential inquiry that stood out for me would be a study that examined how midwives and physicians are able to work together after some form of regulation—How are the tensions reduced or exacerbated?—if the legislation was imposed, as opposed to being introduced with the support of both groups.

There is a wealth of research that can follow this thesis. Understanding the dynamics of change is always a tricky endeavour, but the conversation on social innovation adds a specific focus. What is the innovation that would lead to the desired outcome? Here I have suggested some potential next steps. If I were to choose today, I would probably decide to do an ethnographic project following a team of midwives.
Chapter 9: Implications: Making space for social innovation

“Getting to maybe is about acting deliberately and intentionally in a complex uncertain world by virtue of being in and of that world.”

Westley, Zimmerman, & Patton (2009, p.24.)

Getting to Maybe (Westley, Zimmerman, & Patton, 2009) was the first book that I read that was explicitly about social innovation. I wrote this thesis as way of genuinely responding to the call of “getting to maybe.” Can we embark on intentional and deliberate change that generates changes in resource flows, changes in paradigms and changes in social relationships? Social innovation has always been a part of the human story. This thesis was inspired by what I perceived to be a dilution and consistent misuse of the term “social innovation.” Owing to its rise in popularity, social innovation is finding its way into the mainstream.

This thesis attempts to demonstrate that social innovation is not a new phenomenon, nor has it always been something we have actively or intentionally pursued. Social innovations are not always planned, intentional interventions, and can become invisible over time. Social innovations, as I have conceptualized them in this thesis, meet three criteria:

1. They change or radically challenge existing paradigms.
2. They change resource flows within a social system.
3. They change our social relationships and interactions.

Using these criteria, I have examined midwifery as an example of social innovation. I decided not to use a technical example, but instead argue that social
innovations can be both technical and social activities. At their heart are changes in the way we organize society (Weick, 1993). In exploring potential case studies, one surprising technical innovation emerged as a salient example of a social innovation: the modern elevator.

The modern elevator

I once wrote about the modern elevator as a social innovation (Demming, 2015b). I argued that neither midwifery nor the modern elevator is an intuitive example of social innovation. One of the characteristics of social innovations is that once they have been adopted into society, they tend to “disappear,” in that we tend to take them for granted.

This social innovation is qualitatively different from the way midwives were working to reclaim birth:

the modern elevator is an example of a taken-for-granted artefact that has profoundly changed how we organize and relate to society. This suggests that social innovations can sometimes be extremely counterintuitive.

Modern elevators can be credited with shifting our paradigms, resources flows, and social relationships. In his book *Lifted: A Cultural History of the Elevator*, Bernard (2013) outlines the history of the elevator and its impact on modern society. From his account, I was surprised to learn that early versions of the elevator were designed like rooms. It was not uncommon for gentlemen to engage in heated debates about whether to remove their hats in an elevator or not. Today, there is little debate about whether an elevator is a room or a transport vehicle. In fact, most of us have never
even thought about the idea and would find it silly. In the 1850s, this was a topic of serious debate (Bernard, 2013).

Over the years elevators improved, mostly as result of other improvements such as the introduction of electricity, improvements in building technology, like the introduction of steel beams, and new safety mechanisms that stopped them from plummeting to the ground. Before the modern elevator, few buildings were taller than six storeys. The most valuable rooms were on the ground floor, and the attics were the domain of artists and those who could not afford premium ground-floor rooms. When Bernard (2013) compared the cost of a ground-floor hotel room prior to the introduction of elevators, the highest-priced rooms were usually on the first floors. It would take almost twenty years before the wealthy became comfortable with the idea of “penthouse” living, and it took a considerable paradigm shift for the wealthy to sell their high-priced bottom floors and move into these novel penthouse suites. Additionally, the very idea that the wealthy would have to share a building with these modest commoners also took a considerable paradigm shift. The modern elevator, combined with all the other improvements, transformed modern living (Bernard, 2013).

Today high-rise buildings dominate most city skylines. The elevator has had a profound impact on the way cities evolved. Imagine for moment what the world might look like if it had never been invented. The tallest buildings might have been only six storeys high, we might have had underground dwellings, or we might have more shared-accommodation types of homes. The elevator has helped shape modern cities in profound ways.
Wicked problems never have end solutions. Today our congested cities have brought new social challenges. The example of the elevator accomplishes a few tasks. It highlights how social innovations can be absorbed into culture as these taken-for-granted everyday occurrences. It also demonstrates that social innovations are not always a grandiose plan, but can sometimes be passive occurrences. It is unlikely that someone sat and planned that we would one day have a world where most cities would be dominated by high-rise buildings, so therefore we needed to invent the elevator.

This also serves as a word of caution not to impose too much control on strategies for social innovation. Like the physicians who try to control the process of birth, we need to learn to respond to what is emerging, to develop agile strategic approaches. We live in a world that is recovering from the scientific-management era, when control was the dominant narrative. As social innovation increases in popularity, we will need to continue to develop conversations that bring to the surface these nuanced understandings of social innovation (Demming, 2015b).

**Social innovation as informed by theories of domination**

I have always thought that theories of domination are more helpful than free-market explanations. This thesis has taken a non-traditional approach to exploring the proposed research questions, and although it does not always forefront traditional theories of domination, several of the theories I have drawn on come from this tradition of explaining the world in terms of dominance versus free markets.

Theories of space served as the main starting point for exploring the flowing questions:
1. What do we mean by social innovation?

2. How do we create the conditions that support or generate social innovations?

    Nicolini (2012) proposes a zooming-in and zooming-out approach to studying practice. Drawing inspiration from Nicolini (2012), I have developed a dynamic approach to studying social innovation. Furthering his approach, I combined it with Bryant & Charmaz’s (2010) approach to grounded theory and Boeije’s (2002) outline of the constant comparative method. This thesis was able to develop an approach to research that provided the researcher with a framework that allowed for focused agility, and this dynamic approach meant that the research did not follow a linear path. Instead, as insights emerged, I returned to the literature to explore what other theorists had written about the topic. In reporting the findings of the thesis, I began with the methodology section and developed each section to reflect how the study emerged.

