Linking Critical Social Innovation and Health Promotion –

Reflections on a Project Working with Young Marginalized Mothers in the Outskirts of Denmark

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There has been a remarkable lack of both studies and discussions of social innovation in health promotion literature. In the light thereof, this article pursues three interlinked goals. First, it presents a mainstream conception of social innovation and a more critical strand of social innovation literature depicted as relevant for health promotion. This is done by conceptualizing social innovation as needs-based health promotion. Second this perspective is used to analyze a case of health promotion at the local level. The case is based on interviews and observations from a project dealing with the diverse needs of young, marginalized mothers in the outskirts of Denmark. Thirdly central empirical and theoretical lessons to be learned from the case is lifted forward and perspectives pointing onwards based on the linking of critical social innovation and health promotion concludes the article.

Introduction

Social innovation (SI) is a buzzword. Researchers, think tanks, the OECD and the EU have engaged in debates on this matter for the past 20 years. Sandra Bates argues that we are living under an actual 'social innovation imperative' (Bates, 2011). The EU has christened this an era of social innovation and sees SI as a key concept for both policy development and research (EU 2012, 2014 & European Commission 2010, 2011, 2012 a & b). It is remarkable, that this 'SI imperative' has been left largely untouched by the health promotion (HP) literature. Besides a few exceptions, one finds a lack of studies aiming at linking HP and SI – both empirically and more theoretically (for rare exceptions see Currie & Seddon 2014, Farmer et. all 2018 & Mason et. all 2015). Neighboring concepts such as social capital (Hawe & Shiell, 2000), empowerment (Laverack, 2004) and capacity (Labonte & Laverack, 2001) have continuously drawn atten-

tion in the broad HP literature, but the SI literature has not. This article is an invitation to link new streams of social innovation thinking with health promotion. Before I turn to the question of how we can critically define SI and how this is relevant to HP, I look at mainstream SI. I argue that a critical version of social innovation theory is highly relevant to health promotion research and practice. After outlining this alternative position in the SI-literature, I use this to analyze a case of local health promotion in the outskirts of Denmark: looking into a project working with marginalized young mothers on maternity leave.

Mainstream conceptions of SI

SI is typically seen as a key to developing societies (Grimm et. all 2013). Looking across the literature, SI is hailed as central in gaining momentum in the wake of the financial crises of the late 2000, as a way to deal with ageing populations and simply to create development in more (socially) sustainable ways (Grimm et. all 2013, Kesselring et al., 2014). Essential to mainstream conceptions of SI has been the works by Geoff Mulgan, who was head of the significant think tanks 'The Young Foundation' and Nesta in the UK and served as consultant for the Blair government. Andrew & Klein contents that Mulgan has been 'extremely influential in the increased interest in social innovation in the English-speaking world', Andrew & Klein 2010:12). Mulgan defines SI like this:

> *"Social innovation refers to innovative activities and services that are motivated by the goal of meeting a social need and that are predominantly diffused through organizations whose primary purpose are social."* (Mulgan, 2006, p. 146).

The main function of this definition is to differentiate social innovation from business innovation, which is generally motivated by profit maximization and diffused through organizations that are primarily motivated by profit maximization. This is one of the most cited and used definitions. In general, the mainstream conception(s) centers on how SI creates social value, how SI is intrinsic in solving malignant social problems and how it is often necessary to create new institutions crisscrossing the public, private and third sectors to attain SI in practice. The definition should be critically questioned: social innovation for whom? How? At what cost? By which methods? The definition is too broad, and it shares a pro-innovation bias that is a central feature of many innovation studies (Godin & Vinck, 2017a, 2017b). This calls for an alternative conception of social innovation.

