Managerial relations in Kenyan health care: Empathy and the limits of governmentality

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Abstract

This article describes relationships between a team of mid-level government health managers working in a rural Kenyan District and those whom they managed; health workers based at rural health facilities. In this context, managerial expertise was heavily informed by personal biography and a moral obligation to empathise with the difficult working conditions and familial responsibilities of junior staff. Management should be studied seriously in anthropology, as a powerful social and bureaucratic form. This focus must extend beyond a concern with tactics and technologies of governance to consider how modalities of managerial expertise are also shaped by biography, intersubjectivity and professional identity.

Key words: Management; Kenya; DHMT; health; bureaucracy; governmentality; empathy.

To manage something is to apply skill or care in order to encourage desired outcomes. Ideas about what constitutes good management lie at the heart of organizational cultures, development interventions, and processes of governance. In diverse workplaces around the world, managerial positions are roles that command respect and confer power. The field of management provides insights into how people seek to organise their lives, how structures of power permeate organisations, and the future worlds that people are invested in creating.

Whilst anthropology has a long tradition of investigating questions relating to the composition of power in formal organisations, it has largely neglected the ethnographic study of management as a form of work. Anthropological considerations of management have focused almost exclusively upon the use of bureaucratic tools and techniques in the construction of knowledge (e.g. Li 2007, Mitchell 2002, Riles

2006, Scott 1998). These approaches reflect the intellectual legacy of Michel Foucault's work in recent anthropological writing, with its emphasis on tactics and technologies as central to modern forms governmentality (Foucault 2002 [1978]: 211). As Miller and Rose have it,

> 'To understand modern forms of rule, we suggest, requires an investigation...of the apparently humble and mundane mechanisms which appear to make it possible to govern: techniques of notation, computation and calculation; procedures of examination and assessment; the invention of devices such as surveys and presentational forms such as tables....the list is heterogeneous and is, in principle, unlimited' (Miller and Rose 1990: 8).

The use and implementation of tools and techniques is important to many kinds of management. Managerial instruments are central to interventionist practices which rely upon an ability to render things 'legible' or 'technical' (Ferguson 1990, Li 2007, Scott 1998). Managerial practice can be oriented towards organisational stability or engage the creation of new futures and new ways of knowing. However, management is also a kind of work that involves responding to and shaping relations with other people, whilst manipulating the arrangement of kinds of resource. Organisations, professional identities, and governmental forms are partly shaped by the relational, affective and ritualistic dimensions of their disciplinary orders and techniques (cf. Navaro-Yashin 2012, Weeks 2004).

Management therefore cannot be reduced to the governmental or the bureaucratic in purely technical dimensions. It takes on aspects of both of these fields, but it is also interpersonal, relational and 'interobjective' (Latour 1996) in ways of its own. To understand modern forms of rule requires that a

focus on tactics and technologies of government be complemented by accounts of the ways in which governmentalities are shaped, and on occasion limited or reworked, by the practical, relational and affective dimensions of managerial and other forms of governmental work.

This article draws upon ethnographic fieldwork with a small group of Kenyan health managers who supervised the delivery of health care across a rural Kenyan district.[1] On the face of it, their work was quintessentially governmental in a Foucauldian sense. It was concerned with improving the health of the population through a discursive assemblage of techniques of measurement, representation, and technical expertise. This article moves beyond a concern with management techniques to explore the ways in which for these managers, managerial practice, and in particular the management of junior staff, was also heavily inflected by emotive and relational rationalities that related to the lived experience of bureaucratic labour. Following the example of recent ethnographic studies of government institutions and bureaucracy (e.g. Anders 2009, Chalfin 2010, Feldman 2008, Gupta 2012, Hull 2012, Mathur 2015), the article contributes to a growing concern in anthropology to interrogate the intersections between rationalities of governing and the working lives and practices of those tasked with the practicalities of governing itself. By drawing attention to managerial biographies and relationships, this article makes the case for using broader frameworks for understanding managerial practice and mentalities of rule than a limited conceptualisation of governmentality as primarily relating to the use of bureaucratic techniques. Managerialism is a domain of governance. It is also a domain of care, consisting of practices directed towards the wellbeing of others and shaping the worlds which we share (Bear and Mathur 2015, Brown 2010, Mayeroff 1971).

Being human: Empathy in management practice

To explore management in this setting, I bring insights of governmentality into conversation with an ethnographic theorisation of empathy. My research participants used the phrase 'being human' to describe the practices of affective intersubjectivity which directed their managerial engagements. I gloss this orientation to work as empathetic. Their phrase, 'being human', referred to a social obligation produced by the intersections of personal biography, forms of interrelatedness, and the moral imperative to imagine and respond to the challenging lives and needs of others.

Managers engaged with other health workers in consideration of the obligations that they believed their colleagues had to other people. Building on a sense of personhood as created and shaped by responsibilities that emerged from kinship and other kinds of interpersonal relations, 'being human' took on additional specific meanings in the context of managerial work. Managers believed that all Ministry employees experienced the need for self-betterment through professional and educational development. Also, it was felt that government staff should have a decent enough income to live comfortable lives and support their families. Finally, mangers strove to accommodate the emotional sensitivities of others and underlined the need to respect these in social interactions. Working life was not without conflict and disagreement. Nonetheless, everyday managerial labour was characterised by a moral commitment to a form of bureaucracy which unfolded within an empathetic field concerned with the well-being of fellow workers, a concern which could be extended across scale when managers talked about their desire to 'serve the nation' and the people of Kenya.

In talking of empathy then, I am not grappling with the philosophical question of the extent to which empathy renders the consciousness of the other knowable (e.g. Geertz 1974, Hollan and Throop 2008, 2011, Robbins and Rumsey 2008). Rather, I am using empathy as a heuristic term to describe a field of managerial practice. In *The Theory of Moral Sentiments* (2002 [Original 1759]) Adam Smith outlines a theory of sympathy which is very close to the form of interrelation that my research participants termed

'being human', and which I have termed empathetic. Smith describes sympathy as an intersubjective process that emerges through a person's engagement within a shared social field. Sympathy, for Smith, takes place through a combination of imagination and personal experience, providing a rationale for moral feeling and action. Smith argues, 'Sympathy does not arise so much from the view [i.e. one's opinion or perception] of the passion, as from the situation that excites it' (Ibid: 15). Sympathy for Smith is not an internalised emotional feeling based upon our thoughts about the kinds of sentiment that we observe in others. It is something that materialises through our relationships with others within an interactive, experiential field.

To underline how feelings of sympathy emerge, Smith uses the metaphor of the tightrope walker. Viewing the tightrope walker causes sensations in one's own body as one imagines swaying upon the high wire; 'The mob, when they are gazing at a dancer on the slack rope, naturally writhe and twist and balance their own bodies, as they see him do, and as they feel that they themselves must do if in his situation' (Smith 2002 [Original 1759]: 12). In this sense, Smith was only partly concerned with the imaginative dimensions of this process, which German philosophers later described as 'feeling into' (*einfühlen*), the term which was later translated as 'empathy'.[2] Smith's broader concerns were with the way that knowledge of others and oneself, mediated by sensory and emotional experience, could shape social behaviour and moral action.

As in Smith's examples, the managerial empathy enacted by these Kenyan managers emerged only partly from the imaginative projection of self into other. Feelings of empathy were also shaped by a sense of connectedness assumed to emerge from similar life experiences. There was a sense among this group of Kenyan managers that they were in-it-together with those whom they managed, through their joint experience of working for the Kenyan government. When implementing new forms of health organisation and supervising the practices of junior staff, managers juxtaposed their own experiences

and employment biographies alongside an imagined projection onto junior staff of the challenges they assumed their junior employees faced within and beyond their work. Fundamental to this empathetic orientation to bureaucratic labour was a sensitivity towards the way that the emotional self was understood to be embedded within and shaped by a shared praxiographic field.