**What can we conclude about social innovation?**

From the thesis, we can conclude that social innovation has always been part of the human story. Similarly, there is no end goal. Social innovations never really arrive at one. In Ontario, if for some reason midwives lost their insurance, then the people who would be able to access their services would change. If Canada decided to stop its public health-care system, then midwives would also be affected. Society is dynamic; so is social innovation. Midwives in both contexts are under the constant threat that physicians may undermine their practice. As is the case with Dutch midwives visiting Canada, there is always a new challenge to overcome.
We can also conclude that social innovation does not have to adopt a normative stance. Social innovations can be both good and bad for society. We hope that social innovations add to the common good, but they may not always do so. Hospitals have generally produced improved health outcomes, but there are many aspects of modern medicine that are now themselves complex social problems.

If we subscribe to Weick’s (1989) proposal that good theory should offer citizens heuristics for navigating the complex world, then this thesis has provided two heuristics for social innovation. The first helps citizens identify or label activities as social innovations. People can ask three questions to identify social innovations:

• Has the activity contributed to significant change in a paradigm?
• Has the activity contributed to a significant change in resource flow?
• Finally, can the activity be seen as responsible for a significant change in social interactions or practice?

With this conceptualization, we can begin to place social innovations along a continuum. Providing a method for conceptualizing and identifying social innovations is a major aim of this thesis.

The second heuristic proposed is a framework for generating the conditions for social innovation, which can then be used for developing intentional strategies. I have developed some sample questions practitioners may wish to consider. Under the node “social and spatial practice,” practitioners may want to ask:

1. How do we rethink the everyday practice of agents within the system?
2. How does the physical space affect everyday activity?
3. What types of offstage spaces do we need to foster, if at all?
4. What is the nature of the relationships in these spaces?

5. How we do foster healthy emotional spaces?

Practitioners may wish to ask exploratory questions under each conceptualization of stance. For example, under the complexity stance, a practitioner may want to ask, how do we use complexity as a decision-making framework? What zone of complexity are we in? How might our strategy be aligned with the zone of complexity we are in? What are the rules of the game? What rules, or game, do we believe exist? What rules do we wish to change?

Under the empathic stance, practitioners may want to ask, how do we use methodologies like ethnography and qualitative research to drive empathy-informed approaches? Similarly, under the theme autonomy versus interdependence, practitioners may want to ask questions such as: what social ties currently maintain the status quo? Which rules need to be changed so groups have enough autonomy to make the future they desire? Which relationships of interdependence constrain rather than enable the desired change?

Social innovation offers considerable potential as a framework for understanding change. It shifts our focus away from analysis and critique to one of strategic action. We need analysis and critique, but we also need an approach that follows analysis and critique. In focusing on the strategic activities or leverage points we can bring about a change in resource flow, paradigm, or social interactions. Citizens can be better equipped to create the future they desire.

There are many ways to approach social innovation, and each group will have to decide what is helpful for its context and what is not. The framework presented in this
thesis is an attempt to bring us one step closer to understanding social innovation as a strategic approach to social change. We would be remiss to forget that social innovation is a consistent site of struggle, and current “washed” approaches to social innovation need to incorporate the knowledge that with each attempt to generate social innovation, we evoke a site of struggle.
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Appendix A: Phase II interview protocol

1) Describe for me how you think social change happens.
   - Describe a social intervention for me. What do you think it might look like?
   - Describe what social innovation would look like.
   - Describe where you see social innovation within the context of social change.
   - Describe what a social innovation might look like.

2) Do you know the story of how your (special-purpose collaborative) got started?
   - Please describe where the idea came from.
   - Please describe how you secured funding.

3) Please describe for me how you decided which partners to bring on board.
   - Please describe for me how you approached partners. Who asked? And how?
   - Please tell me the story of how the group selected team members or working-group participants.
   - Tell me the story of how collaborators chose a common agenda.

4) What do collaborative social-intervention practitioners do when they meet or gather? How do they design meeting sessions?
   - Describe what a meeting or gathering might look like. Please provide two examples.
   - How do collaborative social-intervention practitioners decide on a shared measurement?

5) How did your organisation decide what they were going to evaluate?
   - Please describe for me how you decided to measure your activity.
   - Who decides what to measure and when? Tell me a story you can recall that describes how these decisions were made.

6) Please describe for me how you came up with your chosen interventions.
   - Tell me a story of how you decided on your chosen interventions.
   - Tell me the story of who made the decision and how they decided on the chosen criteria.
### Appendix B: Phase IV interview protocol example

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<th>Themes that emerged</th>
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<td>User-centred</td>
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</tbody>
</table>

| Follow-up questions and interesting lines of inquiry | |
|--------------------------------------------------------| |

If you had access to unlimited resources what would you change about the current midwifery model of care?

---

This table is a sample of how I would prepare my notebook prior to interviews.
Appendix C: List of code descriptions

