Professional Pastoral Work in a Kenyan Clinical Network: Transposing Transnational Evidence-Based Governmentality

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Introduction

Health care management research has recently drawn on the Foucauldian (2007) concept of *governmentality* to examine and explain the way health professionals have internalised evidence-based medicine (EBM) (Ferguson and Gupta 2002; Bejerot and Hasselbladh 2011; Ferlie et al. 2012, 2013; Ferlie and McGivern 2014; Martin et al. 2013; Martin and Waring 2018; Waring and Martin 2016; van Rensburg et al. 2016).

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EBM is defined as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients… integrating individual clinical expertise with the best available external clinical evidence from systematic research' (Sackett et al. 1996: 71). EBM was developed and has become institutionalised in Western health care systems as the 'gold standard' of health care provision (Timmermans and Berg 2003). Consequently, most Western health professionals, and many professionals globally, now draw on its governing principles when they think about and enact clinical work.

However, research on the rise of this 'evidence-based governmentality' in health care (Ferlie et al. 2013; Ferlie and McGivern 2014) has given limited attention to the micro-level work entailed in the construction and promotion of, or resistance to, the internalisation of EBM. We also know little about the historical context in which governmentality unfolds. Significantly, most literature on governmentality in health care is based on studies conducted in Western high-income countries, neglecting low- and middle-income counties (LMICs) where *transnational* evidence-based governmentality regimes, originating in the West, shape health care systems (Ferguson and Gupta 2002; Lemke 2011). So, how is EBM developed, internalised and used by health professionals working in LMIC health systems?

Network organisations provide a key mechanism through which government policy, EBM, evidence-based practices and standards have been developed and implemented into health care practice at local level, with professional leaders responsible for and also adapting this process in local contexts (Ferlie et al. 2012, 2013). In LMICs networks are also often more transnational, diffusing evidence between Western countries and LMICs (Ferguson and Gupta 2002), although most research on health care networks has been conducted in the former, again neglecting LMICs.

Addressing this oversight, in this chapter we examine the development and implementation of an evidence-based governmentality in Kenyan paediatric care nationally and, more specifically, in a 'Clinical Information Network' (CIN) spanning paediatric departments in 14 Kenyan district hospitals. We trace the roots of this evidence-based

governmentality in Western transnational organisations and its development and implementation in Kenya, examine how CIN made visible and transformed local clinical practices and professional identities, and highlight the central role and work of key medical professional network leaders ('pastors') within this process.

Our chapter highlights the importance of a 'decentred' (Bevir 2013) approach to analysing health care networks, showing in particular how the dynamics of power need to be situated within particular contexts, traditions, practices and norms. As explained in the introduction to this collection, this approach seeks to look beyond the grand narratives or discourses of policy, to look instead the situated and enacted meanings and beliefs of local actors, albeit in the context of prevailing traditions and in the face of new circumstances or dilemmas. Without understanding the different practices and norms of Western EBM and philanthropic organisations and Kenyan health care, CIN's leaders would have been unable to transpose transnational evidence-based governmentality into Kenya paediatric practice. Using a decentred approach, we explain the pastoral work of these network leaders', and the situated dilemmas, with implications for personal and professional identity, which they faced about how to engage with divergent local circumstances and governmental practices.

Evidence-Based Governmentality and 'Pastoral' Professionals in Health Care

Michel Foucault developed the concept of 'governmentality', defined as 'the ensemble formed by institutions, procedures, analyses and reflections, calculations and tactics… that has the population as its target, political economy as its major form of knowledge and apparatuses of security as its essential technical element' (Foucault 2007: 108), to explain government in neoliberal states. For Foucault, and subsequent theorists of governmentality (Rose 1999; Dean 1999; Lemke 2011), this ensemble leads subjects to internalise the mentality of government, interpret their identities and behaviours as part of a (national) population,

and so freely act in its collective interest. Thus, neoliberal states could govern 'at a distance' by inciting, seducing and making actions easier or harder, negating the need for direct control. Theorists later explained how a governmentality could be actively constructed and managed to control citizens (Rose and Miller 1992; Dean 1999) and organizational employees (Miller and O'Leary 1994; McKinlay and Taylor 2014; McKinlay and Pezet 2010) from afar. Similarly, in health care contexts, governmentality and the mundane 'grey sciences' of 'enumeration, calculation, monitoring, evaluation' (Miller and Rose 2008: 212) quietly reshaped professional work (Ferlie and McGivern 2014).