An alternative – a critical conception of social innovation

In collaboration with a variety of different people and in a range of different EU-funded projects on urban development, professor of spatial planning Frank Moulaert has expanded and qualified a critical understanding of social innovation during the past twenty years. Moulaert developed his critical understanding of SI as a reaction against 'the narrowly defined deterministic views of innovation as a driving force in urban development strategies' (Moulaert et all 2005:1970) and as a critical corrective to mainstream conceptions of (social) innovation. Moulaert and his colleagues advanced this definition of social innovation:

> *"Social innovation […] is about the satisfaction of basic needs and changes in social relations within empowering social processes; it is about people and organizations who are affected by deprivation or lack of quality in daily life and services, who are disempowered by lack of rights or authoritative decision making …"* (Moulaert, 2010, p. 10).

Compared to Mulgan, there are clear gains in Moulaert's needs-based definition. It provides a better compass for evaluating what kind of social value we are searching for regarding the otherwise quite empty signifier 'social innovation'. Furthermore, it offers a firmer strategic direction since this definition targets empowerment, participation and 'voice' for the most vulnerable (e.g. residents in vulnerable residential areas, marginalized young mothers and so on). For Moulaert, SI is about innovations in social relations, especially for marginalized groups and Moulaert and his colleagues are clearly emphasizing power relations, ethics and inequality on the SI agenda. Social innovation is not just about 'solving problems in new ways' (as it roughly is for Mulgan, 2006, 2007), but about focusing efforts where vulnerable groups are most in need (Delica, 2011). Socially innovative efforts will incorporate process, content and empowerment-oriented elements (Bartels, 2017; Van der Have & Rubalca, 2016; Edwards-Schachter & Wallace, 2017). Summing up: As outlined SI does not separate means from ends but treats needs and problems as inherent in social relations. It therefore involves changing relations through the development of new social practices, institutional arrangements and/or forms of participation.

Critical SI and HP

One of the great virtues of health promotion research is the insistence on viewing inequality in health as a complex issue in which numerous dimensions merge and create a composite, layered picture of what health is (Wilkinson & Marmot, 2003; Diderichsen, Andersen, & Manuel, 2011). Following this, it is

more than difficult to say which dimensions will be able to support people's motivations in relation to engaging them in health promotion practices. This is, in my view, an obvious invitation to look into people's everyday life and their often interwoven and interrelated needs – this also means a shift from looking at, for instance, risks factors as a starting point to instead calling for perspectives that address subjective, institutional as well as structural dimensions. In addition, it is a better starting point for discussing the role of the professional (health promoter) dealing with, for instance, marginalized citizens' diversified needs. Along these lines, several researchers underscore the fact that social issues and social policies could form a fitting foundation to enhance our framework for both understanding and addressing the complexity of health promotion (Dixey, 2013; Diderichsen, Andersen, & Manuel, 2011; Bunton 2002).

A crucial element of Moulaert's definition of social innovation is the clearcut focus on basic human needs. Needs are understood in a quite general and comprehensive way: Material (food, clothing, shelter), social (health, education), existential (self-expression, creativity) and political (active citizenship) (Moulaert, 2009 & 2010). Going all the way back to the Ottawa Charter, we see a broad conceptualization of what should be taken into consideration in terms of working with and understanding health – the Ottawa Charter explicitly focuses on a range of 'basic health prerequisites' – from education to food and social justice (WHO, 1986). There is a striking commonality in working with basic human needs and basic health prerequisites. As a way to expand this, a critical understanding of social innovation is an invitation to explore new directions in the field. One of the few studies that is actually linking SI and HP stresses that the value of the approach (also) lies: "… *in its capacity to redress system failures at the local level*" (Mason et al., 2015, p.121). Based on this, SI is an analytic perspective useful in critically evaluating health promotion initiatives. This provides a link to the case that I will unpack in the following section.