<table>
<thead>
<tr>
<th>Code Info</th>
<th>Code descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A small group of citizens</td>
<td>This code related to observation that both case studies were led by a small group</td>
</tr>
<tr>
<td></td>
<td>of citizens</td>
</tr>
<tr>
<td>A woman’s right to choose</td>
<td>A common stance mentioned in many of the interviews. This theme seemed to frame</td>
</tr>
<tr>
<td></td>
<td>the practice of midwifery</td>
</tr>
<tr>
<td>Access or gaining access to resources</td>
<td>This code identified instances where midwives referenced or changed organizational</td>
</tr>
<tr>
<td></td>
<td>structures to improve their access to resources</td>
</tr>
<tr>
<td>Activism</td>
<td>Was activism part of the identity of the interviewee?</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Instances where midwives demonstrated they were advocating for their client</td>
</tr>
<tr>
<td>Authority</td>
<td>Instances when authority roles affected the practice of midwives</td>
</tr>
<tr>
<td>Autonomy</td>
<td>This code identified reference to the importance of autonomy in midwifery practice</td>
</tr>
<tr>
<td>Being open to what may come</td>
<td>Instances when midwives would respond to the context versus imposing their own</td>
</tr>
<tr>
<td></td>
<td>intentions on what was emerging</td>
</tr>
<tr>
<td>Being organized is part of the process of</td>
<td>Instances where being highly organized helped the mobilization and implementation</td>
</tr>
<tr>
<td>change</td>
<td>of midwifery models</td>
</tr>
<tr>
<td>Birthing experience</td>
<td>Instances when interviewees focused on the experience of birth</td>
</tr>
<tr>
<td>Breech</td>
<td>Stories connected to breech births</td>
</tr>
<tr>
<td>Caesarean rate</td>
<td>References to the caesarean rate</td>
</tr>
<tr>
<td>Challenging status quo</td>
<td>Instances where stories indicated a challenge to the status quo</td>
</tr>
<tr>
<td>Champion</td>
<td>A person who was driving the process.</td>
</tr>
<tr>
<td>Change in resource flow</td>
<td>Examples of changes in the way resources were allocated</td>
</tr>
<tr>
<td>Clear policies, standards, and procedures</td>
<td>Any reference to having clear policies and procedures in place</td>
</tr>
<tr>
<td>Client care</td>
<td>Any reference to focusing on client care</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Client-centred or informed</td>
<td>Any reference to practice being centred on the client’s being informed or taking their stance into consideration</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Instances that referenced collaboration</td>
</tr>
<tr>
<td>Communicating with hospital</td>
<td>Instances that referenced stories of communication and integration with the hospital</td>
</tr>
<tr>
<td>Complexity</td>
<td>Stories that reflected complex dynamics</td>
</tr>
<tr>
<td>Constant care</td>
<td></td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Any references to continuity of care</td>
</tr>
<tr>
<td>Control of the economics</td>
<td>Any reference to work affecting livelihood.</td>
</tr>
<tr>
<td>Could risk being arrested</td>
<td>Any reference to a practitioner’s risking arrest</td>
</tr>
<tr>
<td>Creating networks</td>
<td>Any reference to actors building networks and allies</td>
</tr>
<tr>
<td>Credibility</td>
<td>Any reference to the need to develop and demonstrate credibility</td>
</tr>
<tr>
<td>Culture of care</td>
<td>Any reference to a focus on a culture of care</td>
</tr>
<tr>
<td>Debaters</td>
<td>Any reference to the individuals who would argue for the new model</td>
</tr>
<tr>
<td>Demonstrate possibility</td>
<td>Reference to demonstrations of the future that was possible</td>
</tr>
<tr>
<td>Designed by users</td>
<td>Any reference to work being designed by those who would be receiving care</td>
</tr>
<tr>
<td>Designed for the physician/doctor</td>
<td>Any reference to a system of care that was designed for the sake of the physician</td>
</tr>
<tr>
<td>Designers</td>
<td>Any reference to actors designing new systems</td>
</tr>
<tr>
<td>Deviance</td>
<td>Any reference to people who were willing to deviate from status quo</td>
</tr>
<tr>
<td>Difference in training</td>
<td>Any reference to how a difference in training affected a difference in practice</td>
</tr>
<tr>
<td>Disempowering midwives</td>
<td>Stories that reflected midwives being undermined or disempowered</td>
</tr>
<tr>
<td>Don’t want to do high-risk</td>
<td>Any reference to midwives avoiding high-risk births</td>
</tr>
<tr>
<td>Economics inform decisions</td>
<td>Any reference to where a threat to livelihood is thought to affect decisions</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Education</td>
<td>Any reference to how prior education had an impact on practice</td>
</tr>
<tr>
<td>Emotional space</td>
<td>Any reference to holding emotional space as part of the work</td>
</tr>
<tr>
<td>Empathy</td>
<td>Any reference to stories that reflected: “Do unto others as they would have done unto them”</td>
</tr>
<tr>
<td>Empowering midwives</td>
<td>Examples of situations that empowered midwives</td>
</tr>
<tr>
<td>Empowering women</td>
<td>Examples of stories that empowered women</td>
</tr>
<tr>
<td>Evidence-based practice supporting midwifery</td>
<td>Examples where actors relied on evidence to inform their practice</td>
</tr>
<tr>
<td>Existing status quo</td>
<td>Any reference to actors maintaining the status quo</td>
</tr>
<tr>
<td>Fact-check</td>
<td>This label is used to identify data that needs multiple sources</td>
</tr>
<tr>
<td>Faith in institutions</td>
<td>Examples where actors had blind faith in an institution</td>
</tr>
<tr>
<td>Family support</td>
<td>Examples of instances where family support played a role</td>
</tr>
<tr>
<td>Fathers can be present at birth</td>
<td>Examples of stories where fathers’ being present for birth was of importance</td>
</tr>
<tr>
<td>Finding opportunity in crisis</td>
<td>Examples where actors found opportunity in crisis</td>
</tr>
<tr>
<td>Follow-up questions</td>
<td>Code identifies data that needed to be unpacked more</td>
</tr>
<tr>
<td>Free spaces</td>
<td>This code identified examples of free spaces within the stories recorded</td>
</tr>
<tr>
<td>Game-playing</td>
<td>Instances where agents were engaged in game play</td>
</tr>
<tr>
<td>Gaze or perspective</td>
<td>Identified instances where gaze or perspective influenced practice</td>
</tr>
<tr>
<td>Gentle but firm pulling</td>
<td>Referred to a strategy of resistance: midwives were firm but gentle</td>
</tr>
<tr>
<td>Global history of midwifery</td>
<td>Any stories that referenced the global history of midwifery</td>
</tr>
<tr>
<td>HR approach to paying midwives</td>
<td>The role of HR in paying midwives/midwifery practice</td>
</tr>
<tr>
<td>History of the ICM</td>