Foucault's (2007) related concept of 'pastoral power' explains how individuals internalise external (governmental) discourses; by externalising ('confessing') inner thoughts and hidden behaviours to 'pastors' who then help them internalise external discourses reconceptualising their thoughts and behaviours. Using the analogy of Christian priests leading their 'flock' to 'salvation', Foucault showed pastors' key roles as intermediaries in governmentality (Martin and Waring 2018). Pastoral power thus operates at the intersection between disciplinary discourses, pastors' and other individuals' agentic attempts to cultivate their own identities in ways that align with (but also depart from) such discourses (Martin et al. 2013; McKinlay and Pezet 2010). Today, pastoral power can be understood as about cultivating ethical behaviour benefitting collective social welfare. Contemporary pastors include experts and therapists, promoting and inculcating socially desirable behaviour among their patients, clients and the public and medical professionals (Dean 1999; Rose 1999). Foucault (2007: 199) notes: 'in its modern forms, the pastorate is deployed to great extent though medical knowledge, institutions and practices… medicine has been one of the great powers that have been the heirs to the pastorate'.

The concepts of governmentality and pastoral power have been usefully deployed to explore and explain governance and leadership in Western health care and clinical networks, where evidence-based medicine (EBM) has been institutionalised (Ferlie and McGivern 2014). Ferlie and colleagues (2013) describe an 'evidence-based governmentality', which underpinned effective service reconfiguration and quality improvement in health care networks. This evidence-based

governmentality contained four elements: an evidence-based clinical *episteme*; clinical audit making local practices *visible*; local *technical* processes enacting evidence and audit into practice and ways in which they shape professionals' *identities.* Clinical professionals internalised, constructed and regulated their professional identities and behaviours in relation to the governing principles of EBM as a consequence of network leaders' work assembling these four elements (Ferlie et al. 2013).

We suggest that understanding of the work involved in constructing evidence-based governmentality can be furthered through engagement with Foucault's notion of pastoral power. In their study of EBM and health care networks, Ferlie and McGivern (2014) show how pastoral power operates during collective professional discussions of clinical outcomes, which reinforce evidence- and audit-based professional identities and behaviours. The authors explain how, in making clinical practices and outcomes visible against national standards and targets, and sharing these data among clinicians, network leaders (pastors) exerted peer pressure on underperforming professionals to adopt best practice and improve their clinical performance. Furthermore, by encouraging their colleagues to think about and disclose thoughts and practices in relation to EBM-based standards, these network leaders cultivated EBM-based subjectivities among their professional peers more generally.

Similarly, Martin and Waring (2018) discuss the operation of pastoral power within the process of translating and embedding governmental discourses into individual subjectivities and collective routines within medical professional communities. They also describe pastoral medical professionals focusing attention on individuals' statistical performances compared with populations of similar professionals, then creating spaces in which clinicians interacted, expressed and developed collective notions of professionalism and identity drawing on audit, evidence and quality improvement. Again, this then became inherent in the way doctors constructed their individual and collective responsibilities as professionals.

In related work, Waring and Martin (2016) described leadership in health care networks involving four 'pastoral practices': (1) *Constructive practices* re-coding rationalities and translating evidence in a way relevant and comprehensible to local communities; (2) *Inscription practices* communicating and framing the re-coded discourses in ways

encouraging network members to internalise them; (3) *Collective practices* in which pastors shape and reframe collective professional subjectivities and social identity through socialising as a professional community; and (4) *Inspection practices* in which pastors provide ongoing guidance to the community, identifying practices and subjectivities conforming with or deviating from acceptable behaviours, and, in doing so, create, maintain or disrupt social order.

McGivern et al. (2017) developed Waring and Martin's (2016) concept of pastoral practices to explain how the Kenyan clinical network discussed in this chapter introduced evidence-based governmentality. They described: Constructive practices developing local *evidence-based guidelines* and *audit practices* making local health care provision and outcomes visible; Inscription practices of *championing* use of guidelines and audit, *demonstrating* how they improved care, and *supporting/mentoring* professionals to use them; Collective practices of *meeting and sharing as a professional community* and *collectively championing and demonstrating evidence-based professionalism*; and inspection practices in which network participants *disciplined* themselves and colleagues to use guidelines and audit to improve health care quality and their professional status. Crucially, these pastoral practices relied upon the work of medical professionals in 'pastoral' leadership roles, influencing their colleagues to adopt evidence-based governmentality (McGivern et al. 2017).

The concept of 'knowledge leadership' (Fischer et al. 2016) may also be useful in explaining leadership in networks. Also drawing on Foucauldian theory, Fischer and colleagues explain how individual knowledge leaders mobilised management research and evidence into health care practice by 'becoming the knowledge object'. By personifying and role-modelling this knowledge as identity projects they were deeply vested in, knowledge leaders *transposed* it into new organizational contexts, *appropriating* salient aspects of knowledge and evidence, using them to *contend* established practice and bring about changes.

Taken together, the Foucauldian literature has been useful in advancing understanding of the way professionals internalise evidence-based discourses in health care, while a number of its limitations have been identified, which we discuss next.