Case and methods

The case consists of the project: *Young mother – In job or education*. The project targets young marginalized mothers (between the age of 15 and 25) that volunteer for weekly, themed gatherings. They have little or no formal education; they are mostly unemployed and struggle with troublesome life trajectories. Seen from the point of view of the municipalities, these young mothers pose a severe challenge to the mainstream welfare institutions. The idea is that the project should explicitly help the mothers with health-related, educational and social-oriented issues, and the goal is to minimize the risk of them ending their maternity leave without a plan for their future. The project is a form of systematic, institutionalized 'out-reach', which in practice follows recommendations and experiences

of what can be seen as holistic health promotion efforts aimed at vulnerable groups (Diderichsen, Scheele, & Little, 2015, Hansen & Stevnhøj, 2004, Bremberg, et al., 2006). The project is located in the city of Nakskov in the municipality of Lolland (two hours south of Copenhagen). Lolland is amongst the poorest municipalities in Denmark, inhabited by more people with unhealthy eating habits and severe obesity than other parts of the region of Zealand. The average lifespan is amongst the lowest in Denmark (77,9 years according to Statistics Denmark). In a health promotion context, it makes sense to reach out to this specific, marginalized group since there is a tendency for '... *healthcare services to be used less often in rural and remote municipalities, where there may be far to midwives, doctors and hospitals*' (Stegeager et al., 2015, p. 25). Additionally the group of young mothers is at risk of not completing an education, not gaining foothold in the labor market and they risk ending up on long-term public benefits (Hansen & Stevnhøj, 2004).

Methodologically the case is a hybrid between an intrinsic and an instrumental case (Stake 1994). It is intrinsic and exploratory since it empirically represents a quite rare example of cross-sectoral health promotion work and it is instrumental in regards to showing how insights from critical social innovation studies can point towards new vistas for health promotion research. I base the construction of the case on observations and interviews. In practice, I did a range of field visits by joining the weekly gatherings a handful of times, observed what went on, how the structure of the day were, how the talk and lingo was. These visits were instrumental in getting to know the professionals and the mothers prior to setting up qualitative live world interviews with them (Brinkmann & Kvale 2015). Getting to know the drills and practices I learned that the project also consisted of a cross sectional group of leaders representing different parts of the administration of the municipality: education and labor market, social policy, health and youth. I did interviews with four young mothers, four professionals and the four municipal leaders.

My ethical concerns circled around the asymmetrical power relations in the interview situation (Kvale 2006, Briggs 2003). Interviewing the mothers, I, as a university researcher, represent someone very far from them in relation to both educational merits and socio-economical privilege. Conversely this could also play a role when I was interviewing the professionals and the leaders, since they could 'school me' in order to lay out 'the truth' about the project (in which they were the everyday experts). Trying to deal with this, my strategy was to use my field visits not only to observe, but also to small talk with the young mothers in order to demystify my interests in their everyday life. The fact, that I was a father was a good common ground to interact from – later, in the interview situations, I could draw on our previous interactions, and it helped create a con-

nection with the mothers. This was also the case when I interviewed the professionals – we had many informal talks prior to the formal interviews. It was somewhat tougher for me to interview the leaders and I actually experienced being 'taught' the facts of the matter. However, this was part of the motivation to interview the leaders in the first place so I did not stop them 'teaching' me.

In the following, I will provide empirical insights from the case, underscoring how I view this as social innovation in practice.

Critical social innovation and health promotion in practice

Starting with a snippet from the interview I did with the project leader (a trained social worker), the diversified needs, the mothers are dealing with becomes visible. Here he is describing the term 'everyday counselling':

> *"… we often write recommendations for the young mothers. This could be in order to secure a one-time grant to help them move from a mold-infested apartment…* (…) *… in relation to communication with the public sector, I help and assist. I help them read the mails they get electronically, help them apply for housing subsidies, to get their hands on the right forms. Simply responding to the different requests from the system…"*

This shows that professionals have a broad range of tasks: They provide knowledge based on their profession, and they all do different kinds of counselling. Here, the social worker simply helps the mothers navigate the public sector. At times, they act as ombudsmen 'within the system'. Related to the understanding of social innovation I outlined above, this is also a sign of how many different types of needs the mothers have.