<td>Stories related to the history of the International Confederation of Midwives</td>
</tr>
<tr>
<td>How the Ontario Birth Centre ended up being built in Trinidad</td>
<td>Stories that helped tell the story of how the Toronto Birthing Centre was first built in Trinidad</td>
</tr>
<tr>
<td>Ideal future</td>
<td>Responses to the question: if you had access to unlimited resources, what would you change about the current midwifery model of care?</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Imperfect solution</td>
<td>Examples that highlighted that solutions were imperfect</td>
</tr>
<tr>
<td>Individual transformation</td>
<td>Code to represent individual transformation</td>
</tr>
<tr>
<td>Integrating into the health-care system</td>
<td>Stories that referenced midwives being integrated into the health-care system</td>
</tr>
<tr>
<td>Interdependence</td>
<td>Stories that reflected how agents were limited by their social ties</td>
</tr>
<tr>
<td>Intervention rates</td>
<td>Reference to rates of intervention</td>
</tr>
<tr>
<td>Irresponsible practice</td>
<td>Stories that were judged to reflect irresponsible practice</td>
</tr>
<tr>
<td>Judgement</td>
<td>Stories that reflected instances where clients might feel judged</td>
</tr>
<tr>
<td>Lay midwives</td>
<td>Stories that referenced lay midwives</td>
</tr>
<tr>
<td>Legal backlash</td>
<td>Stories that reflected the potential legal consequences of activity connected to practicing midwifery</td>
</tr>
<tr>
<td>Legitimacy or Credibility</td>
<td>Stories that reflected the importance of having legitimacy and credibility within the system</td>
</tr>
<tr>
<td>Leverage point</td>
<td>Stories that seemed to reflect some sort of leverage point</td>
</tr>
<tr>
<td>Locally-trained midwife</td>
<td>Code represented midwives trained in Trinidad and Tobago</td>
</tr>
<tr>
<td>Long game</td>
<td>Code reflected activity that shows thought about the long-term consequences of actions</td>
</tr>
<tr>
<td>Media backlash</td>
<td>Examples of stories related to media backlash</td>
</tr>
<tr>
<td>Medicalization</td>
<td>Stories that describe the medicalization of birth</td>
</tr>
<tr>
<td>Midwife-friendly movements</td>
<td>Examples of movements that supported midwifery</td>
</tr>
<tr>
<td>Midwife gaze or stance</td>
<td>Example of how the midwifery stance affected practice</td>
</tr>
<tr>
<td>Midwife was respected</td>
<td>Examples of midwifery holding respected community position</td>
</tr>
<tr>
<td>Midwifery and its scope</td>
<td>Examples identifying the scope of midwifery practice</td>
</tr>
<tr>
<td>Midwifery education and</td>
<td>Examples of midwifery education</td>
</tr>
<tr>
<td>Training</td>
<td>Examples</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<tr>
<td>Midwives as threat</td>
<td>Examples where physicians saw midwifery as a threat</td>
</tr>
<tr>
<td>Midwives have no privileges in hospitals</td>
<td>Example of some of the consequences of midwives not having privileges in hospitals</td>
</tr>
<tr>
<td>Misunderstandings of midwifery</td>
<td>Examples of how citizens misunderstand midwifery</td>
</tr>
<tr>
<td>Modernization</td>
<td>Examples of how midwifery unfolded with modernization</td>
</tr>
<tr>
<td>Moving to conservation</td>
<td>Examples of midwifery in the conservation stage of the adaptive cycle</td>
</tr>
<tr>
<td>Mutual respect between midwife and physician/doctor</td>
<td>Examples where midwives and doctors had mutual respect for each other</td>
</tr>
<tr>
<td>Myths around birthing</td>
<td>Examples of myths around birth</td>
</tr>
<tr>
<td>NGO sacrifice mantra</td>
<td>There is a notion that by working in NGOs employees may sacrifice, compared to the private sector</td>
</tr>
<tr>
<td>NGOs think like a business</td>
<td>Examples of NGOs operating like a business</td>
</tr>
<tr>
<td>Natural birth</td>
<td>Explanations of natural birth</td>
</tr>
<tr>
<td>Networks</td>
<td>Examples of the role of social networks in midwifery</td>
</tr>
<tr>
<td>Niche innovation</td>
<td>Examples of midwifery in very contained, well-defined settings</td>
</tr>
<tr>
<td>No local funding</td>
<td>Examples of no access to local funding</td>
</tr>
<tr>
<td>Not challenging status quo</td>
<td>Examples of actors being afraid to challenge the status quo</td>
</tr>
<tr>
<td>Not a choice, but couched as a choice</td>
<td>Examples where activity is framed as a choice, but is not a choice</td>
</tr>
<tr>
<td>Not client-centred</td>
<td>Stories that reflect a non-client-centred approach</td>
</tr>
<tr>
<td>Not in a culture of using statistics</td>
<td>Examples of lack of a culture of evidence-based practice</td>
</tr>
<tr>
<td>Not quality of care</td>
<td>Examples of citizens not receiving quality care</td>
</tr>
<tr>
<td>Nothing happens without asking the woman first—ever</td>
<td></td>
</tr>
<tr>
<td>Obstetric violence</td>
<td>Examples of obstetric violence</td>
</tr>
<tr>
<td>Obstetrician gaze</td>
<td>Stories that reflect the obstetric gaze</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Offstage</td>
<td>Examples of offstage spaces</td>
</tr>
<tr>
<td>Old midwives</td>
<td>Examples of traditional midwives</td>
</tr>
<tr>
<td>Ontario could start from scratch</td>
<td>Example of a critical incident</td>
</tr>
<tr>
<td>Ontario midwifery history</td>
<td>Examples of the history of midwifery</td>
</tr>
<tr>
<td>Organizational culture</td>
<td>Examples of where organizational culture influenced care</td>
</tr>
<tr>
<td>Organizational structure needs to be aligned</td>
<td>Examples of how midwives aligned their organizations with their stance on midwifery</td>
</tr>
<tr>
<td>Paradox</td>
<td>Examples where agents were caught in double-bind situations</td>
</tr>
<tr>
<td>Passion for midwifery</td>
<td>Examples of how passion for midwifery influenced participation in midwifery</td>
</tr>
<tr>
<td>Pathology</td>
<td>Examples where birth was viewed as a pathology</td>
</tr>
<tr>
<td>Perfect storm</td>
<td>Examples of serendipity</td>
</tr>
<tr>
<td>Physician/doctor support</td>
<td>Examples of physicians supporting midwifery</td>
</tr>
<tr>
<td>Physician/doctor actively undermines midwifery</td>
<td>Examples of physician actively undermining midwives</td>
</tr>
<tr>
<td>Physician/doctor-centred</td>
<td>Examples where practice was centred on physicians</td>
</tr>
<tr>
<td>Physician/doctor scope of practice</td>
<td>Examples reflecting the scope of physicians</td>
</tr>
<tr>
<td>Poet</td>
<td>The typology of a person who told the story of midwifery</td>
</tr>
<tr>
<td>Poor infrastructure</td>
<td>Examples where poor infrastructure affected midwifery</td>
</tr>
<tr>
<td>Poor oversight</td>
<td>Examples where poor regulation influenced the unfolding of midwifery</td>
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<tr>
<td>Potential trap</td>
<td>Examples of traps in the adaptive cycle</td>
</tr>
<tr>