Criticisms of the Governmentality Literature

The governmentality literature has been subject to several criticisms. First, its relative inattention to agency and work promoting or resisting internalisation of external governmental discourses (Caldwell 2007; Power 2011), perhaps due to neglect of Foucault's later work. As McKinlay and Pezet (2010: 494) note: 'Studying governmentalisation requires us to attend not just to the programmes of the powerful but to their operation and the manifold ways that individuals, groups and populations absorb, comply with and resist these projects'. Likewise, Bevir argues that governance is realised both through the top-down imposition of governance frameworks and also actors implementing them within local circumstances, traditions and beliefs and wider social, economic and political contexts. Understanding governmentality from this 'decentred perspective' therefore requires examples and explanations of how 'agents apply norms in creative ways that transform power relations' (Bevir 2013: 38). Similarly, Martin and Waring (2018) argue that an appreciation of governance in health care also requires attention to both dominant discourses and their agentic use by individuals in local practices.

Second, and relatedly, Bevir (2010) calls for more examination of the *genealogy* of governmentality; examining the historical context in which governmentality arose, the contingent appropriations and modifications to historical traditions in responses to novel circumstances and dilemmas, and the processes of social construction of practices through which individuals construct meaning. He suggests that such analyses focus on specific individuals' micro-level actions and the way they are influenced by specific contexts, narratives and traditions.

Third, most literature on governmentality in health care draws on empirical examples taken from Western high income countries, which represent a type of neo-liberal governmentality that Foucault was talking about, neglecting LMICs (Ferguson and Gupta 2002; Lemke 2011). We thus know little about evidence-based governmentality in LMICs, where governmental regimes may be different to those in the West (cf Bevir 2010, 2013). Moreover, this also leads to ignoring the significance

of ‘transnational governmentality’ (Ferguson and Gupta 2002) in shaping LMIC health care. Medical research in African countries is often conducted in collaborations with Western government institutions and international organisations such as the World Health Organization (WHO), Non-Governmental Organisations (NGOs), and internationally-operating Western philanthropy organisations (e.g., Wellcome Trust or Gates Foundation). These transnational collaborations require surveillance and governance transcending national boundaries, shaping health systems in many African countries that, in the absence of sufficient government funding, rely on such collaborations as a means of providing sufficient health care for their populations (Greissler 2015; Ferguson and Gupta 2002). This transnational context raises a number of important questions, not least the question of (neo)colonialism and its effects on transnational governmentality (see e.g. Boussebaa 2015, 2017, 2020).

In the African context, research suggests that health care professionals continue to follow local ‘practical norms’, i.e. ways of working which deviate from the professional and official norms as well as standards typically found in the West (de Sardan 2015). For example, Brown’s (2016: 595) anthropological study of governmentality in Kenyan hospitals describes ‘monitoring and the management of systems as insufficient for managing the conduct of others’ and how ‘Formal disciplinary procedures were also rarely undertaken. Even in quite serious cases of professional misconduct’ (ibid.: 600). Nzinga et al. (2019a) describe clinical-managers navigating between professional, official and practical norms in the challenging Kenyan health care contexts, in ways providing scope for agency and maintenance of professional legitimacy.

In this chapter, we are interested in the question of micro-level implementation and its limits. While the introduction of EBM, transparency and clinical audit have improved health care in many Western countries, there is less evidence of their use and effectiveness in LMIC health systems (Cleary et al. 2013; Nxumalo et al. 2018). Moreover, as in Western health care (McGivern and Fischer 2012), there is evidence of transparency having perverse unintended consequences in LMICs (Cleary et al. 2013). For example, Litorpa et al. (2015), in a Tanzanian study, showed transparency raising fear of blame for poor obstetric care, resulting in an increase in more unnecessary caesarean sections being

carried out. Thus, different norms and traditions in LMICs may produce a different form of governmentality to that in developed countries in the West.

Accordingly, we need to understand how and why transnational evidence-based governmentality, commonly originating in Western countries, is enacted into practice and internalised by professionals in LMIC health care contexts. We aim to address limitations in prior research by examining professional work to construct, implement and use a Western evidence-based governmentality as a means of improving paediatric health care in a Kenyan clinical network. We discuss our methodology next.

Methods

This chapter is written by an international and interdisciplinary team of network insiders and outsiders to CIN, with a diverse range of perspectives on the CIN case study. Mike English, a Kenya-based but UK trained paediatrician centrally involved in CIN with insider experience of the Kenyan health system, commissioned Gerry McGivern, a UK-based organisational theorist conducting qualitative research in health care, to conduct a formative qualitative evaluation of the CIN. Gerry McGivern collected and analysed data on CIN with Jacinta Nzinga, a Kenyan qualitative social scientist, with Mike English supporting data analysis by providing an interpretation of emergent findings based upon his insider experience and expertise. Mehdi Boussebaa, a UK-based international management and organisation scholar, contributed understanding of the importance of the transnational context and postcolonial theory.

We conducted the CIN case study in 2015–2016, drawing on observation and interviews (for more detail about data collection, see McGivern et al. (2017)). Gerry McGivern and Jacinta Nzinga attended three bi-annual CIN meetings as non-participant observers, examining training, discussion of evidence-based guidelines and data collection, network leadership and participants' reactions. Informal conversations with meeting participants also informed understanding of CIN.