The District Health Management Team

In Kenya, the District Health Management Team (DHMT) is a group of health professionals with divergent areas of expertise, whose mandate is to organize the delivery of health services across a large administrative area.[3] The managerial team who participated in this study comprised a medical doctor, two clinicians,[4] a nurse, an administrator, a records officer, a laboratory technician, a public health officer, a nutritionist and a pharmacist. In addition to its core members, the team also included a number of 'co-opted' members responsible for particular programmatic interventions, such as the Kenya Expanded Programme for Immunisation, and for particular areas of health care, including HIV/AIDS and reproductive health. The District where they worked contained a total of 23 health facilities which served a population of around 150,000 people. All but three health facilities in the District (two missionary and one private hospital) were managed by the Government of Kenya.[5]

Falling within the mandate of the Ministry for Public Health and Sanitation,[6] the tasks of the management team involved collecting large amounts of information about the effectiveness of health services in the District; co-ordinating training and other meetings; managing the distribution of pharmaceutical and non-pharmaceutical supplies; supervising relationships between the Ministry and 'partner organisations' (NGOs and foreign governmental organisations); and co-ordinating a range of community-based health outreach initiatives. The work of the team rarely involved clinical practice. With the exception of the District pharmacist who was tasked with the management of the pharmacy at

the District hospital, none of my research informants directly offered patient care within the scope of their work for the government.

Although the District health managers worked to disseminate new recommendations on best practice for care and treatment, only very rarely (and usually by chance), did they observe clinical practices such as patient consultations. For example, a Provincial directive ordered all health facilities to provide an Oral Rehydration Therapy (ORT) corner, where young children suffering from diarrhoea or vomiting could receive potentially life-saving rehydration fluids whilst waiting to see medical staff. This initiative was vigorously managed by the managers. Oral Rehydration corners were carefully inspected during supervisory visits – Were cups available? Clean water? Were Oral Rehydration sachets easily accessible? Was the Oral Rehydration corner arranged tidily? Any necessary improvements or comments were documented in an action plan at the end of the visit. One research participant took photographs of Oral Rehydration corners at different health facilities and showed these at a staff meeting, drawing attention to well and less well-organized arrangements. However, although the technical aspects this intervention was managed diligently, the practical aspects of ORT delivery fell outside of managerial concern. During visits to health facilities, the DHMT members did not check among patients to see if very sick children had been given ORT, nor did they attempt to observe the delivery of ORT in practice.

In this sense, the work of the District Health Management Team was the epitome of a managerial biopolitics (Foucault 2008). Here, 'the clinic' as a set of institutionalised knowledge practices that coalesce around a 'gaze' upon the body (Foucault 1989 [1973]), was not so much absent, as elaborated upon a more removed scale through the management of interventions upon bodies (rather than the direct management of bodies themselves). Yet whilst these managerial forms might seem paradigmatic of a modern liberal form of governmentality concerned with the 'conduct of conduct', the mangers with whom I worked viewed the technical rationalities of monitoring and the management of systems as

insufficient for managing the conduct of others. Health managers spoke frequently of the need to 'encourage', 'motivate' and 'support' junior staff. Indeed, part of the reason why the managers did not observe the delivery of oral rehydration was because to do so would have been ridiculous and belittling to their staff; clinical care itself was an area in which managers viewed their staff as being already experts, and which therefore did not require management. Managers feared that they risked demoralising staff if they appeared to disrespect their colleagues' professional expertise.

Failing to properly support the emotional needs of junior staff was a substantial concern for managers. These needs had both professional and personal dimensions. A managerial sensibility towards the context in which subordinate staff worked involved frequent reference to the underlying difficulties health workers faced in their everyday work – repeatedly making visible of factors that have been called 'structural' in other contexts (see e.g. Farmer 1992, 2004, Kleinman, Das and Lock 1997). These constraints were foregrounded in such a way that managers could demonstrate empathy with the emotional burden of working in such a context. Writing about medical students in Malawi, Clare Wendland has described a similar institutionalised orientation towards others, described by her informants as needing to have 'a heart for the work', which she translates 'as a sort of responsible empathy, or empathetic responsibility' (Wendland 2010: 177). Wendland argues that 'heart' emerges as an important extension of what it is possible for Doctors to provide to patients in a context of intractable difficulties and shortages; 'these Malawians saw attachment and love as key to doing good work in a situation of suffering' (Ibid: 179-180).

Whilst Wendland's focus is on engagements between Malawian doctors and their patients, for the District Health Management Team, managerial empathy towards colleagues similarly emerged from a sense of structural constraints and the difficulties faced by people who worked for the Ministry of Health. The intensity of this empathetic sentiment was further related to the somewhat precarious

status embodied by these managers themselves, a group of people whom as mid-level bureaucrats held positions of relatively high status, yet whose position as 'elites' was markedly ambivalent. In contemporary Kenya, as elsewhere in Africa, social influence is increasingly held by those who work in politics or for international agencies, rather than as civil servants (see also Anders 2009). The concerns which managers recalled through empathetic sentiment as they managed others were the same ones which they themselves felt; the struggle to educate oneself and one's children; the demoralising nature of working in a health system marred by lack of resources and equipment; and the sense that remuneration for one's labour was inadequate.

The remainder of this article explores these dynamics of empathetic management in more detail. My focus is upon the management of junior staff, because it was in such instances that the imperative to empathise was most visible. I begin by describing the working biographies of the District Health Management Team themselves to outline how their own employment trajectories and sense of professional precarity shaped the way that they engaged with others as managers. I then go on to describe in more detail how empathy became an organising principle in managerial practice, with a particular focus upon how orderings of kinship provided motifs for structuring empathetic managerial relations. In the final sections I return to the question of the relationship between empathetic bureaucracy and mentalities of government.

Working for Government

Among members of the District Health Management Team, the ambivalent nature of their own status as elites shaped boundaries around the moral and practical possibilities for managing others. This ambivalence was experienced in two ways; firstly, through the limits of their power and professional standing in the present, and secondly, through personal recollections of their own past struggles. These

struggles were brought to mind empathetically as the managers observed the experiences of others. The economic and professional difficulties that most members of the District Health Management Team experienced in their own working life had affected them profoundly. For example, as is common for those employed by the Ministry of Health, many had been posted to remote parts of Kenya early in their professional careers. These informants spoke of the kindness of people who had befriended them during these difficult and lonely periods of their lives; emphasising how such interactions took on the quality of kinship relations, their caring and supportive qualities underlined by the sharing of food and company. In the present, it was the constant struggle to make ends meet whilst pursuing the bourgeois goals that were deemed to be fitting to their station that troubled these managers, who worried about paying the school and university fees of their children, and the success of their house building and business projects.

There were two main career paths into the District Health Management Team. For a small minority with a degree-level qualification in the medical professions, appointment to the District Health Management Team was an early level career position, often a first posting.[7] This employment trajectory applied to the team leader, the District Medical Officer, who was a medical doctor, the District Pharmacist, and the District nutritionist, who were educated to degree level, all of whom were in their early to mid-30s. The nutritionist and the pharmacist were both in their first job since gaining their degree. The second mode of entry into the District Health Management Team was via gradual career progression through government ranks, as a nurse, laboratory technician, public health officer, clinician or administrator and applied to the remaining members of the team, all of whom were in their 40s or 50s. It was those members of the District Health Management Team who had experienced long careers within the Ministry of Health whose employment biographies most profoundly shaped their own managerial practice. Progression through employment ranks was often marked by accepting transfers, which involved long periods of working away from spouses and children, and struggling to pay privately for

academic qualifications that would aid promotion. At the time of fieldwork, many of these managers were engaged in self-funded private study at Masters level, a mark of prestige in its own right, but also a sign of an implicit intention to manoeuvre into better employment positions in the future.

Recollections of the struggles they had undergone to succeed professionally and gain promotion were counterpoised by difficulties that these managers experienced in their work in the present. Employment in mid-level management of the Ministry of Health conferred ambiguous social status for a number of different reasons, many of which could be traced back to the sense that remuneration was viewed as inadequate and working conditions difficult. Kenya is a country where regular salaried employment is highly prized. Official unemployment in the country is around 40%[8] and is substantially higher than this in rural areas. Travelling out to remote health facilities, the DHMT were revered by praise names, like *Jatelo,* meaning leader, or referred to respectfully in terms of their qualifications; *Dactari* (Doctor) or *Sista* (nurse). Yet the salary received by these managers was not sufficient to meet their aspirations and obligations to their family members, and did not compare well to what their contemporaries earned in the NGO or business sectors.