Shifting focus to how the mothers sees the project, the experience of being helped is strikingly central in the interviews I did with them. I asked, in different ways, about the 'effects' they experienced from participating in the project. Overall, they express a variety of needs, and that it makes sense for them to show up on a weekly basis. Two of the mothers pinpoint it here:

> *"I have gained more from coming here than from the help the municipality can give me. When I'm here (…) they give good advice. When I talk to representatives from the municipality, they are condescending, but here we look into what can be done…" (*Interview with 'Mette')

In addition, from an interview with 'Camilla':

> *"I wouldn't have been the same kind of mother and I wouldn't have been able to make my mind up about my plans for the future if I hadn't been coming here".*

In the narratives, the mothers are appreciative of what they learn in the project regarding health-related issues concerning their children and themselves as new mothers (hygiene, nutrition, physiology and so on), but it is statements like the ones above, that stand out. They experience being heard, being recognized and that the adults help them with whatever difficulties they face in their everyday lives.

As a final example, I will draw attention to a central point, pushed forward by the head of the job center in one of the interviews. We were discussing the conditions for making a project like this, and she said:

> *"…. It may very well be that the preventive measures are not directed at the mothers, but perhaps through the young mothers, we can create prevention for their children. It has been made clear that the effect of this will not be seen within a period of four years, but we might be able to see changes in 8, maybe 12 years' time. When these youngsters are starting in school or in nurseries…. that's when we should measure the effect on their behavior…"* (Manager at the job center).

The quote is essential. It signals that maybe the children are the main target of the initiative and that you need to be patient about when you can 'measure an effect'. Health promotion takes time –so does social innovation. It is pivotal that the managerial level helps create a free space where one is not expected to deliver results or effects from day one.

Concluding remarks – lessons from the case and looking ahead

Linking critical social innovation and health promotion has a large potential. This short discussion is an invitation to push the companionship further – to challenge and qualify the multiple, possible connections. We need further empirical insights and theoretically grounded discussions. Nevertheless, building on the brief insights from the case above, it is, firstly, promising to explore health-promoting innovations in social relations. Secondly, to advance discussions of 'system failures' in, for instance, mainstream health initiatives in the public sector, perspectives derived from a critical perspective on social innovations stand out as productive (Mason et al. (2015). This case also shows how futile it is to utilize sharp demarcations between social and health-based initiatives. For the young mothers, these demarcations will only add to the burden of managing a stressful everyday life. Working explicitly with needs and 'innovating social relations' can be conceptualized as sense making – it creates a sense of coherence for the mothers to use Antonovsky's (1998) concept.

Theoretically, a critical social innovation perspective can help formulate and qualify a needs-based health promotion approach. As hinted, this can revive

previous, yet ongoing discussions about relations between social and health-oriented policies (Bunton, 2002). However, the concept of 'needs' have to be refined, challenged, further developed and linked more firmly with, for instance, discussions of needs assessment, empowerment and capacities in existing health promotion literature (Dixey, 2013; Laverack, 2004).

References

Andrew, Caroline & Klein, Juan-Luis (2010). *Social Innovation: What is it and why is it important to understand it better.* Report prepared for the Ontario Ministry of Research and Innovation. CRISES, Quebec

Antonovsky, A. (1998). The sense of coherence: An historical and future perspective. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. E. Fromer (Eds.): *Resiliency in families series*, Vol. 1. S*tress, coping, and health in families: Sense of coherence and resiliency*, 3-20. Sage Publications

Bates, S. (2011). *The Social Innovation Imperative: Create Winning Products, Services, and Programs that Solve Society's Most Pressing Challenges.* McGraw-Hill

Bartels, K. (2017). The double bind of social innovation: Relational dynamics of change and resistance in neighbourhood governance, *Urban Studies*, Vol 54, Issue 16, 3789-3805

Bremberg S. et al. (2006). *New tools for parents: Proposals for new forms of parent support.* Swedish National Institute of Public Health, ISBN 91-7257-443-7

Briggs, C. (2003). Interviewing, power/knowledge, and social inequality. In Gubrium, J. F., & Holstein, J. A. *Postmodern interviewing*, 242-254. Thousand Oaks, CA: SAGE Publications

Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the Craft of Qualitative Research Interviewing.* (3. Ed.) SAGE Publications

Bunton, R. (2002). Health Promotion as Social Policy. In Bunton & Macdonal ed. *Health Promotion. Disciplines, diversity and developments.* Routledge. (Orig. 1992)

Currie, W. L. & Seddon J. M. (2014). Social Innovation in Public Health: Can Mobile Technology Make a Difference? *Information Systems Management*, 31:3, 187-199

Delica, K. (2011). Social innovation og områdebaserede indsatser - mod en kritisk socialvidenskab om innovation. I S. Voxted, & C. J. Kristensen (red.), *Innovation og entreprenørskab*, 113-130. Hans Reitzels Forlag.

Delica, K. N. (2016). *Multilevel (mental) health promotion as social innovation in peripheral areas of Denmark: reflections on a local initiative targeting vulnerable young mothers.* Paper presented at 4th Nordic Conference for Rural Research, Akureyri, Island.

Delica, K. N., & Lau, C. B. (2020). Håndholdte indsatser som behovssensitiv sundhedsfremme i en kommunal kontekst. I P. Tanggaard Andersen, C. Bech Lau, & H. L. Andersen (red.), *Sundhedsfremme i kommuner og lokalsamfund: Mellem forskning, planlægning og praksis* (s. 193-211). Hans Reitzels Forlag

Diderichsen, F., Andersen, I., & Manuel, C. (2011). *Ulighed i sundhed - årsager og indsatser.* København: Sundhedsstyrelsen.

Diderichsen F., Scheele C.E., Little I. G. (2015). *Tackling health inequalities locally – the Scandinavian experiences.* Københavns Universitet.

Dixey, R (2013). *Health promotion - global principles and practice.* CAB International.

Do Adro, F., Fernandes, C.I (2020). Social innovation: a systematic literature review and future agenda research. *International Review on Public and Nonprofit Marketing*, 17, 23–40.

European Commission (2010). *This Is European Social Innovation*. Brussels: European Union.

European Commission (2011). *Horizon 2020 – The Framework Programme for Research and Innovation*. Brussels: European Union.

European Commission (2012a). *Financing Social Impact. Funding Social Innovation in Europe mapping the way Forward*. Brussels: European Union.

European Commission (2012b). *Strengthening Social Innovation in Europe*. Brussels: European Union.

European Union (2011): *Empowering People, Driving Change: Social Innovation*. Bureau of the European Policy Advisers, European Commission. Available at: http://ec.europa.eu/archives/bepa/pdf/publications_pdf/social_innovation.pdf

European Union, Bureau of European Policy Advisors (BEPA) (2014). *Social Innovation. A Decade of Changes*. Available at: https://europa.eu/espas/orbis/document/social-innovation-decade-changes

Edwards-Schachter, M. & Wallace, M. (2017). 'Shaken, but not stirred': Sixty years of defining social innovation. *Technological Forecasting and Social Change*. Vol. 119. 64-79.

Farmer et all. (2018). Applying social innovation theory to examine how community co-designed health services develop: Using a case study approach and mixed methods. *BMC Health Services Research*. 18: 68.

Godin, B. & Vinck, D. (2017a). Innovation: From the Forbidden to a Cliché. In Godin & Vinck (ed.): *Critical Studies of Innovation – Alternative Approaches to the Pro-Innovation Bias*. Edward Elgar.

Godin, B. & Vinck, D. (2017b). Conclusion: Toward Critical Studies of Innovation. In Godin & Vinck (ed.): *Critical Studies of Innovation – Alternative Approaches to the Pro-Innovation Bias*. Edward Elgar.

Hansen, A. & Stevnhøj, A. L. (2004). *Ung og sårbar mor – fra før graviditet til job. Håndbog I sammenhængende indsatser*. CABI

Hawe, P. & Shiell, A. (2000). Social capital and health promotion: a review. *Social Science & Medicine*. Vol. 51, Issue 6, 2000. 871-885.