Gerry McGivern and Jacinta Nzinga also interviewed 34 Kenyan health professionals (33 Kenyans) involved with CIN, individually and in mono-professional groups, asking them about their careers, professional identities, experiences of Kenyan health care and of CIN, including its impact on them, colleagues, patients and the hospitals involved. Interviewees included: two CIN directors (interviewed individually); 12 consultant paediatricians (ten interviewed individually; two together); Nine nurses 'in-charge' of paediatric departments (interviewed in three groups); a medical officer (junior doctor—interviewed individually); seven Health Records Information Officers (HRIOs; interviewed in two groups of three and one individually); a medical epidemiologist and representatives of the Kenyan Paediatric Association and the Kenyan Ministry of Health (all interviewed individually).

Interviews (22–90 minutes in duration) were then audio-recorded and transcribed, thematically coded and analysed drawing on theory relating to evidence-based governmentality and pastoral power as outlined above.

Empirical Findings

Development of a Transnational Evidence-Based Governmentality in Kenyan Paediatric Care

First, we examine the development (genealogy in Foucauldian terms) of the broader evidence-based governmentality underpinning CIN, particularly drawing on the interview narratives of CIN's network director (ND) and clinical director (CD).

CIN's ND is a British paediatrician, who trained at elite medical schools in the UK, where EBM and clinical audit were core elements in the curricula. He worked in Kenya early in his career, experiencing at first hand problems facing its resource constrained public health care system. ND noted: "*Working as a medical officer in the government hospital, which is very… short of resources… I was very well aware of how difficult it can be*." Indeed, one in five basic resource items necessary for the

provision of care to seriously ill children and new-borns were typically not available (English et al. 2014). ND started writing guidelines for clinicians and medical students in a Kenyan district hospital paediatric department he oversaw, as an attempt to improve the quality of care it provided in its resource-constrained context. During this time, he made contact with experts from and visited the World Health Organisation (WHO), an international organisation constructing and promoting evidence-based guidelines in health care globally.

ND then started working at the national policy level in Kenya. ND described: "*Looking at what care was actually provided, whether people were aware of existing technical guidance, whether they had the resources to follow any of that guidance, what the practical challenges were of providing care… [which] suggested major challenges*". This led the ND to question the value of developing clinical guidelines "*in a technical bubble*", which would not be implemented, leading him to refocus his career and research on implementing evidence into practice.

CIN's CD is a Kenyan paediatrician, who initially trained in medicine in Kenya and then did postgraduate medical training in the USA. She was inspired by the senior doctors who taught her in the USA, who always consulted the latest evidence and guidelines, rather than "*what I have always done*" as she had experienced among senior Kenyan doctors. This overseas training stirred the CD's "*passion*" for developing and implementing evidence-based health care, which she brought back to Kenya and enacted in roles teaching in a Kenyan medical school and CIN.

Training in Western countries provided CD and ND evidence-based expertise and an elite medical professional identity, which they enacted in their pastoral roles. In theoretical terms, they personally transposed (Fischer et al. 2016) evidence-based governmentality by personifying and role-modelling it as identity projects they were deeply embedded in. They also experienced professional 'identity violations' (Pratt et al. 2006); ND realising that research and guidelines he had been developing were not being used to improve health care in Kenya in practice; CD realised that the senior clinicians who taught and inspired her in the USA consulted evidence and guidelines rather than just with advocating what they had always done, as she had experienced among senior

doctors in Kenya. These identity violations lead them to question their pre-existing professional identities and roles, and engage in professional 'identity work' reorienting their careers mid-career (McGivern et al. 2015) towards implementing EBM into practice.

In 2005, CD and ND then became involved in developing national paediatric guidelines, drawing on existing WHO recommendations, conducting systematic reviews of evidence and meeting stakeholders, including from the Ministry of Health, Medical Schools and Kenyan Paediatric Association to discuss them. These were first published as Kenyan Ministry of Health guidelines in 2006, although only distributed in small numbers initially. 10,000 copies of the guidelines were distributed in 2008. The guidelines were subsequently updated in 2010, 2013 and 2015, with 12,000 copies distributed on each occasion. CD and ND were also involved in developing a training course (an extended version of the WHO's Emergency Triage Assessment and Treatment (ETAT+) training programme) on how to use the paediatric guidelines and practise evidence-based medicine (for more detail see English et al. [2014, 2017a, b]). CD recalled: "*When WHO came up with the [paediatric] guidelines… I was actually chosen to help in adopting… [and] adapting the guidelines to the Kenyan needs and… local context.*"

ND struggling to mobilise financial resources to support the implementation of evidence-based standards in Kenya, noting: "*It took a while to get that funding, because it wasn't very mainstream at that stage*" but eventually "*got funding*" from a Western-based global philanthropic organisation, "*following the sort of biomedical model to develop an intervention and test it*" *which "resulted in developing a set of tools… national guidelines*", adding: "*We used this approach 'GRADE', and I think we were the first country in Africa to do it at country level*". ND convened a meeting of "*various parts of the paediatric community… the Ministry [of Health]… university medical schools*" at which they agreed to adopt the evidence-based paediatric guidelines that the ND had previously developed.