The lure of work outside of the Ministry was one mark of the ambivalent value accorded to working for the government. One distinguishing factor of the better-qualified group of managers was that their career aspirations more commonly included moving to jobs outside of government to become employed by international or non-governmental agencies. Those who left government service for the NGO sector often enjoyed significantly higher salaries, travelled to conferences and meetings where they stayed in expensive hotels, and received other benefits such as private health care. Moreover, they worked in well-equipped offices with the necessary resources. Frustration at not being able to do their jobs 'as they were supposed to' and being unable to provide services to the Kenyan people was a recurring theme in accounts of people who had left the Ministry. One former government employee whom I

interviewed recalled his decision to move from the government to the NGO sector after years of professional difficulties, emphasising his desire to work in an organisation where he could make a difference. He recalled, 'improving services in the public sector I was seeing it as a tall order because, most of the times you have shortage of what you need to use so that you ... become frustrated and [in the beginning] you think you can do much [to improve things], but things are not going on, resources are not being allocated as you wish', before going on to describe leaving government work to go to an NGO as a way to motivate himself, 'Yeah so I thought, fine I also need to motivate myself to see that I need to do this, I have the resources then I create a difference then I get motivated also.'[9]

Another retired informant similarly recalled the years he spent in a District Health Management Team[10] as a time of frustration, describing how dispiriting it was to travel around the District on supervision visits and have no capacity to deal with problems facing staff in the peripheral health facilities. Although he wanted to support his colleagues, funds to repair and fuel vehicles to visit more remote facilities were limited and visits were infrequent. His team often only managed to visit the health facilities once every six months. During visits, they marked issues on their checklist that need resolving, only to return to the same health centre six months later and find the same list of issues, the same unresolved problems. Emphasising how deeply this had demoralised him, he reminisced, 'It was not really effective and I would not wish to go back to that job.'[11]

In addition to seeking out employment with NGOS, often by building strategic relationships through encounters during their work for the government, many of the District Health Management Team had business interests, which augmented their government salaries. One had a small transport business, collecting commission from a mini-bus (*matatu*) and three-wheeled taxi (*tuk-tuk*) as well as some flats that she rented out. Others had partnerships in private medical practices and pharmacies in the nearby city of Kisumu. Pursuing an entrepreneurial side line, or 'hustle' as a column in one popular Kenyan

newspaper had it, is common practice among wealthier Kenyans, and is not limited to those who work in the public sector. However, despite the commonality of such practices, the search for wealth and personal development outside of their salaried employment was also a reflection of the limited economic potential of these mid-level managerial positions.

My informants' emphatic statements that such work was 'only done after working hours', or more commonly, their reluctance to discuss these topics at all, underlined further sensitivities around this kind of work that were shaped by a very dense register of associations around 'corruption'. A dominant public discourse in Kenya at the time assumed that corruption was widely practiced, particularly among elites, and frequently endemic in government institutions. Corruption scandals and misuse of public funds were the continual focus of print and social media. At the same time, this public narrative overwhelmingly condemned corruption as both morally reprehensible at the individual level and on a wider scale as detrimental to national development. The shadow of assumed or potential corruption cast itself over many aspects of the managers' work. In particular, concerns around corruption were rendered visible in relation to a final point of ambivalence surrounding the managers' professional status, the allowances that they received as part of their work. Allowances contributed up to one third of monthly salaries and the amount and frequency which with they were received was a mark of seniority within the Ministry.[12] Highlighting the centrality of these allowances to daily survival, the managers often referred to them colloquially through metaphors of eating, and some allowances were referred to as 'lunches.'[13] On one occasion when there were no training courses or workshops on the horizon, I overheard someone ask, 'What do we have on this week?' and receive the jocular reply, '*Njaa!',* which is the Swahili term for hunger.

In Kenya, as in many other countries in Africa, the payment of allowances is a marker of prestige, associated with professional labour and business (Brown and Green 2015: 75-6, Green 2015: 67). But

metaphors of eating also have more rapacious connotations across many parts of Africa, including Kenya (Bayart 1993, Wrong 2009). Many members of the managerial team arrived regularly at work before 8am and worked with dedication, and viewed the allowances they received as a well-deserved entitlement, which augmented their small salaries. However, managers were so often called to meetings and training courses that it could be hard to find them in their offices, and they were sometimes tempted to chase allowances, for example by attending a training course that was not relevant to their own expertise. This fed into stereotypes of self-interested government bureaucrats who prioritised attending meetings in order to receive allowances and neglected other important activities. One employee of an organisation who worked closely with the District Health Management Team spoke of the prioritisation of allowances over other kinds of organisational vision as 'a disease, *per diem*usis.' My research informants – including those who worked for the government – revelled in stories of how key participants at meetings had quickly 'run away' when it was clear that there would not be an allowance paid to them, but also spoke with concern about people who took allowances meant for others, or who used their cunning to move between two or more meetings on the same day and receive multiple allowances without engaging properly with the matter at hand. 'That is not good', they might say, 'It is nice to get something but you have to be human' (cf. Olivier de Sardan 1999).

This reliance upon allowances had a further problematic register, which was perhaps even more consequential to my research participants than concerns about 'corruption'. The majority of allowances and 'lunches' were paid by non-governmental and foreign governmental agencies that worked in the District. These aid organisations funded vast swathes of health care in the region. The material and financial presence and influence of these organisations was such that managerial capacity became symbolically and practically undermined as government staff worked alongside organisations which were clearly much better resourced than the Ministry of Health. Managers sometimes complained that they had been 'reduced to begging from our partner [organisations]' and that they worked in

environments where 'nothing was government'. Allowances revealed the unequal developmental economy within which managers worked and the limits of their power in relation to that of those whom they called their 'partners' (Brown 2015).

Bureaucrats and bureaucracy are often the subject of prejudice and critique (e.g. see du Gay 2000). However, the extent to which these women and men felt forced to seek additional income to meet financial shortcomings and class-based expectations; the range of meanings attached to the allowances paid to these health workers and other inferences associated with 'working for government' rather than in business or for NGOs, are examples of how negative associations of bureaucratic labour can be experienced more acutely by bureaucrats working in Africa than elsewhere. There is no doubt that the District managers led privileged lives in relation to many Kenyan people, especially those who lived in the rural District which they served. This gave way to a sense of status and respect. However, the power acquired through this status was markedly ambiguous; shortages of resources and low salaries received for their work could leave managers despondent, tired of trying to perform important work without the necessary resources and forced to search for additional forms of income through *per diem* and private enterprise. These factors in turn fed into entrenched negative stereotypes of bureaucrats. In working for government, the District Health Managers incorporated this range of contradictory and sometimes stigmatising associations. Their elite status was profoundly ambivalent.

Empathy in management practice

The difficulties that the District Health Management Team experienced in their own working lives were extended empathetically towards those whom they managed. It was widely understood that staff who worked in rural facilities were struggling financially, had many responsibilities outside of work to family

members, and – like themselves – needed to be 'motivated' through invitations to training events and meetings where they would receive financial incentives.

In this context, management practice took place within a moral economy shaped by a 'politics of recognition' (Fraser 1997) relating to employment biography and professional status.[14] Empathy was central to this. Demonstrating empathy allowed managers to underline an emotional orientation to others, which they could use to encourage staff to be ready for the difficulties which might befall them, but also to give their junior staff strength in the knowledge that they shared – and understood – their difficulties. For example, the District Tuberculosis Co-ordinator recounted the story of his first government posting during a training course for health workers. He described arriving to work at a District Hospital to find that his boss was just about to retire. The boss retired a month later. The following week the only remaining nurse working in the TB clinic told him that he might be late on Monday and left him with the keys so that he could open up. Monday came, and when the nurse didn't show up he was told that he was on leave for six weeks! Left on his own, he had to do the best that he could. The manager emphasised this in his speech to these junior employees; 'The reason we send you for training is because if you are well prepared for your work you can see what you can do.' In other words, we support you as best we can, because we know the struggles that you suffer in your work.

While managers used empathy as a way of encouraging staff to work hard in difficult conditions, empathy was also a structuring mode in other kinds of management encounters. During seven months of ethnographic fieldwork with these managers, I recorded no cases of open disciplinary action, of any kind, taken against health workers. Perhaps more significantly, the majority of management team members avoided *any* kind of criticism of those whom they managed. Even what might be thought of as relatively minor reproaches, like telling staff at a facility that their maternity room was not clean enough, were broached with utmost care and approached indirectly, for example by framing critique

through fictive kinship addresses that allowed managers to position themselves as offering the caring guidance of parents rather than directly engaging in critique or reprimand. I was frequently told that it was bad management practice to be overly critical. What was important, as a manager, was to listen and be supportive, particularly given the difficult working conditions that many of their junior staff faced in remote, ill-equipped facilities. Being too critical, some informants worried, might 'chase people away' from work within the government.