<td>Prefigurative</td>
<td>Examples of actors prefiguring their future</td>
</tr>
<tr>
<td>Prepared to be arrested</td>
<td>Examples where citizens were prepared to be arrested for their beliefs</td>
</tr>
<tr>
<td>Protecting the status quo</td>
<td>Examples of actors protecting the status quo</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Prototypes exist elsewhere</td>
<td>Examples of prototypes that existed outside the context they are in</td>
</tr>
<tr>
<td>Public benefit</td>
<td>Examples of public benefit</td>
</tr>
<tr>
<td>Public perception</td>
<td>Stories reflecting the public perception of midwifery</td>
</tr>
<tr>
<td>Quality care and service</td>
<td>Stories reflecting quality care and service</td>
</tr>
<tr>
<td>Race-linked health outcomes</td>
<td>Examples of race-determined health outcomes</td>
</tr>
<tr>
<td>Reframing</td>
<td>Examples of how reframing one’s stance can change the outcome</td>
</tr>
<tr>
<td>Representational space: meaning</td>
<td>Stories that reflected the meaning of space</td>
</tr>
<tr>
<td>Representations of space-form</td>
<td>Stories that reflected how the physical form of space affected midwifery</td>
</tr>
<tr>
<td>Reputation</td>
<td>Examples of how reputation influenced midwifery practice</td>
</tr>
<tr>
<td>Resistance strategies</td>
<td>Stories of cunning and resistance</td>
</tr>
<tr>
<td>Rude to clients</td>
<td>Examples of practitioners being rude to clients</td>
</tr>
<tr>
<td>Saw possibility</td>
<td>Examples where actors saw what was possible and acted as a result</td>
</tr>
<tr>
<td>Scaling the social innovation</td>
<td>Examples of how SI scales or can scale</td>
</tr>
<tr>
<td>School capacity</td>
<td>Examples of how the capacity of schools affects the supply of practitioners</td>
</tr>
<tr>
<td>Scope</td>
<td>All stories and examples related to scope of practice</td>
</tr>
<tr>
<td>Seeing to believe</td>
<td>Examples where actors needed to see what was possible to believe what was possible</td>
</tr>
<tr>
<td>Self-starter or problem-solver</td>
<td>Examples of an actor having that entrepreneurial spirit</td>
</tr>
<tr>
<td>Social-justice stance</td>
<td>Examples of how a social-justice stance affected midwifery</td>
</tr>
<tr>
<td>Social-enterprise model</td>
<td>Examples of social-enterprise model</td>
</tr>
<tr>
<td>Space practice: use</td>
<td>Examples of how the way a space is used influences practice</td>
</tr>
<tr>
<td>Starting small</td>
<td>How small, slow starts can have big outcomes</td>
</tr>
<tr>
<td>Stigmatizing midwifery</td>
<td>Examples of the stigmas of midwifery</td>
</tr>
<tr>
<td>Topic</td>
<td>Examples</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Still vulnerable</td>
<td>Examples of how established organizations are always vulnerable</td>
</tr>
<tr>
<td>Strategy</td>
<td>Examples of midwives being strategic</td>
</tr>
<tr>
<td>Struggles of entrepreneurship</td>
<td>Examples of actors learning to become entrepreneurs</td>
</tr>
<tr>
<td>Student delivery in Trinidad</td>
<td>Examples of students assisting with birth</td>
</tr>
<tr>
<td>Support for the woman</td>
<td>Examples of how women are supported during birth</td>
</tr>
<tr>
<td>Support groups</td>
<td>Examples of support groups around birth</td>
</tr>
<tr>
<td>Systems approach</td>
<td>Examples of a systems approach to care</td>
</tr>
<tr>
<td>Tension between physician/doctor and midwives</td>
<td>Examples of tension between physicians and midwives</td>
</tr>
<tr>
<td>Tension between hospitals and midwives</td>
<td>Examples of tension between hospitals and midwives</td>
</tr>
<tr>
<td>Tension between local midwives and foreign-trained midwives</td>
<td>Examples of tension between Trinidad-trained midwives and foreign-trained midwives</td>
</tr>
<tr>
<td>Tensions between midwife and doulas</td>
<td>Examples of tensions between doulas and other health practitioners</td>
</tr>
<tr>
<td>The social-innovation fight is never over</td>
<td>Examples of how ambiguity plays a role in decision-making</td>
</tr>
<tr>
<td>The subjective decisions</td>
<td>Examples of how ambiguity plays a role in decision-making</td>
</tr>
<tr>
<td>The authority of physician/doctor</td>
<td>How authority of doctors seems to take precedence</td>
</tr>
<tr>
<td>The fall of midwifery in Trinidad</td>
<td>Examples of the decline of midwifery in Trinidad</td>
</tr>
<tr>
<td>The independence of midwifery</td>
<td>Stories reflecting the need for midwives as autonomous practitioners</td>
</tr>
<tr>
<td>The key-decision in the Ontario movement</td>
<td>Examples of key decisions that influenced the Ontario midwifery movement</td>
</tr>
<tr>
<td>The memory of birth</td>
<td>Examples of how women remember birth</td>
</tr>
<tr>
<td>The midwife as tradition</td>
<td>Examples of traditional midwives in Trinidad</td>
</tr>
<tr>
<td>The midwife as an authority on natural birth</td>
<td>Stories reflecting how midwives perceive themselves as the authorities on birth</td>
</tr>
<tr>
<td>The midwifery model of care</td>
<td>Examples that explain the midwifery model of care</td>
</tr>
<tr>
<td>The role of volunteers and volunteering</td>
<td>Examples of how volunteers contributed to the movement</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Too good for the poor</td>
<td>One funder thought the birthing centre was too nice for the poor</td>
</tr>
<tr>
<td>Trust</td>
<td>Examples of trust playing into practice</td>
</tr>
<tr>
<td>User-centred or -informed</td>
<td>Examples where actors adopted a user-centred focus</td>
</tr>
<tr>
<td>Way we do things here</td>
<td>Examples of legacy and tradition</td>
</tr>
<tr>
<td>Women are disempowered</td>
<td>Examples of when women are disempowered</td>
</tr>
<tr>
<td>Work hours</td>
<td>Examples of how working hours affect midwifery practice</td>
</tr>
<tr>
<td>Working conditions</td>
<td>Examples of working conditions affecting midwifery practice</td>
</tr>
<tr>
<td>Working with institutions</td>
<td>Examples of the dynamics between organizations and institutions</td>
</tr>
<tr>
<td>Working with public sector</td>
<td>Examples of Trinidad midwives working in the public sector</td>
</tr>
<tr>
<td>Working with what you have.</td>
<td>Working from where you are</td>
</tr>
<tr>
<td>History of Canadian midwives</td>
<td>Stories that reflected the history of midwifery in Canada</td>
</tr>
<tr>
<td>Organizational alignment</td>
<td>Examples of how organizational alignment affected practice</td>
</tr>
<tr>
<td>Silo’d ministries</td>
<td>Examples of how silo’d ministries affect practice</td>
</tr>
<tr>
<td>Unethical practice</td>
<td>Examples of unethical practices related to birth</td>
</tr>
<tr>
<td>Unsustainability of volunteering</td>
<td>Examples of how volunteering can cause burnout</td>
</tr>
</tbody>
</table>
Appendix D: the four major themes and their subcategories