Here we see the ND and CD engaging in pastoral work and related constructive practices (Waring and Martin 2016); identifying and translating evidence in a way relevant and comprehensible and relevant to local communities and health contexts. However, in this transnational

context, we also see their work bridging between the WHO, an international organisation with an established set of evidence-based guidelines, and the local Kenyan health system and medical profession. ND also describes mobilising funding by constructing the development and implementation of Kenyan guidelines as a biomedical intervention, tested in a LMIC national context, in which results could be fed back to the transnational funder based in the UK, reflecting the transnational governmentality described elsewhere (Greissler 2015; Ferguson and Gupta 2002).

In 2008, ND and CD both began teaching a postgraduate course in paediatrics at the University of Nairobi Medical School, which then trained over 70% of medical students in Kenya, using the paediatric guidelines and ETAT+ course. This introduced over 1000 undergraduate medical students and trainee specialist paediatricians to the principles of evidence-based paediatrics. CD complained that Kenyan medical schools were "*not using WHO guidelines, we were using textbooks from abroad*" which were focused on the needs of patients in Western countries rather those of Kenyans. ND noted:

> "*I began… teaching at the post-graduate level… helping to push this training into the post-graduate and under-graduate curriculum… the majority of paediatricians in training had been produced through the University… it meant that I knew quite a lot of the younger paediatricians… what we had been up to was more widely known because of our engagements with the university and disseminating these guidelines… We benefitted from trying to present things to them as a new way of doing business. And they were… receptive to that because… there has been a dissatisfaction with the sort of old professor stands in the corner and tells you. Younger clinicians… appreciate that knowledge is changing. So I think we fitted into a… generational issue… people seeing that there is more than just doing what you were told fifteen years ago.*"

Here again we see ND and CD adapting Western evidence-governmentality to the Kenyan health care context and inscribing, communicating and framing the discourse of EBM in a way that resonated with trainee paediatricians' agendas and norms. Indeed, most paediatricians involved in the CIN that we interviewed said they subsequently became involved in CIN because they had been taught and

inspired by the network leaders during postgraduate paediatric training. As one paediatrician (4) noted: "*Blame Professor [ND]. Blame Professor [CD]. They were my teachers in University… they're really good mentors*." We see here knowledge leadership (Fischer et al. 2016); ND and CD personally *transposing* evidence-based paediatrics into Kenyan healthcare by "*becoming known*" to trainee Kenyan paediatricians, fulfilling roles as pastoral role models and mentors, improving the status of professionals they mentored. This created a wider 'pastoral constellation' (McGivern et al. 2017) of professionals committed to promoting and implementing EBM-based practices into Kenyan health care.

This foundational work (developing paediatric guidelines, a paediatric medical curriculum and professional pastoral constellation), involving eight years of sustained 'whole systems' working with political, social and political complexity (for more detail see English et al. 2011, 2014, 2017b; Nzinga et al. 2009a, b), provided the foundation for CIN's establishment, which we discuss next.

Formation of the Clinical Information Network

We next explore the link between the development of evidence-based guidelines and governmentality and the development of a clinical network focused on implementing them.

ND applied for funding from a UK-based global philanthropic organisation, to develop what he described as "*a network of places to work together to improve what they were doing and demonstrate that improvement, in the hope of spread*". ND commented that he initially proposed "*a kind of 'N of 1' study*", which the funder "*couldn't fathom*", questioning "*where are your controls? How do you know that whatever changes you observe aren't going to be happening naturally? So, I wasn't able to provide a convincing argument, so they rejected the proposal*." However, he was invited to develop a new proposal, which he submitted a year later, that was "*framed as a randomized control trial… the network was then a vehicle for testing alternative forms of intervention, that… would result in more rapid implementation or adoption of better practices, and thereby improve quality. Trying to steer away from having it labelled as a more quality improvement initiative*". The new proposal was funded.

So here again we see a Western philanthropic organisation and a Western governmentality discourse disciplining local activities through its allocation of funding. ND noted: "*The bottom line is to run these things takes funding. And the funding will have to come from somewhere. And that … it won't come from government*". We also see the work of ND, whose understanding of the Western medical scientific discourse and experience working in Kenyan health care, enabled him to bridge between transnational governmentality and the Kenyan health system. While CIN's purpose was ostensibly implementing evidence-based quality improvement, we see ND redesigning the CIN proposal to discursively frame it in Western medical scientific discourse to secure funding. Indeed, we also see the Western evidence-based governmentality vested in ND personally as a professional pastor, who noted, "*I am kind of the proxy for… the money*".