Meanwhile, subordinate staff engaged this empathetic managerial style by presenting themselves not simply as people with professional difficulties, but as human beings who were sensitive, struggling individuals requiring care and support. When the staff of one health facility were told that they should discontinue the practice of using a safe motherhood grant to pay themselves a locum fee to provide night-time maternity care on top of their regular salaries, they sent back a message to the District Managers that it would be detrimental to staff morale to reduce or stop the payment given that they had already started such a system and had 'become used to receiving this money.' They sought to persuade their managers into a particular course of managerial action by foregrounding the relationship between their own emotional sensitivities and their working outputs.

Health workers also raised complaints when they felt they had been 'treated harshly'. After receiving some sharp words from a manager regarding persistent absenteeism in her facility, one health worker visited another manager's office in tears, complaining that the management team were not supporting her in her efforts to improve health care. She argued that she had been working hard in difficult circumstances and deserved the respect of the District managers. Instead she was being criticised and people were talking badly about her! When I enquired of my informant whether he thought that managerial practice should involve a balance between reprimand and encouragement, he told me, 'No,

the way we are doing supervision nowadays we don't reprimand we just find the problem and then look for the way forward.'

Formal disciplinary procedures were also rarely undertaken.[15] Even in quite serious cases of professional misconduct, such as stealing, fighting, non-attendance at work or repeated drunkenness, managers spoke about the importance of giving a person a second chance, preferring resolution through talking to encourage behaviour change rather than formal disciplinary procedures and suspension or dismissal. One manager member explained, 'We don't like to discipline staff [formally] because once you start those procedures they lose salary and you know *those people have families* and if that money is taken it can be very hard to get it back. That money can be gone forever.'

Employment is scarce in Kenya and even middle-class families struggle to make ends meet. It is not surprising therefore, that managers avoided starting procedures that might cause people to lose their jobs or part of their salary. Like other health workers, the management team knew the pressures of demands from large extended families, and did not wish to be responsible for taking away what might be the sole source of income for many people. The District Clinical Officer spoke to me on one occasion of his own struggles to further his career and also meet the needs of his extended family. I noticed that someone was repeatedly 'flashing' his phone – ringing and quickly hanging up – a way of requesting a telephone call from somebody when one is out of cash to buy phone credit. 'This guy is sending me messages telling me that his children are sick, everyone in his home is sick', he told me. I sympathised, commenting that life in Kenya is hard for people who are successful and obliged to support their family members. I include his long response here to underline the entanglement of financial, educational and professional struggle, and the ways that these are experienced through a deep sense of obligation to family members,

'I have been supporting my family for 20 years and I tell you that it has been a struggle. But one thing that I am pleased about is that I managed to send my two younger brothers to school up to Form Four [the final year of secondary education] and now they are both employed, one of them is a soldier! I was the second born in my family and [until I helped my brothers] I was the only one to finish Form Four, the others were dropouts. At the time my father retired I had finished Form Two, and I went on through Form Three looking for hand-outs. When I got to Form Four the head teacher told me that I could just stay [at school] but you know I had been sent away [from school] a lot because of lack of fees, so there was no certificate. They let me in to A-levels in the same school but I had similar issues, then I managed to get a job and that was how I saved enough money [to pay the balance of fees] and I went back there and I got those two certificates.

Then at that time they were advertising for MTC [Medical Training College] students so I went with those certificates. That place was government-sponsored; in fact we were given 300 Kenya shillings to support ourselves although that money dried up in the second year. When I finished I was posted to a District hospital and that is when I went back [to study] and did specialisation in lungs and skin. From there I went to Tanzania for a few years and then when I came back I was posted to Provincial General Hospital, Kisumu. That is when I could see that I was not going anywhere and I paid for a Masters at Maseno [University] from my own pocket; 300,000 Kenya Shillings.'[16]

This impromptu professional history underlines how the challenge of simultaneously supporting family members and maintaining a professional career can extend throughout a person's working life. It is

these kinds of struggles that are brought to mind though comments such as, 'Those people have families.'

In encounters between managers and their junior staff, the emotional subjectivities and experiences of others were of primary importance. This observation chimes with ethnographic accounts from across East and Southern Africa, which have documented examples of the active capacity of emotions, and distaste for open criticism of others.[17] Emotions such as jealously and anger are often carefully controlled because of the assumed agentive qualities of these emotions and their potential to act (negatively) upon other people independently of individual intentionality (e.g. Brown 2010, Durham and Klaits 2002, Klaits 2002). In a related vein, Susan Reynolds Whyte (e.g. 2002) has written at length about the virtue of 'civility' in East Africa, underlining a commonly-held consensus that 'showing respect to others brings respect, whereas confrontation and anger are usually thought to make people look foolish' (2002: 186). Whyte argues that civility structures engagements with others in contexts where people are highly interdependent and where there is great uncertainly about what the future might hold. Awareness of intersubjective entanglements and the possibility that one may need to call upon others for support in the future, results in a 'practical wisdom' which is 'predicated on continuity in personal relationships and strengthens the possibility of mutuality to come' (2002:183). A similar sensitivity towards caring for the emotional self and the affective potential of emotions informed the strong sense of obligation experienced by managers to not only act in awareness of health workers emotional and familial needs but also to shy away from any criticism which could be construed as a personal attack and which might detrimentally affect future relationships.

There is a potential for tension between the moral and social obligations faced by health workers and the need to ensure the delivery of quality health care, and these issues have received attention across Africa (e.g. Jaffré 2012, Jaffré and Prual 1994). For example, managers were sometimes empathetic that

a colleague had a sick family member and was forced to be absent from her work station, but were limited in their ability to provide cover for her absence. In my own work in the same part of Kenya, I have described very different kinds of moral orientation from health workers towards the care of patients, based on hierarchical distinction rather than empathetic engagement (Brown 2012 see also Andersen 2004). These cultures of care can create spaces of mortal neglect, and concerns about hospital care are raised frequently in the media across Africa, as they are in the U.K. and other countries in the global North. A failure to sanction the bad practice of health workers through critique and reprimand may contribute to certain problematic modalities of care. However, an empathetic managerial culture does not necessarily affect patient care detrimentally. Among the District Health Management Team, whilst formal reprimands were not encouraged, other ways of sanctioning health workers were sometimes adopted as part of strategies for managing the health system effectively. For example, during fieldwork one experienced but temperamental nurse had a difficult relationship with colleagues at the health centre where he worked. Eventually the situation deteriorated to the extent he started a brawl with his colleagues at the health centre. He was moved to open a new facility and work there alone. It was clear that at one level this was a sanction for his difficult and aggressive behaviour. But publicly, managers spoke of his skills and expertise as making him suitable for the new posting, thus transforming the move into an empathetic and strategic managerial act. The intersections between forms of empathetic management and health outcomes or organisation are something that requires further scrutiny. Indeed, one might argue that the of issue supporting the professional needs of staff who work in very difficult conditions, whilst maintaining good quality of care for patients, should in fact be a major concern for those seeking to improve health systems in resource-poor settings.

Kinship forms

In this context, professional labour was inflected by a deeply ingrained sentiment that government bureaucracies were made up of people with a range of intersecting connections with differing but overlapping needs. Kinship tropes, which often drew on similar ideas about the forms that relations with others should take, were therefore powerful as idealised forms for organisational arrangements. As others have shown, moral regimes generally not considered 'economic', such as those of kinship and relatedness, often extend into the work place and shape working and managerial decisions (e.g. de Neve 2008). Among the managers with whom I worked, kinship did not simply 'encroach' into bureaucratic processes in the sense that people felt pressured to support kin requiring health services, or to put forward relatives when job opportunities came about, although this certainly did happen. Kinship relations and interactions also often provided a template for organisational form and managerial practice because they offered a repertoire for social engagements with others.