<table>
<thead>
<tr>
<th>Autonomy vs Interdependence</th>
<th>Stance</th>
<th>Social and Spatial Practice</th>
<th>Free spaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space Practice—use</td>
<td>Activism</td>
<td>Representational Space—Meaning</td>
<td>Representational Space—Meaning</td>
</tr>
<tr>
<td>Authority</td>
<td>User-centred or - informed</td>
<td>Working with institutions</td>
<td>Change in resource flow</td>
</tr>
<tr>
<td>User-centred or informed</td>
<td>Client-centred or informed</td>
<td>Space Practice—use</td>
<td>Access or gaining access to resources</td>
</tr>
<tr>
<td>Client-centred or informed</td>
<td>Systems approach</td>
<td>Representations of Space—form</td>
<td>Authority</td>
</tr>
<tr>
<td>Medicalization</td>
<td>Professionalization</td>
<td>Activism</td>
<td>Free spaces</td>
</tr>
<tr>
<td>Scope</td>
<td>Public perception</td>
<td>Free spaces</td>
<td>Autonomy</td>
</tr>
<tr>
<td>Interdependence</td>
<td>Gaze or perspective</td>
<td>Challenging status quo</td>
<td>Challenging status quo</td>
</tr>
<tr>
<td>Nurse-midwife</td>
<td>Tension between physician/doctor and midwives</td>
<td>Gentle but firm pulling</td>
<td>Interdependence</td>
</tr>
<tr>
<td>The independence of midwifery</td>
<td>Education</td>
<td>Existing status quo</td>
<td>Prefigurative</td>
</tr>
<tr>
<td>Tension between physician/doctor and midwives</td>
<td>Champion</td>
<td>Tension between physician/doctor and midwives</td>
<td>Networks</td>
</tr>
<tr>
<td>Difference in training</td>
<td>A woman’s right to be able to choose</td>
<td>Irresponsible practice</td>
<td>Creating networks</td>
</tr>
<tr>
<td>Quality care and service</td>
<td>Women are disempowered</td>
<td>Unethical practice</td>
<td>Perfect storm</td>
</tr>
<tr>
<td>A woman’s right to be able to choose</td>
<td>Empowering midwives</td>
<td>Not challenging status quo</td>
<td>Offstage</td>
</tr>
<tr>
<td>Support for the woman</td>
<td>Physician/doctor-centred</td>
<td>Mutual respect between midwife and physician/doctor</td>
<td>Midwife-friendly movements</td>
</tr>
<tr>
<td>Women are disempowered</td>
<td>Mutual respect between midwife and physician/doctor</td>
<td>Resistance strategies</td>
<td></td>
</tr>
<tr>
<td>Empowering midwives</td>
<td>Disempowering midwives</td>
<td>Tensions between midwife and doulas</td>
<td></td>
</tr>
<tr>
<td>Physician/doctor centred</td>
<td>Obstetric violence</td>
<td>Clash with existing status quo</td>
<td></td>
</tr>
<tr>
<td>Not client-centred</td>
<td>Social-justice stance</td>
<td>Being organized is part of the social innovation</td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td>Working with public sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual respect between midwife and physician/doctor</td>
<td>Resistance strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric violence</td>
<td>Faith and belief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not quality of care</td>
<td>Obstetrician gaze</td>
<td></td>
<td></td>
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<tr>
<td>Birthing experience</td>
<td>Midwife gaze or stance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The midwifery model of care</td>
<td>Reframing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwifery and its scope</td>
<td>Fathers can be present at birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/doctor scope of practice</td>
<td>Imperfect solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working with what you have</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apprenticeship approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evidence-based practice supporting midwifery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Babies do not need to come into hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/doctor scope of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protecting the status quo</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organizational alignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tension between local and foreign-trained midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tension between hospitals and midwives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admitting privileges</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emotional space</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social and spatial practice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appendix E: Approved ethical consent form**
Individual Participant Consent Form