Implementation of an Evidence-Based Governmentality Within the Clinical Information Network

In 2013, CIN was established as a clinical network spanning 14 Kenyan public district hospitals, aiming to improve paediatric health care, including by conducting discrete related RCTs. CIN focused on promoting the adoption of recommended evidence-based best-practices, using clinical audit to highlight poor practice as well as improve quality, and training participants in quality improvement techniques and leadership. CIN also holds regular network meetings, enabling participants to share experience and learning, and providing a form of support network for doctors and nurses working and trying to improve clinical care in challenging circumstances (English 2013; English et al. 2017a).

Developing evidence-based guidelines does not mean that they will be implemented; this depends on the 'inscription practices' (Waring and Martin 2016) of network leaders; *championing* use of evidence-based guidelines, audit and quality improvement techniques, highlighting poor practices in local contexts and *demonstrating* how evidence and audit could improve them, and *supporting/mentoring* local clinicians and nurses in their attempts to make improvements (McGivern et al., 2017). ND and CD initially conducted much of this work. ND noted:

"*Supervision and mentorship was supplied by myself and [CD]… we would go back with the survey results and we would discuss those with them, trying to get them to both acknowledge the problems – which they did quite readily – and then kind of come up with action plans to deal with them*."

As CIN became more established, this inscription work also involved a wider pastoral constellation (McGivern et al. 2017) of paediatricians, whom ND and CD had first met and inspired during postgraduate training as we noted earlier. For example, Paediatrician 2 commented on the importance of championing, role modelling and checking on interns: "*checking in a guideline … now when they realize that even the consultant refers to it, then it's not a weakness. So that I think mind-set has changed*" and that "*improving the system… should also improve your career.*" Paediatrician 4 commented: "*I mentor a lot of the doctors and tell them why I love paediatrics… [and] leading quality improvements… It's kind of catching… Do it with passion… you can make a difference… You catch more flies with honey than with vinegar*" (Paediatrician 4).

Indeed, CIN's "*passionate*" and positive approach was inherent to its success, which was very different from the practical norm of senior Kenyan doctors intimidating junior clinical staff (cf Nzinga et al. 2019a, b). Paediatrician 11 described many senior Kenyan doctors as:

> "*dictators not really wanting to listen to people and just want to give the solution to problems [but] they don't want to know what your problems are… they just tell you there is no money, they do not help you come up with the solutions…The traditional way of teaching [is] where you are basically want to intimidate everybody and scare everyone… to the point that even trying to consult them [senior doctors] you need to think twice.*" (Paediatrician 11)

By contrast, CIN's modus operandi involved: "*positivity… [CIN] teach you how to not admonish people… you are always told off like there is no tomorrow… during a ward round, in front of your juniors, that has been the trend but they [CIN] have changed things*" (Paediatrician 13) and "*Getting to the bottom of things and sorting them out… not in a harsh way, just finding out where the problem is and not putting the blame on anyone*" (Paediatrician 8). Here we see the affective component of pastoral work implementing the evidence-based governmentality; it was not

solely the discourse of EBM that interns bought into but the individual promoting it and their positive approach. We note that in the Kenyan health care context there is usually only one highly trained paediatrician in Kenyan district hospitals, so these individuals have a particularly important pastoral role.

In Foucauldian terms, network leaders were supporting their 'flock' of patients and junior professionals in a way enhancing the identity and status of Kenyan evidence-based paediatrics. Pediatrician 10 commented: "*We [CIN] move together to improve the quality of care for our children [patients], individually and then collectively*." Paediatrician (11) noted:

> "*The most satisfying [aspect of her involvement in CIN]… has been basically to improve the quality of life for our patients… Not just the child but even the family and the community… [and] teaching younger colleagues, to see the transformation… from a doctor who had just learnt the theoretical knowledge to actually being able to apply it in the bedside.*"

Indeed, CIN attempted to build the Kenyan paediatric community. As English et al. (2017b: 850) note: 'creating social and professional norms among both decision makers and practitioners to use evidence has been an effective strategy for awareness raising at scale and has helped reshape professional identity towards acceptance of common practice standard'. ND commented:

> "*We have worked very much through the paediatricians as professionals… conscious of not trying to tell them what to do… recognising … fundamental challenges and trying to approach people with possible solutions obviously helps. Particularly when they are very under-resourced themselves and don't have much recourse to developing their own solutions, or implementing their own solutions. So, being seen as somebody who can support an agenda that is meaningful to them… [give] voice to the profession, because they can unite across counties.*"

CIN participants also reported that during CIN meetings there were, "*sharing experiences… meeting as colleagues… from different places facing*

actual challenges on the ground… being part of this community of people involved to similar work" (Paediatrician 2). They used CIN meetings as what can be thought of as semi-private 'relational spaces' (Kellogg 2009) in which to build an evidence and audit based collective professional identity, discuss, develop and test ways of contending outdated clinical practices. They then returned to local district hospital sites and began presenting clinical audit data about health care delivery and clinical outcomes in professional meetings and comparing these to local evidence-based guidelines and deliver and outcomes in other hospitals. These district hospital meetings, exposed and undermined the legitimacy of poor practices, bringing in the new evidence-based professional norms. Like Foucauldian pastors, we see that these local pastoral professionals' work purpose and identity was deeply embedded in the evidence-based 'salvation' of their 'flock' of patients and professional community.