In management work, some managers, particularly women, addressed younger and more junior staff as 'my son' or 'my daughter' as a way of marking out concern and attachment. Others reminded health workers that they were 'sons and daughters of this community', urging an empathetic attention to those whom they served, which they saw as being amplified through shared ethnicity. Most prominently, the metaphor of 'sides' was visible within managerial practice. 'Sides' originates in Luo kinship organisation but is a much broader social motif among Luo people. The majority of the managers identified as ethnically Luo, a few were from neighbouring tribes.[18] In its idealised form among Luo people, 'sides' marks differences that are a matter of quality rather than hierarchy. The preeminent example of this is the relationship of people whom one classes as kin *jodala, jogweng'* (lit. people from home, people from the village) with those classed as in-laws. 'Sides' are articulated visually at large social events, such as funerals, where kin and in-laws sit in rows of chairs positioned directly opposite one another; equivalence, difference and interrelation reproduced through the spatial rendering of relations. Sides are also marked within people's homes. Visitors are expected to sit against the outer wall of the house,

while hosts sit opposite them with their back to the interior of the domestic space. In house-building arrangements it is customary for sons to build their houses alternately upon different 'sides' of the compound gate in a visual representation of the relational order of birth.

In managerial work the metaphor of sides was used to render unequal relations more equal. For example, the managerial team described employees of one large foreign governmental agency whose offices were close to the hospital as working on 'the other side', a turn of phrase which partly served to reclaim a sense of egalitarian difference and equivalence between the government staff and their wealthier collaborators. In this case 'sides' became a way to reclaim a sense of equality in these forms of partnership. At meetings with these and other non-government partners managers sat in seating arrangements that echoed those of funerals, with different 'sides' of the relation facing each other.

Managers also adopted the spatial seating arrangements familiar from domestic organisation and funerals when visiting smaller health facilities to supervise on going work. This was unlike training meetings with health workers, where seating arrangements mirrored the didactic goals of the meeting and took on a hierarchical spatial arrangement, in the style of a classroom or lecture theatre. In contrast, the frequent visual rendering of 'sides' during supervision meetings with junior staff served to visually project a sense of the flattening of hierarchical relationships through spatial expressions of equivalence, and empathy.

<IMAGE ONE>

Figure 1. DHMT members enact 'sides' during a supervision meeting at a dispensary

Conclusion: Humanitarian Bureaucracy and Ecologies of Labour

This article has drawn on ethnographic descriptions of Kenyan health management to explore a context where new technical interventions shaped many aspects of managerial expertise. However, management was also shaped by broader ecologies of labour, interpersonal relations, and the biographical dimensions of work. The working practices of these Kenyan managers were inseparable from the broader economic and organisational contexts through which their professional and individual identities emerged (cf. du Gay 2007, Jones 2008, Sennett 1998, Thrift 2000, Yarrow 2008). Being a good manager was shaped by a moral sense of the importance of 'being human'. It required one to engage a skill-set that emerged from the emotional and intellectual experience of a life worked for the government and the relationships that were part of this experience.

This reading of the way in which managers acted as persons (and were shaped as persons within this particular organisational setting) raises questions about managerialism as a form of expertise. Although management is relatively little studied in anthropology, it surely stands alongside similar forms of social practice as a significant social mode for both producing knowledge and acting upon the world (e.g.Ferguson 1990, Ferguson and Gupta 2002, Latour and Woolgar 1986, Li 2007, Mitchell 2002, Power 1997, Strathern 2000). Prominent among existing theorisations of managerialism are reflections on its forms of governmentailty (Foucault 2002 [1978]). These analyses are dominated by narratives of the encroachment and extension of managerial expertise. Government is viewed as comprising new forms of expertise which extend along a continuum through technologies of the state and trans-state organisations to the management of the self (Lemke 2001, Rose 1999 [1989]). In management studies, managers and workers are seen as increasingly tasked with learning how to better manage their work by managing themselves (Bjerg and Staunæs 2011, Valerie and Munro 2005). Emotions too, are potential objects of managerial attention and control (Fineman 2008, Hochschild 2003 [1983]). From this perspective, subjectification has come to replace commodification as the dominant mode of control at

work. Emerging managerial regimes create new alignments in which the better self *is* a better worker (Miller and Rose 1995) and the world in general is viewed as becoming increasingly managerial.

The material presented in this article suggests that this is an overly narrow theorisation of management. As theorists working in a range of other contexts have argued forcefully, changing economic regimes and modes of work shape new cultures of identity. Our examples might include the white-collar American workers described by Richard Sennett (1998) for whom work in new, more 'flexible' economies erodes the integrity of the self; the 'fast' managerial subjects whom Thrift (2000) describes as learning to deal with work in a context of constant emergency, or the importance of empathetic sentiment within the managerial practice of this small group of health managers in Western Kenya. What is clear is that identity, working practices, economic changes and new forms of governmental intervention come together in an ecology of labour which is shaped by and at the same time reconfigures all of these constituent parts. A conceptualisation of identity or subjectivity as the 'managed self' (Hochschild 2003 [1983], Miller and Rose 1995) within organisations shaped by new forms of governmentality is too narrow to capture the intersection of other forms of identity at work, or to take account of the affective experience of ecologies of labour within particular organisational contexts. In the organisation described here, whilst much managerial attention was turned to the collection of data, report writing and the monitoring of systems, this work took place alongside other moral and emotional regimes of rule. Managerial expertise was shaped by economic pressures, professional biographies and understandings of personhood as much as by new governmental regimes.

Managerial forms are powerful and there is much evidence that new managerial discourses and technologies are increasingly extending around the globe (Bear and Mathur 2015). As with other globalised social forms, new governmental forms and mobile managerial techniques are engaged and reconfigured in new ways as they travel (cf. Ong and Collier 2006, Tsing 2005). The empathetic

engagements of managers that I describe in this article often chimed with new management techniques including, for example, practices of 'supportive supervision' or 'servant leadership' which were being trialled in the Ministry at the time of fieldwork. The managers I worked with also reported increasingly reflecting upon their own management practice, and one could perhaps argue that through these new forms of subjectification they were indeed 'managing themselves' in new ways. In these senses my observations support narratives of encroachment. They also show how techniques of management such as 'supportive supervision' were 'engaged universals' (Tsing 2005), which through processes of introduction in specific contexts became entangled with the social dimensions of place, changing both the context of their introduction and their own content as a managerial form.

However, the reflections in this article on empathy as an expression of management, and its sedimentation in organisational process and managerial biographies, offer an additional vantage upon the universal dimensions of management and the ways these are reconfigured in different places. These Kenyan managers expressed empathy in ways that were particular to specific forms of Kenyan sociality (for example through the articulation of 'sides' and the avoidance of critique) and through forms of shared biographical experience. At the same time, these particular and located forms of managerial intersubjectivity remind us that management is something which is *always* done through personal relationships as well as through technologies of conduct.[19] The assumption that what is universal about management is its tools and techniques, rather than its relations, constitutes a fetishisation of the technical in our understandings of social universals. The mentality of management is as much one of relation as of rule.

[1] Undertaken by the author between March 2011-September 2011 and funded by the Leverhulme Trust (Geissler F/02 116/D) and the British Institute in East Africa (small grant award). Prior to this fieldwork, I previously conducted ethnographic fieldwork on HIV care in a different Kenyan hospital and had spent a year working for an NGO in the same region. I spoke Luo and Swahili. These skills and experiences helped me to develop rapport with my informants and gain access to their work. I also had research clearance from the Kenya Medical Research Institute, which is a highly respected institution within the Ministry of Health.

[2] The argument that Smith makes is similar to the understanding of *einfühlung*, (a German term translating as (feeling into') which was elaborated most extensively by Theordore Lipps, who was also interested in interpersonal perceptions of bodily action. Lipps' work was very likely the inspiration for Edward Titchener, who in 1909 coined the term 'empathy'. Stueber, K. 2013. Empathy. In The Stanford encyclopedia of philosophy ed.^eds. Eidtor. http://plato.stanford.edu/archives/sum2013/entries/empathy/.

[3] The District covered an area of 358.7km^2 and in 2011 had a projected population of 151,123 based on the 2009 census and estimates for population growth.

[4] In Kenya the 'clinical officer' is a cadre of medical professional more senior than a nurse but who is less senior and has less training than a medical doctor. Unlike nurses, clinical officers are officially allowed to prescribe medicine.

