Demonstrating Development: Meetings as Management in Kenya's Health Sector

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Abstract

International development operates as a system of meetings. This paper shows how meetings work within aid regimes to structure responsibilities for implementation, to situate projects within funding streams and to realize the effects of scale. Where donor aid is increasingly allocated to support national plans which are the responsibility of recipient governments, monitoring outcomes requires the instantiation of project forms within and across existing state institutions. This involves the delineation of specific sectors and their scale of operation alongside the maintenance of relations with external funders. Drawing on ethnographic material from the Kenyan health sector we show how development projects are realized as tangible social institutions through the structure of formal meetings. Meetings mark the temporality and trajectory of development as a set of planned activities contributing to specific targets. In the context of specific projects they become fora where commitment to development goals of participation, capacity building and effective management can be demonstrated.

Introduction

Development finance makes a substantial contribution to Kenya's growing national economy where net official development assistance has stabilised at around USD $2.6 Billion annually.[i] The effects of this spending extend far beyond the confines of the projects and programmes aid officially sustains. As in other countries where the presence of international development is significant, its organisational forms and the resources which accompany it are evident across Kenyan society, economy and culture (e.g. Ferguson 1990, Green 2014). Signboards advertising small scale projects are commonplace in densely populated urban areas and in remote rural locations.Offices of development agencies, from international organisations to local NGOs are dispersed throughout the country. Along with projects and programmes directed at specific categories of beneficiaries, the development sector provides employment, opportunities for volunteers and access to resources, as well as sustaining an expanding economy of support services, from consultancy to communications (Brown and Green 2015, Swidler and Watkins 2009). Meetings are integral to this economy and to development practice within it. Development workers in Kenya expect to spend a substantial proportion of their time travelling to and participating in various kinds of formal development meetings. This paper explores the central place of meetings in the organisation of international development through an examination of meetings in the Kenyan health sector.

Meetings comprise a huge part of international development work, ranging from large multinational events within annual calendars to the numerous small-scale meetings that make up the `project cycle' of appraisal, implementation and evaluation (cf. Ferguson and Gupta 2002, Green 2003). From global summits to local stakeholder consultations and participatory workshops, these varied types of formal meetings enact the relations through which the social organisation of international development as a system of politically motivated resource transfers is structured. Development interventions seek to direct outcomes through financial transfers that occur within specific time frames. Accountability and temporality generate the architecture of development organisational forms. In contexts where vertically organized state structures become incorporated into development interventions, lattices of control and

accountability are created which aim to track multiple layers of accountability within different funding streams and timeframes. In Kenya, meetings embed the activities of numerous organisations and agencies involved in the delivery of aid into lateral relations with state organisations, integrating external agencies into the architectures of developmental governance. Meetings connect the different levels of a vertically and hierarchically structured state that extends down from the National, encompassing the smaller administrative divisions of Provinces, Counties and Districts. Meetings enact the time, space and relations of development interventions and are themselves ordered by these spatial and temporal visions.

Formal meetings, for example planning meetings between bilateral partners or appraisals between donor and beneficiary, have always been important in the social organisation of development (e.g. Harper 2000). However, the structuring role of meetings in the development order has been transformed since the start of the twenty-first century with the inception of the development partnership aid regime. This regime is associated with the alignment of political objectives among certain donors, known as `harmonisation'; the increased devolution of spending to local `partners' and inclusion of a wider constituency of civil society and other stakeholders in development planning, evaluation and implementation processes (Craig and Porter 2006, Green 2014). A greater proportion of development spending has been integrated, where accountability allowed, into national processes. These changes required a proliferation of meetings where debates about spending could demonstrate national ownership of and accountability for aid agendas. At the same time, with the agglomeration of aid into sector programmes and budgets, meetings become crucial as sites where the sub projects within different sectors become visible. Meetings therefore enact the relations of 'sectors' and 'scale' which are the structural components of contemporary development infrastructure. These conceptual artefacts are the 'conjured contexts' (Abram, this volume) of meeting organization and practice. At the same time, meetings constitute the social space for the demonstration of other requirements of the development partnership funding regime; effective management, capacity building, participation and partnership.

Specialised forms of meetings have become established as essential to development infrastructures along with specific social categories of participant and attendee. Meetings enrol actors and agents who are situated at nodes of interface between different organisations or 'levels' of development as 'partners', 'stakeholders' and 'managers'. The changing implementation, monitoring and review processes entailed in meetings have implications for the practice of management within development and within the sectors and institutions supported by it. In the Kenyan health sector, the work of managers in the district health system is no longer only focused on managing the delivery of local health services. Significant effort must be put into managing relations with donor agencies as development `partners' (Brown 2015). Development success partly rests on the management of expectations and the political context in which outcomes are deemed to be achievable, (Mosse 2005).The management of development therefore cannot be accomplished `at a distance' (Latour 1987, Miller and Rose 1990). In addition to the high volume of reports and specialised modes of accounting which script development success (see Tendler 1975) and which are an important component of extending development practices across different spaces through inscriptions of expertise, development management requires new social fora where relations can be nurtured, strengthened and consolidated. This is achieved through meetings.