Disciplining and Normalisation of Evidence-Based Governmentality in Kenyan Paediatric Care

Having developed a shared evidence-based professional identity, professionals in CIN engaged in pastoral work and practices *disciplining* (Waring and Martin 2016) peers and junior colleagues in their ongoing use of the evidence-based guidelines. Interviewees described:

> "*Medical Officer interns, often they are not listening to experienced nurses who have done the job a lot, who are, you are able to discipline them and put themstraight when they are doing wrong things... [because] we, I give out the standards of the wards, [as] expectations from them.*" (Nurse 6)

> "*Keep checking [interns] in the [ward] rounds, then they know that it is checked. Unfortunately, that is what it takes to get some people to use guidelines.*" (Paediatrician 2)

Reflecting research in Western health care we discussed earlier (Ferlie and McGivern 2014; Martin and Waring 2018), we see professionals in CIN making clinical outcomes visible and holding colleagues

accountable in ways making poor performance professionally untenable. Medical Officer 9 described feeding back results to colleagues in their paediatric department: "I *gave them the feedback. When they saw it for themselves some of them were embarrassed by some of the bad work that had been doing but they were very motivated [to improve]*." So, here again the professional pastoral work that disciplined health care delivery to conform to evidence-based best practice. Accordingly, at least initially, the evidence-based discourse alone did not discipline medical interns and trainee nurses but also the work of their professional colleagues.

Yet, over time, a combination of Panopticon (Foucault 1977) and lateral relational transparency (Nxumalo et al. 2018; Cleary et al. 2013) led to the normalisation of an evidence-based governmentality among professionals within CIN. Nurse 15 commented: "*somewhere somebody watching on you how do to do things you become better and more conscious*". Paediatrician 11 described CIN members: "*all holding each other accountable*". Nurse 7 described working within CIN as, "*a kind of competition when you get feedback and look at the graphs; how you are performing, look at the other hospital… healthy competition*". Knowing clinical provision and outcomes were being monitored against guidelines and observed by peers, professionals disciplined themselves to provide evidence-based care and constructed their identities in relation to clinical outcomes compared with the wider population of hospitals within the network. Like members of a pastoral congregation, professionals within CIN came to accept, normalise and even welcome evidence-based governmentality.

Discussion

We contribute towards the literature on governmentality in clinical networks and health care by explaining work, practices and process through which a Western transnational evidence-based governmentality was transposed into a LMIC health system. In doing so, we provide new insights addressing previous limitations in this literature (cf Bevir 2010, 2013; Lemke 2011; Ferguson and Gupta 2002). We show the micro-level work involved in developing and implementing

a transnational evidence-based governmentality, explore its genealogy in novel circumstances and traditions in the Kenyan context, and thus extend analysis of evidence-based governmentality beyond Western countries into a LMIC.

Our study highlights two particularly novel features of this evidence-based governmentality. First, the *transnational* nature of evidence-based governmentality in LMICs, emanating from Western-based global philanthropic organisations (cf Ferguson and Gupta 2002; Greissler 2015). Second, addressing interest in the work conducted in organisations (Barley and Kunda 2001), professional identity work (Pratt et al. 2006; McGivern et al. 2015), identity management (Boussebaa 2020) and pastoral practices (Waring and Martin 2016), we show the importance of what we describe as '*pastoral work*' by senior medical professionals and highlight the personal nature of transposing (Fischer et al. 2016) governmentality.

We show how a Western philanthropic organisation disciplined the development of CIN and evidence-based paediatrics in Kenya through its allocation of funding essential for these activities. While ostensibly focused on improving the quality in Kenyan health care, CIN's British director (ND) secured funding only after framing his proposal in experimental biomedical terms, reflecting a Western-dominated transnational governmentality. However, allocation of funding can also be seen as a 'practice of freedom' (Rose 1999); ND was not forced to adopt the philanthropic funder's transnational governmentality. Yet after an initial funding proposal for quality improvement work reflecting the needs of local Kenyan paediatrics was rejected, ND would not otherwise had funds to improve the care he knew was so needed. Hence ND chose to adopt transnational governmentality in response to a situated professional dilemma (Bevir 2013) of how to fund improvement work in clinical care.

Funding, along with responsibility for CIN's activities, was then invested in ND (describing himself as a "*proxy for the money*"), again reflecting the personal nature of knowledge transposition, with ND 'becoming the knowledge object' (Fischer et al. 2016). Echoing health care management research drawing on the notion of pastoral power (Ferlie and McGivern 2014; Waring and Martin 2016; Martin and

Waring 2018), we explain network leaders as 'pastors' inculcating the discourse of transnational evidence-based governmentality among their professional 'flock'. This pastoral work was essential for the development of CIN and an evidence-based governmentality in Kenyan paediatrics.