[5] The DHMT were not technically responsible for management of the three larger health facilities in the district (referred to as District or sub-District hospitals, or 'level 4' facilities). These facilities were managed within the Ministry of Medical Services (see below note 3). However, the DHMT nonetheless visited these facilities for supportive supervision and collected data from them as part of health information and reporting systems.

[6] The Kenyan Ministry of Health was split in two as part of the power-sharing agreement that followed the disputed elections in 2007 and the post election violence of early 2008. The Ministry for Medical Services was given the mandate for managing larger health facilities (sub-district hospitals and larger) whilst the Ministry of Public Health and Sanitation was given responsibility for managing the smaller health facilities; health centres and dispensaries and all public health work. Following the period of fieldwork the two Ministries have again been

subsumed within a single Ministry of Health and the District administrative system has been replaced by a County system.

[7] Many observers within and outside the Ministry of Health feel this employment dynamic is a key weakness in the country's health system; young newly-qualified doctors often find themselves overwhelmed by the responsibility for running District hospitals and similar senior roles in their first posting and are tied up in administrative positions within a context where there is a chronic shortage of medical professionals.

[8] 2008 figure, source CIA world fact book.

[99] Former District Public Health Nurse working for an NGO
[10] 1996-2006

[11] Former District Clinical Officer.

[12] Allowances are a common feature of government and development work across Africa. For a useful review see Søreide, T., T. A & A.S. INgvild 2012. Hunting for per diem: The uses and abuses of travel compensation in three developing countries ed.^eds. Eidtor. Oslo, Norway: Norwegian Agency for Development Cooperation (NORAD).
[13] In the region of £8.

[14] For an interesting comparison, see Yarrow (2008) who writes about the intersections between biography and professional recognition among NGO activists in Ghana.
[15]There had not been any cases of formal disciplinary proceedings taken against staff in the District since its creation in 2007

[16] Approximately £2400. Equivalent to six months' salary for this Clinician.

[17] I'm grateful to Nadine Beckmann for encouraging me to think about the literature on civility and the absence of criticism in relation to this ethnographic material.

[18] I am not able to comment upon how far these spatial forms extend beyond Luo forms of sociality.

Note on contributor

Hannah Brown is a lecturer in the Department of Anthropology at Durham University. Her research interests include economies and practices of care; governance; the state; hospitals; global health interventions; development; community-based health care; and public health.

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[19] This point has also been argued by theorists of relational management. Useful examples include: Checkland, K., S. Snow, I. McDermott, S. Harrison & A. Coleman 2012. 'Animateurs' and animation: what makes a good commissioning manager? Journal of Health Services Research and Policy 17, 11-17, Cunliffe, A.L. & M. Eriksen 2011. Relational leadership. Human Relations 64, 1425-49.

References Cited

Anders, G. 2009. In the shadow of good governance: An ethnography of civil service reform in Africa.). Leiden: Brill.

Andersen, H.M. 2004. "Villagers": Differential treatment in a Ghanaian hosptial. Social Science & Medicine 59, 2003-12.

Bayart, J.-F. 1993. The state in Africa: Politics of the belly. (trans. M. Harper & C.E. Harrison).). Harlow: Longman.

Bear, L. & N. Mathur 2015. Intoduction: Remaking the public good: A new anthropology of bureaucracy. Cambridge Anthropology 33, 18-34.

--- 2015. Special Issue: Remaking the public good: A new anthropology of bureaucracy. Cambridge Anthropology 33.

Bjerg, H. & D. Staunæs 2011. Self-management through shame - Uniting governmentality studies and the 'affective turn'. Ephemera: Theory and politics in organization 11, 138-56.

Brown, H. 2010. Living with HIV/AIDS: An ethnography of care in Western Kenya ed.^eds. Eidtor. Unpublished doctoral thesis, University of Manchester, Manchester.

--- 2012. Hospital Domestics: Care Work in a Kenyan Hospital. Space and Culture 15, 18-30.

--- 2015. Global health partnerships, governance, and sovereign responsibility in western Kenya. American Ethnologist 42, 340-55.

Brown, H. & M. Green 2015. At the Service of Community Development: The Professionalization of Volunteer Work in Kenya and Tanzania. Africa Studies Review 58, 63-84.

Chalfin, B. 2010. Neoliberal frontiers: An ethnography of soverignty in West Africa.). Chicago and London: University of Chicago Press.

Checkland, K., S. Snow, I. McDermott, S. Harrison & A. Coleman 2012. 'Animateurs' and animation: what makes a good commissioning manager? Journal of Health Services Research and Policy 17, 11-17.

Cunliffe, A.L. & M. Eriksen 2011. Relational leadership. Human Relations 64, 1425-49.

de Neve, G. 2008. We are all *sondukarar* (relatives)!: Kinship and its morality in an urban industry of Tamilnadu, South India. Modern Asian Studies 42, 211-46.

du Gay, P. 2000. In praise of bureaucracy: Weber, organization, ethics.). London: Sage.

--- 2007. Organizing identity: Persons and organizations 'after theory'.). Los Angeles and London: Sage.

Durham, D. & F. Klaits 2002. Funerals and the public space of sentiment in Botswana. Journal of Southern African Studies 28, 777-95.

Farmer, P. 1992. AIDS and accusation: Haiti and the geography of blame.). Berkeley, Los Angeles and London: University of California Press.

--- 2004. An Anthropology of Structural Violence. Current Anthropology 45, 305-25.

Feldman, I. 2008. Governing Gaza: Bureaucracy, authority and the work of rule 1917-1967.). Durham: Duke University Press.

Ferguson, J. 1990. The anti-politics machine : "Development", depoliticization, and bureaucratic power in Lesotho.). Cambridge: Cambridge University Press.

Ferguson, J. & A. Gupta 2002. Spatializing states: Toward an ethnography of neoliberal governmentality. American Ethnologist 29, 981-1002.

Fineman, S. (ed.)^(eds.) 2008. The emotional organization: Passions and power Oxford: Blackwell.

Foucault, M. 1989 [1973]. The birth of the clinic: An archaeology of medical perception. (trans. A.M. Sheridan).). London and New York: Routledge.

--- 2002 [1978]. Governmentality. In Michel Foucault: Power: Essential works of Foucault 1954-1984. Volume 3 ed.^eds. Eidtor, (trans. R.H.a. others.). London: Penguin.

--- 2008. The birth of biopolitics: Lectures at the Collège de France 1978-1979. (trans. G. Burchell).

Fraser, N. 1997. Justice interruptus.). New York and London: Routledge.

Geertz, C. 1974. "From the native's point of view": On the nature of anthropological understanding. Bulletin of the American Academy of Arts and Sciences 28, 26-45.

Green, M. 2015. The development state: Aid, culture and civil society in Tanzania.). Woodbridge: James Currey.

Gupta, A. 2012. Red tape: Bureaucracy, Structural violence and poverty in India.). Durham and London: Duke University Press.

Hochschild, A.R. 2003 [1983]. The managed heart: commercialisation of human feeling.). Berkeley, Los Angeles and London: University of California Press.

Hollan, D.W. & C.J. Throop 2008. Whatever Happened to Empathy?: Introduction. Ethos 36, 385-401.

Hollan, D.W. & C.J. Throop 2011. The anthropology of empathy: Introduction. In The anthropology of empathy: Experiencing the lives of others in Pacific societies ed.^eds. Eidtor. New York and Oxford: Berghahn.

Hull, M. 2012. Government of paper: The materiality of bureaucracy in urban Pakistan.). Berkeley, Los Angeles and London: University of California Press.

Jaffré, Y. 2012. Towards an anthropology of public health priorities: maternal mortality in four obstetric emergency services in West Africa. Social Anthropology 20, 3-18.

Jaffré, Y. & A. Prual 1994. Midwives in Niger: An uncomfortable position between social behaviours and health care constraints. Social Science & Medicine 38, 1069-73.

Jones, A. 2008. The rise of global work. Transactions of the Institute of British Geographers 33, 12-26.

Klaits, F. 2002. Housing the spirit, hearing the voice: Care and kinship in an apostolic church during Botswana's time of AIDS, *Unpublished Ph.D. dissertation*, The John Hopkins University.

Kleinman, A., V. Das & M. Lock 1997. Social suffering.). Berkeley: University of California Press.

Latour, B. 1996. On Interobjectivity. Mind, Culture and Activity 3, 228-45.