Dear ________________

The purpose of this letter is to provide you with information about the research project. This information will help you decide whether or not you would like to participate in this study. Your participation is completely voluntary, and you are free to withdraw at any time. Only Keita Demming, principal researcher will know who has participated in the project.

At the end of the letter, you will find a form to indicate that you wish to participate. If you are at least 18 years old, please fill in the form and sign it. Keep a copy for your records.

The name of this research project is: Understanding the practices of Collaborative Social Intervention

The study is largely interested in understanding organisational approaches to collaborative approaches to social interventions. In this study, they are referred to as Collaborative Social Intervention Organisations (CSIOs). It is important to acknowledge that others may refer to these organisations as lab-like approaches, collective impact approaches or may even see it as the way they work, without labeling their approach.

CSIOs usually meet the following conditions:

- take a multi-stakeholder, multi-sector approach towards implementing social interventions
- strategically take a collaborative cross-sector approach towards developing social interventions
- hold to a common agenda, that is to say, all participants come together to collectively define the problem and create a shared vision for solving it
- work to foster reinforcing activities
- encourage a culture of continuous communication, which helps to build trust and relationships among all participants,
- have a strong backbone organisation or team dedicated to coordinating and orchestrating the activities of the working groups
- agree on a common approach to tracking progress by agreeing on shared measurements which allow for continuous improvement, while others explicitly agree on adopting an experimental or prototyping approach to social interventions.

Nature and Purpose of the Research

The main purpose of the project is to meet the requirements of completing a PhD in Workplace Learning and Social Change at the Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). Other objectives of the study are:

- To understand the practice of collaborative social interventions in order to develop insights, principles, models, and strategies to help build capacity around collaborative approaches to social interventions.
- Explain the main factors that contribute to successful collaborative social interventions.

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Individual Participant Consent Form

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The purpose of this letter is to provide you with information about the research project. This information will help you decide whether or not you would like to participate in this study. Your participation is completely voluntary, and you are free to withdraw at any time. Only Keita Demming, principal researcher will know who has participated in the project.

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Potential harm if any is:
• No harm is anticipated.

I hope that you decide to participate. If you have any questions, please contact me at keita.demming@mail.utoronto.ca or at 416 939 1040 (Canada) or 868 769 0102 (Trinidad and Tobago). Questions can also be addressed to the Office of Research Ethics (ethics.review@utoronto.ca, 416-946-3273).

Sincerely,

Keita Demming
PhD student,
OISE, University of Toronto
keita.demming@mail.utoronto.ca
416 939 1040 (Canada)
868 769 0102 (Trinidad and Tobago)
I have read through this description of the case study and I understand what is required for participation. I understand the nature and limitations of the research. Your signature below indicates how you have decided to allow disclosure of your identity as a participant in the study. You will be given a signed and dated copy of this form to keep.

I understand that my name and/or potentially identifying information will be used in conjunction with the presentation/publication of the results of this research and agree to waive my rights to protect the confidentiality of my responses. In signing this waiver, I further understand that I will be given the opportunity to review and approve or reject material related to my responses prior to publication. Upon review of the material, I also have the right to request that my name not be used in connection with the published material, thereby rescinding this waiver.

**Option 1**
Participant's Name (print): ______________________

Participant's Signature: ______________________ Date: ____________

Participant's contact Information:
Email:
Phone:

**Option 2**
I agree to participate, but wish for my name and/or potentially identifying information to be anonymized in conjunction with the presentation/publication of the results of this research and agree to retain my rights to protect the confidentiality of my responses.

Participant's Name (print): ______________________

Participant's Signature: ______________________ Date: ____________

Participant's contact Information:
Email:
Phone:

I understand that I am free to withdraw my participation at any time and there will be no implications as a result of my non-participation.

Name:

Date:
Organization Consent Form

Dear Manager/Director,

This letter invites your organisation to participation in a study on collaborative approaches to social interventions. For this study we refer to them as Collaborative Social Intervention Organisations (CSIOs) while acknowledging that others may refer to them as lab-like approaches, collective impact approaches or may even see it as the way they work, without labelling their approach. CSIOs usually meet the follow conditions:

- take a multi-stakeholder, multi-sector approach towards implementing social interventions
- strategically take a collaborative cross-sector approach towards developing social interventions
- hold to common agenda, that is to say, all participants come together to collectively define the problem and create a shared vision for solving it
- work to foster reinforcing activities
- encourage a culture of continuous communication, which helps to build trust and relationships among all participants,
- have a strong backbone organisation or team dedicated to coordinating and orchestrating the activities of the working groups
- agree on a common approach to tracking progress by agreeing on shared measurements which allows for continuous improvement, while others explicitly agree on adopting an experimental or prototyping approach to social interventions

Nature and Purpose of the Research:

The main purpose of the project is to meet the requirements of completing a PhD in Workplace Learning and Social Change at the Ontario Institute for Studies in Education of the University of Toronto (OISE/UT). Other objectives of the study are:

- To understand the practice of collaborative social interventions in order to develop insights, principles, models, and strategies to help building capacity around collaborative approaches to social interventions.
- Explain the main factors that contribute to successful collaborative social interventions.
- Identify through the research, common approaches or strategies for agreeing on and developing evaluation criteria.
- Describe the process of starting a collaborative social intervention project.
- Outline the kinds of activities that practitioners do when they meet or gather.
- Develop criteria or strategies for both selecting and approaching potential partners.

What we will be doing is conducting interviews with staff and volunteers, and analyzing secondary documents. The interview schedule will be based on your organisation’s schedule and will strive to be as unobtrusive as possible.

- The results of the study will be summarized and shared with participating organisations, presented at at academic and community focused conferences.
- Another objective of this study is to develop learning material that can help build the capacity of other organisations.
- The findings of the case study will be published as part of a thesis manuscript.
- Sections of the manuscript will be turned into papers, presentations and workshops for both academic and practitioner audiences.