The importance of network leaders and their work reflects the broader literature showing the role of professionals implementing new knowledge and evidence in health care (Mitton et al. 2007; Currie and White 2012; Fischer et al. 2016; Ferlie et al. 2018). The transnational nature of the process and its LMIC context highlight something new. Both ND and CD had training in evidence-based paediatrics in Western medical schools and first-hand experience of the challenges of delivering health care in the resource-constrained Kenyan context. Without experience and understanding of Western evidence-based practice they would not have had the credibility to secure global philanthropic funding to develop evidence-based paediatrics in Kenya. Without long-term experience and understanding of Kenyan health care they would have been unable to implement evidence-based care in it. Thus, CIN's network leaders needed knowledge and experience of both in order to bridge between them, adapt and implement Western evidence-based governmentality into this LMIC context.

However, knowledge and experience alone were not sufficient to transpose this evidence-based governmentality into practice. Significantly, CD and ND were also personally and professionally invested in improving clinical practices in Kenya by transposing evidence-based practice. Both had worked in the Kenyan system long term and experienced mid-career professional identity violations (cf Pratt et al. 2006; McGivern et al. 2015) leading them to question the value of their pre-existing professional work (e.g. ND realising the futility of developing evidence-based guidelines "in a technical bubble" that were not used in practice) and reoriented towards implementation of evidence based practice. Thus, both were motivated to personally develop evidence-based Kenyan paediatric guidelines and medical school curricula, which they taught, championed, mentored and role-modelled as identity work maintaining their status as professionals doing their best for patients.

As a result of these network leaders' affective identity-enhancing pastoral work, challenging pre-existing norms and introducing a new "*positive*" and "*passionate*" approach to paediatric care, a pastoral constellation of professionals developed around them. Trainee paediatricians enthusiastically adopted this new approach, creating a professional network committed to implementing evidence-based paediatrics. CIN formed the basis of Kenyan paediatricians' work to collectively enhance their shared evidence-based professional practice and identity. Professionals governed themselves, their peers and the wider profession using evidence and audit because, in doing so, they demonstrated quality improvement and professionalism, enhancing their identity, legitimacy, and status as a form of individual and collective 'cultivation of self' (Foucault 1990). While top-down transparency and governance is often ineffective, even undermining professionals' ability to improve health care (de Sardan 2015; Cleary et al. 2013; Brown 2016; English 2013; Litorpa et al. 2015), *lateral* relational transparency (Nxumalo et al. 2018; Cleary et al. 2013; Barker 1993) and *synopticon* transparency, involving watching and seeking to emulate an admired few (Mathiesen 1997), normalised evidence-based practice as good professionalism.

Our chapter speaks to the importance of a 'decentred' (Bevir 2013) approach to analysing EBM and networks in their particular contextual circumstances. Without understanding of the traditions, practices and norms of Western EBM, transnational philanthropic organisations and Kenyan health care, network leaders would have been unable to transpose evidence-based governmentality, and we would have been unable to explain their pastoral work. From a 'decentred' perspective, we show that the genealogy of governmentality is inherently personal; it involves situated dilemmas, with implications for personal and professional identity, about how to engage with divergent local circumstances and governmental 'practices of freedom' (Rose 1999) (e.g. ND framing a proposal in biomedical terms to secure funding for activities aimed at quality improvement). Moreover, our case illustrates that people do not simply adopt an impersonal governmentality; people internalise a governmentality promoted by individuals (pastors) whom they know, understand, trust, like and seek to emulate, and a governmentality they

can draw upon to maintain and enhance their local circumstances and status.

Our analysis also reveals how LMICs, such as Kenya, occupy a subordinate position vis-à-vis their Western counterparts and one in which the latter play a critical role in constructing the former in line with practices considered 'normal' in the West. In other words, LMIC health care discourses and professional identities are disciplined in line with Western norms and expectations. Yet the process may not go smoothly, as LMIC professionals not only conform but also modify and, in some cases, pay lip service to Western discourses and practices (cf Boussebaa 2015, 2017; Boussebaa et al. 2014). Furthermore, as we noted above, the question of governmentality in African countries and indeed in LMICs more generally needs locating in the wider uneven geography of the global political economy. That is, it requires appreciating that transnational governmentality occurs across 'societies that have been intertwined in a complex and shifting hierarchy of nations' (Boussebaa et al. 2012: 470) and is thus produced in a wider context of power asymmetry rooted in long-term processes of (neo)colonial domination (Boussebaa 2020).

Finally, in closing, it is important to acknowledge that our analysis is based on the experience of professionals in one African country only: Kenya. Based on this analysis, we have tended to generalise to Africa as a whole but this would be to portray Africa in unitary terms; research is therefore required in other African settings. Future research might also examine transnational evidence-based governmentality on a wider basis, examining similarities and differences not only in Africa but also in other LMICs such as those in Asia and Latin America.

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