Latour, B. & S. Woolgar 1986. Laboratory life: the construction of scientific facts.). Princeton: Princeton University Press.

Lemke, T. 2001. 'The birth of bio-politics': Michel Foucault's lecture at the Collège de France on neo-liberal governmentality. Economy and Society 30, 190 - 207.

Li, T.M. 2007. The will to improve: Governmentality, development and the practice of politics.). Durham and London: Duke University Press.

Mathur, N. 2015. Law, bureaucracy and the developmental state in Himalayan India.). Cambridge: Cambridge University Press.

Mayeroff, M. 1971. On caring.). New York: Harper Perennial.

Miller, P. & N. Rose 1990. Governing economic life. Economy and Society 19, 1 - 31.

--- 1995. Production, Identity, and Democracy. Theory and Society 24, 427-67.

Mitchell, T. 2002. Rule of experts: Egypt, techno-politics, modernity.). Berkeley, Los Angeles and London: University of California Press.

Navaro-Yashin, Y. 2012. The make-believe space: Affective geography in a postwar polity.). Durham and London: Duke University Press.

Olivier de Sardan, J.P. 1999. A moral economy of corruption in Africa? The Journal of Modern African Studies 37, 25-52.

Ong, A. & S.J. Collier (ed.)^(eds.) 2006. Global Assemblages: Technology, Politics and Ethics as Anthropological Problems Oxford: Blackwell.

Power, M. 1997. The audit society: Rituals of verification.). Oxford and New York: Oxford University Press.

Riles, A. (ed.)^(eds.) 2006. Documents. Artefacts of Modern Knowledge Ann Arbor: University of Michigan Press.

Robbins, J. & A. Rumsey 2008. Introduction: Cultural and Linguistic Anthropology and the Opacity of Other Minds. Anthropological Quarterly 81, 407-20.

Rose, N. 1999 [1989]. Governing the soul: The shaping of the private self.). London and New York: Free Association Books.

Scott, J.C. 1998. Seeing like a state: how certain schemes to improve the human condition have failed.). New Haven, Conn. and London: Yale University Press.

Sennett, R. 1998. The corrosion of character: The personal consequences of work in the new capitalism.). New York and London: W.W. Norton and Company.

Smith, A. 2002 [Original 1759]. The theory of moral sentiments.). Cambridge: Cambridge University Press.

Søreide, T., T. A & A.S. INgvild 2012. Hunting for per diem: The uses and abuses of travel compensation in three developing countries ed.^eds. Eidtor. Oslo, Norway: Norwegian Agency for Development Cooperation (NORAD).

Strathern, M. (ed.)^(eds.) 2000. Audit cultures: Anthropological studies in accountability, ethics and the academy London and New York: Routledge.

Stueber, K. 2013. Empathy. In The Stanford encyclopedia of philosophy ed.^eds. Eidtor. http://plato.stanford.edu/archives/sum2013/entries/empathy/.

Thrift, N. 2000. Performing cultures in the new economy. Annals of the Association of American Geographers 90, 674-92.

Tsing, A.L. 2005. Friction: An ethnography of global connection.). Princeton and Oxford: Princeton University Press.

Valerie, F. & R. Munro 2005. Undoing management: Markets, virtual absense and the stratification of managerial practice. University of Keele. TS.

Weeks, J.R. 2004. Unpopular culture: The ritual of complaint in a British bank.). Chicago: Chicago University Press.

Wendland, C.L. 2010. A heart for the work: Journeys through an African medical school.). Chicago and London: Chicago University Press.

Whyte, S.R. 2002. Subjectivity and subjunctivity: Hoping for health in Eastern Uganda. In Postcolonial Subjectivities in Africa ed.^eds. Eidtor, 171-90. London and New York: Zed Books.

Wrong, M. 2009. It's our turn to eat: The story of a Kenyan whistle blower.). London: Fourth Estate.

Yarrow, T. 2008. Life/History: Personal narratives of development amongst NGO workers and activists in Ghana. Africa 78, 334-58.

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Ref.: Ms. No. JRAI-D-14-00009
Managerial relations in Kenyan health care: Empathy and the limits of governmentality
The Journal of the Royal Anthropological Institute (incorporating Man)

Dear Dr Brown,

Thank you for your submission to JRAI. I now have three reviews of your essay and have had a chance to consider them in relation to my own reading. The reviewers are rightly enthusiastic about the piece and all three recommend that it be published with only minor revision - this very much accords with my own reading. I am therefore happy to accept this piece for publication, subject to satisfactory (minor) revisions in response to the comments contained in the reviews below.

While I do hope you will consider all of the reviewers' suggestions, however, the strength of the piece is such that I leave it up to you how you do so - and you do not need to take them all up (in which case simply let us know why not in the cover letter attached to your revised submission). The only specific point which I as editor would really like to insist on is the first one raised by reviewer 1: I agree with the reviewer that the piece's abstract and introduction rather undersells the potential of the piece and that the broader contribution to anthropology could be more forcefully highlighted there.

Please attend to the instructions for authors in revising; papers, even after revision, should be no longer than 10,000 words (inclusive of notes, bibliography and abstract) unless we have agreed otherwise.

To submit a revision, go to http://jrai.edmgr.com/ and log in as an Author. You will see a menu item call Submission Needing Revision. You will find your submission record there.

Thank you again for your submission; we appreciate the opportunity to consider your work.

Yours sincerely,

Matei Candea, PhD
Editor
The Journal of the Royal Anthropological Institute (incorporating Man)

Reviewers' comments:

Reviewer #1: This is an excellent article. It tackles a much neglected topic in anthropology (management), challenges predominant theorisations of management through the concept of governmentality, and introduces new and original ethnographic material from current health management practices in Kenya. In fact one of my few criticisms of the paper is that the author does not make enough of its contribution to a variety of fields. This article really could put management on the map in anthropology and I felt that bigger claims could be made to the significance of this as a field. I also thought that the abstract could have emphasised some of the theoretical arguments made in the paper, not least the way in which the author shows the limitations of theories of governmentality that focus myopically on techniques, technologies and rationalities. At present the abstract is suggestive of a far more humdrum ethnography of bureaucracy than this really is. To be published in JRAI I think the abstract and the article need to make more of its contribution to anthropology at a general level. Some minor queries and comments follow:

I thank the reviewer for these positive comments, and the push to underline more powerfully the contribution of the article. I have significantly revised the introduction and abstract in the manner suggested.

1. The author might want to edit and cut down some of the extensive quotations. Currently they are difficult to read and follow and longer than they need to be. This might help keep the momentum of the article going.

This was a useful criticism. I have cut most of the long quotes, keeping only one, which I feel is useful as an example for the familial and educational pressures faced by the managers.

2. The section on management biographies is wonderful and provides a brilliant antidote to the more sociological work that dominates studies of govern mentality.

Thank you!

3. The author might want to address the extent to which the 'empathy' expressed by the Kenyan health managers as integral to management is particular to Kenyan modes of relatedness (this is implied in the section on kinship and on sides), or to the sense of shared experience and bonding created by working in contexts of hardship and suffering (implied by some of the references e.g. to

Wendlands work), or part and parcel of managerial practices in general (i.e. management is ultimately always done through personal relationships as well as mediated by technologies of conduct).

I thank the reviewer very much for this comment, which really helped me to pin down a part of my argument that was somewhat eluding me. The answer is, of course, that all of these things are true –managerial practice is shaped by local forms of sociality and shared experience, but is at the same time also necessarily always achieved through relationships. I have taken this (very helpful!) point up in the conclusion.

4. Perhaps more importantly I thought the author could have done more to examine the ways in which affect and emotion are actually central to contemporary managerial discourse and the ways in which Kenyan manager's ideas of empathy might chime with rather than against western schools of management. I saw this, for example, in the emphasis on motivating rather than disciplining subordinates.

This is a helpful point. I felt the space available in the article was not sufficient to explore these dynamics in full, but I agree with the reviewer that this is an important issue. I briefly consider this in the conclusion in a discussion of mobile universals and management of the self.

5. Is 'sides' an indigenous term? I thought this last section was slightly weaker than the previous ones and could do with a little more fleshing out to warrant the theorisation of 'sides' as a transferrable form in Kenyan relations. Does the author have any further ethnographic evidence they could draw on here to make that case?