Kesselring et all (2014). *Social Innovation for Active and Healthy Ageing – A Case Study Collection*. The King Baudouin Foundation, Bruxelles.

Labonte, R & Laverack, G. (2001). Capacity Building in health promotion, Part 1: For Whom? And for what purpose? *Critical Public Health* vol 11, no. 2. 111-127.

Laverack, G. (2004). *Health Promotion Practice: Power and Empowerment*. Sage Publications.

Kvale, S. (2006). Dominance Through Interviews and Dialogues. *Qualitative Inquiry*, 12(3), 480–500.

Mason et. all (2015). Social innovation for the promotion of health equity. *Health Promotion International*, Volume 30, Issue 2, 1. 116-125.

McCallum et all (2009). *Social Innovation and Territorial Development*. Ashgate. Farnham.

Moulaert, F. (2009). Social Innovation: Institutionally Embedded, Territorially (Re)Produced. I McCallum et all (2009). *Social Innovation and Territorial Development*. Ashgate. Farnham.

Moulaert, F. (2010). Social Innovation and Community development: Concepts, theories and challenges. I Moulaert F., Martinelli F., Swyngedeuw E., Gonzales S. (red.). *Can Neighbourhoods Save The City? Community Development and Social Innovation*. Routledge. London.

Moulaert et. all. (2005). Towards Alternative Model(s) of Local Innovation. *Urban Studies*, 42(11), 1969–1990.

Moulaert et all. (2014). *The international handbook on social innovation: Collective action, social learning and transdisciplinary research.* Edward Elgar, Cheltenham, UK

Mulgan, G. (2006). The Process of Social Innovation. *Innovations*. Volume 1, Issue 2. 145-162.

Mulgan, G. et. all. (2007). *Social Innovation: what is it, why it matters, how it can be accelerated.* The Young Foundation.

Grimm et all (2013). Social innovation, an answer to contemporary societal challenges? Locating the concept in theory and practice. Innovation: *The European Journal of Social Science Research*. 26:4, 436-455.

Skov, H. K & J. Wittrup (2015). *Sårbare børn – hvem er de, hvor bor de, og hvordan klarer de sig i skolen?* København: Socialstyrelsen og KORA.

Socialstyrelsen (2013). *Inklusion, deltagelse og bedring – unges med psykosociale vanskeligheder i lokalsamfundet*. Socialstyrelsen.

Stake, R. E.(1994). Case studies. In N. K.Denzin & Y. S.Lincoln (Eds.), *Handbook of qualitative research* (pp. 236–247).Thousand Oaks, CA: Sage.

Statistic Denmark, Table of life expectancy for different municipalities in Denmark: https://www.statistikbanken.dk/10015

Stegeager, N., Kildedal, K., Laursen, E., & Verwohlt, B. (2015). *En særlig indsats - Målrettet socialt udsatte børn og unge på Lolland-Falster.* Institut for Sociologi og Socialt Arbejde, Aalborg Universitet.

The Young Foundation (2016). *Social Innovation in Health and Social Care*. Policy Paper for Social Innovation Europe (SIE).

Van der Have, R. P. & Rubalcaba, L. (2016). Social innovation research: An emerging area of innovation studies? *Research Policy*. Vol. 45, issue 9. 1923-1935.

WHO (1986). *The Ottawa Charter for Health Promotion*. First International Conference on Health Promotion, Ottawa, 21 November 1986.

[i] Based on Google Scholar Mulgan 2006 has 1049 citations and Mulgan et all 2007 has 1554 citations (as of April 2020). Comparatively Moulaert et all 2014 and Moulaert et all 2009, that can be seen as central publications in the alternative, critical social innovation research has 665 and 334 citations. Additionally it is telling, that one of the most recent literature reviews in the field of social innovation (do Adro & Fernandes, 2020) do not cite any of Moulaerts central texts on social innovation or even the authoritative 'International handbook on social innovation' (Moulaert et all 2014). This substantiate, that Moulaerts critical grasp of social innovation is not mainstream.