Your part in the research, if you agree, is:

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To give your permission to involve your organization in the research.
- To provide input on the models, insights, principles and strategies developed.
- To agree that organization members’ decision to participate will be based on personal choice, be confidential and that you will not influence their decision to participate or not to participate in any way.
- To forward the researchers’ recruitment letter to staff and volunteers who as individuals will choose whether or not to participate.

What we will do protect your privacy and confidentiality:
- All information will be confidential and anonymous to protect the identity of participants and minimize any potential risk.
- Data will be placed in a locked filing cabinet for five years, and then destroyed.
- All electronic data will be encrypted and stored for five years and then destroyed.
- Only the primary investigator will have access to this data unless otherwise indicated.
- Only Keita Demming, the principal investigator will know who has participated in the project.
- Individual participants will remain anonymous in any presentations of the findings.

Potential limitations in our ability to guarantee anonymity are:
- There are no anticipated limitations and anonymity will be guaranteed as far as the law permits.

Potential benefits, which you might derive from participating, are:
- The study will provide participants with a better understanding of the kinds of principles or strategies they adhere to, whether explicit or implicit.
- Determine if the findings reflect the direction that organisation hopes to be heading.
- The study will help participants understand how they are evaluating their success and will give them time to come develop their own evaluation tools and metrics.
- The study will provide participants with the opportunity to consider how they select and develop partnerships.
- The study will provide the organisation with an opportunity to reflect on the kinds of activities it does when they meet or gather. This can often be a very enlightening process for both the researcher and the participants.

Potential harm if any is:
- No harm is anticipated.

I hope that you decide to participate. If you have any questions, please contact me at keita.demming@mail.utoronto.ca or at 416 939 1040 (Canada) or 868 769 0102 (Trinidad and Tobago)

Sincerely,

Keita Demming
PhD student,
OISE, University of Toronto
keita.demming@mail.utoronto.ca
416 939 1040 (Canada)
868 769 0102 (Trinidad and Tobago)
To Be Completed by Participants

I have read through this description of the case study and I understand what is required for participation. I understand the nature and limitations of the research. I agree to participate in the ways described. I have authority to and give permission for [researcher] to recruit participants for this research. If I am making any exceptions or stipulations, these are:

Name:

Date:

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Appendix F: History of midwifery in Trinidad

The evolution of the Trinidad Midwife

by E. Williams-Cook
Senior Nursing Instructor (Midwifery)
Port of Spain General Hospital

The evolution of the Trinidad Midwife

The evolution of the Trinidad Midwife

The evolution of the Trinidad Midwife

The evolution of the Trinidad Midwife

The evolution of the Trinidad Midwife

The evolution of the Trinidad Midwife
### Appendix G: List of critical incidents that contribute to social innovation

<table>
<thead>
<tr>
<th>Year</th>
<th>Critical Incident</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1700-1720</td>
<td>First hospitals established. Previously all births occur in the home and the community</td>
<td>McIntosh, 2003; Porter, 1999</td>
</tr>
<tr>
<td>1826</td>
<td>Midwifery regulated in Trinidad and Tobago</td>
<td>Appendix E</td>
</tr>
<tr>
<td>1860</td>
<td>Florence Nightingale founded her school for nurses</td>
<td>McIntosh, 2003</td>
</tr>
<tr>
<td>1914</td>
<td>Joseph DeLeed introduced his forceps methods and the idea of pain-free birth. He is considered the father of obstetrics</td>
<td>McIntosh, 2003; Porter, 1999</td>
</tr>
<tr>
<td>1977</td>
<td>Ina May Gaskin publishes her book <em>Spiritual Midwifery</em>. She is credited with being a main contributor to the revival of midwifery in North America during a time when the discourse of the back-to-the-earth movement opened hearts and minds to new ideas</td>
<td>Gaskin, 1977</td>
</tr>
<tr>
<td>1982</td>
<td>Kitchener inquest spurred midwives to get politically organized</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1983</td>
<td>Formation of the Midwifery Task Force</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1983</td>
<td>College of Physicians and Surgeons of Ontario releases statement against midwifery as an autonomous practice</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1983</td>
<td>Midwifery Coalition of Ontario’s first submission to the Health Professions Legislation Review</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1983</td>
<td>Ontario Association of Midwives and the Ontario Nurses and Midwifery Association merge. In joining forces midwives had one new ally and increased legitimacy</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1985</td>
<td>Toronto island inquest into the death of baby Daniel McLaughlin launched midwifery into the public spotlight. The parents of baby Daniel openly support midwives. They gain the support of pro-life and pro-choice groups. Health Profession Legislation Review (Ontario) recommends that midwifery be regulated</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1987</td>
<td>Midwifery Task Force (Ontario) submits its final report</td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>Midwifery Act makes the practice of midwifery legal in Ontario. It should be noted until 1974 the profession of midwifery was written into the license to practice medicine in Ontario, but doctors, because they didn’t value it, had it removed</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1991</td>
<td>Association of Midwives (Ontario) secures liability insurance for practicing midwives</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>Year</td>
<td>Event Description</td>
<td>Source</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>--------</td>
</tr>
<tr>
<td>1993</td>
<td>Midwifery is publicly funded in Ontario</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1993</td>
<td>Midwifery Act in Ontario proclaimed</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1993</td>
<td>Transitional Council of the College of Midwives Ontario is formed. Midwifery education begins at Ryerson, McMaster, and Laurentian Universities</td>
<td>Bourgeault, 2006</td>
</tr>
<tr>
<td>1994</td>
<td>Ontario midwives gain privileges in hospitals</td>
<td>Bourgeault 2006</td>
</tr>
<tr>
<td>2001</td>
<td>A group of Trinidad midwives decide to set up a birthing centre</td>
<td>Trinidad interviews</td>
</tr>
<tr>
<td>2008</td>
<td>Birthing centre established in Trinidad and Tobago</td>
<td>Trinidad interviews</td>
</tr>
</tbody>
</table>