I have extended this section slightly to include more ethnographic detail about the ways in which the social forms of kinship provide motifs for managerial practice.

6. I think the author should consider how the arguments made in this paper may depart from or reinforce colonial and postcolonial stereotypes of african bureaucrats as incapable of performing the kind of distance and impersonal relations that are necessary to effective governance. For example someone from DFID reading this might despair at the refusal to discipline bad practice. Are there other instances in which Kenyan health managers do employ technologies of governance in more conventional ways? Or is the author suggesting that empathy is actually what makes bureaucracy work in contexts of resource shortage? Either way, I think this potential critique needs to be addressed.

I thank the reviewer for the criticism. I agree that I somewhat skirted around this (difficult!) issue in the original version of the article. I have inserted a paragraph at the end of the section ‘Empathy in Management Practice’ which addresses this issue.

In all, however, I would say this article is ideal for JRAI and would only need very very minor revisions in order to be ready for publication.

Reviewer #2: I liked this paper a lot! It is an excellent study of the relational and emotional rationalities that shape the working lives and practices of government officials in Kenya. Following recent ethnographic work on governance and bureaucratic labour, it argues that relational forms shaping organization life - in particular, feelings of empathy and responsibility for the often challenging lives of junior staff - are as important as techniques and tools of bureaucratic management. The paper is based on ethnography of health managers within a district health team in Kenya.

Challenging a narrow focus on technologies of managing the 'conduct of conduct' as the defining feature of governance, the author looks at how managerial subjects and expertise are produced within broader 'ecologies of labour' and forms of personhood which emerge through biographical experiences and organizational configurations. Being a good manager, in western Kenya, is a quality of 'being human' and having empathy for others, particularly for junior staff. Management was about encouraging, supporting and motivating junior staff as much technical supervision and intervention. Such 'managerial empathy' emerged from having shared experiences of the difficulties government employees face, from low pay to remote postings far away from family. New managerial techniques do not so much encroach upon as become embedded within these ecologies of labour.

The paper also nicely shows how the emphatic labour of managers emerges from their own somewhat precarious position within the Kenyan middle class, subject to high expectations of financial support from family members; and within professional life, as they struggle to achieve organizational goals within a health system marked by inadequate resources.

Challenging stereotypes of corrupt and lazy African bureaucrats, the paper opens up an empathic understanding of the moral economy of bureaucratic labour as it takes shape within government institutions in Kenya. As such it makes an important contribution to the

anthropology of bureaucracy, and the understanding of the state in Africa.

I am grateful for the reviewer's positive reading of the article

I have no major concerns with the paper. The argument is clear and well-situated in the literature on governance and government; the paper is well structured and well written. A few minor concerns are sketched out below:

1. The use of the term 'humanitarian bureaucracy' is a bit misleading. 'Humanitarian' implies non-governmental governance, while the author is trying to convey a sense of the empathic and humane thrust of bureaucratic labour among Kenyan government officials. The section could instead be labelled 'Being Human', taking up the term used by the informants.

Yes, I agree with the reviewer and have removed the use of this term.

2. I would like to see some reflection on the position of the anthropologist and ethnographer in this study. Given the sensitivities surrounding the working lives of government bureaucrats, such as multiple 'jobs', business interests and moonlighting in the NGO sector, how much was revealed to the ethnographer? How did the ethnographer gain trust, and with whom?

This is a very difficult and complex critique to respond to fully. I do talk in the article about my informant's reluctance to discuss the more sensitive dimensions of their job and consider this as an ethnographic fact of interest, which points to the ambivalence of their professional situation. I have added some further reflection on my own position in the first footnote.

The paper presents a very positive picture of government managers and their relations with junior staff, which raises questions about how the author's empathic relationships with informants shape the arguments developed in the paper. Why do negative stereotypes about government officials circulate and have currency? Does 'being human' towards one group of staff members entail distancing oneself from other people with whom they interact? Does this also involve conflicting goals, and does it cause managers concern?

As a way of trying to address this issue I have added a paragraph at the end of the section 'empathy in management practice' which reflects on the problems of empathetic management and it's limitations in terms of inclusion. I have also extended slightly the discussion on 'corruption' to show why the negative stereotypes circulate, and to show that the managers did sometimes engage in 'corrupt' behaviour.

3. The pgh at the end of p14 needs clarification: 'the negative

associations of bureaucratic labour can be experienced more acutely by bureaucrats in Africa'.

I have extended and clarified this point.

4. The reference to 'global work' needs some unpacking; presumably the author is referring to managerial work as a globalized technology of governance.

Yes, I agree this was not clear. I find the reference useful for understanding changing relationships between work and identity, and have kept the reference in the conclusion but removed this mention.

5. The novelty of these forms of governmental intervention is claimed (by referring to Rose etc) rather than described (p23). The paper does not explain how these government interventions are new - i.e. there is no historical overview of the introduction of new governmental techniques in Kenya. The conclusion thus Places too much emphasis on the novelty of the ecology of labour described. The point about novelty is not really necessary for the paper. The argument that a conceptualization of identity as the managed self is too narrow to capture what is going on within this particular organizational context, is strong enough.

I am grateful for the criticism. I have substantially revised the theoretical sections of the paper, including the conclusion, and am no longer relying on the discussion on novelty.

6. Literature: Tom Yarrow has a paper on the professional biographies of NGO workers in Ghana, which would provide a useful comparison (Africa, 2008, 78, no3). Richard Werbner's work on elites in Botswana might be useful. There are ethnographic studies from Kenya which suggest that inequalities and working relations within transnational organizations intervening in health are managed quite differently (e.g. Geissler,'Public Secrets', American Ethnologist 2013). Prince and Marsland discuss relations between government, NGOS and transnational organizations in 'Making and Unmaking Public Health in Africa' (2013).

I am grateful for the suggestions and I have included some of the references.

Reviewer #3: I do not have enough expertise to judge the quality of style.

On the merits , the article is interesting in particular by its specific empirical data.

The paper demonstrates , through a real " field anthropology" the reality of interactions between health workers and teams supervisory or managment.

This is a good approach of « reality » , but also can be useful for the every day's work of practitioners of public health.

Moreover, this article shows the referents of terms such as " a heart for the work"? And these terms are the categories through which the actors are engaged in action.

The text also demonstrates how the working relationship is never limited to labor relations, but include a range of social, emotional and economic dimensions .

Finally, this paper demonstrates how " ways of being " go far beyond just the technical proposals.

All this is well described and useful.

I thank the reviewer for the positive comments.

I would , however , make three or four negative comments.

In terms of literature, these issues have been addressed in articles and books by French researchers for a decade, and I regret that this bibliography is not mentioned.

It is to my great shame that I am not a French speaker, and am unable to read some of the extensive literature on bureaucracy and health care in Africa. I have included a reference to Olivier de Sardan's work in the section on corruption and some references to Yannick Jaffré's work in the last paragraph of the section 'empathy in management practice' which discusses the limits of empathetic management.

However, I do not know what the reference to M Foucault, actually brings . Rather, the paper demonstrates a certain freedom of actors and therefore this empirical data are rather a critique of the concept of " government bodies " ? For this reason, the author of reference would be rather Michel de Certeau than M Foucault ?

I have revised the introduction and conclusion of the article (which are the main theoretical sections), and have emphasised more clearly that the article is a critique of the myopic focus on the implementation of techniques and tools in management practice and theorisations of expertise.

The article talks of understanding attitudes of supervisors, who do not want to blame the health personnel. « No blame no shame » but? is it possible in case of malpractice?

The punishment is not necessary ? What could be the status of « sanction » ?

What to do to reduce the violence of health professionals towards people ?

I have address these comments, which were also raised by the other reviewers, in the final paragraph of the section ‘empathy in management practice’.

Finally, I think author should make, at the end of the article, the difference between "emotions ", moral categories and social and family constraints. All these dimensions can not be confused.

The discussion of emotion is restricted to the section on civility, which draws on comparative ethnography to reflect upon the reluctance of managers to offer criticism. I would argue that the theorisation of empathy as a management heuristic in this context is such that the moral and social/family are tightly intertwined, because it is precisely because people recognise the social and family constraints of others that they develop this sense of empathy. I have done my best to clarify this in the article.

In conclusion, this is a good article to be published , with these reservations .

Figure

Image 1 (Photograph by the Author)