The everyday work of managers and staff in the Kenyan health system involves several kinds of meetings. Staff may request a meeting with a senior colleague to get advice or discuss an ongoing problem. They are likely to meet informally with colleagues when they travel to collect supplies or deliver reports. Managers carry out supervision visits which involve unscheduled but relatively formal meetings with front line staff. Some meetings may anticipate future development interventions, for example when NGO staff visit a senior government official, introduce themselves, sign a visitor's book, and say that they look forward to working together in the future. These meetings are part of everyday working life but they do not make development infrastructure in the way that we are concerned with. The meetings we discuss in this article are pre-planned events timed to coincide with development planning,

implementation and reporting cycles. They are documented through minutes and in reports to funders. They require the attendance of certain people who are accorded the capacity to act on behalf of a development constituency, either through professional office or their position as representing a particular group, as when a member of a local civil society organisation can act as a representative of beneficiary communities (Brown and Green 2015, Mercer and Green 2013). For Kenyan health managers, such meetings included weekly team meetings; monthly `in-charges' meetings; annual planning meetings and quarterly stakeholders meetings. Such meetings populate the encompassing development orders of sectors and vertical programmes with roles and duties, realizing the formal architecture of responsibilities outlined in project documentation as tangible social relations.

Meetings in development: The reorganisation of international aid

Since the turn of the century, international development promoted by northern agencies, including bilateral and multilateral organisations, has been increasingly concerned with scaling up isolated projects through sector-based interventions and harmonization of implementation, with donor funds aggregated within a single budget (Craig and Porter 2006, Harrison 2004). At the same time, ideologies of public management informed by neoliberal paradigms seek to reduce transaction costs, increase efficiencies and devolve responsibility for implementation through a hierarchical structure of development 'partnerships' (Abrahamsen 2004, Brown 2015, Mercer 2003). These approaches are exemplified in the World Bank's Poverty Reduction Strategy approach, and in participatory approaches through which those defined as stakeholders are engaged in the design and implementation of development programmes (Green 2010, Lie 2015). Development interventions under this regime also contain capacity building components that aim to enhance continuity, ownership and sustainability after the project is ended with a view to improving processes of governance (Phillips and Ilcan 2004, Watkins and Swidler 2013). This organisation of development requires new modes of engaging

those defined as stakeholders and a reconceptualization of the project as the vehicle through which aid spending produces development outcomes.

Previous aid regimes operated bilaterally and vertically through short chains of relationships between donor and recipient, with implementation undertaken by donor agencies themselves or their representatives. Development projects were discrete entities, often bundling in multiple activities in 'technical' interventions which operated as stand-alone endeavours in parallel to state structures (Hirschman 1967, Tendler 1975). Project employees were clearly differentiated from civil servants and government staff. Meetings and documentation played important roles in representing projects as managed interventions and constituting the political space through which objectives and agreements were negotiated (e.g. Harper 2000, Tendler 1975). The formal meetings through which social relations of aid were organised were limited to the dyad of donor and recipient in a bilateral relationship. Representatives of beneficiary groups and so called 'stakeholders' did not generally participate in the formal social spaces through which development projects were assessed, monitored and subject to management.

The current aid regime has different requirements. The "good project" (Krause 2014) is no longer a standalone endeavour. Development requires changed forms of organisation, which can demonstrate the progress of initiatives by making them visible as sets of activities which are internal to, and integrated within, national systems. Dyadic relations between donor and recipient have been replaced with complex latticed arrangements that enrol numerous different participants through processes of 'partnership', 'participation' and 'stakeholder involvement'. This is achieved through the official meetings that populate the global social order of international development. Temporally, through progress markings against timelines of development targets within project and budget calendars (five year plans, annual reviews, end of project reviews); territorially (country strategies, regional frameworks) and vertically (global visions).

In Kenya, the organisation of development aid within the health system has followed a trajectory similar to that of other countries that have been in receipt of large amounts of foreign funding. In the period immediately following independence in 1963 there was a strong political will to extend health services (Maxon 1995: 132-4), including through `*harambee'* self-help activities to which communities contributed labour or money (Holmquist 1984). Population increases and economic decline in the 1970s and 1980s, and a global political context where there was pressure to reduce state expenditure, meant that the government struggled to meet these goals (Barkan and Chege 1989, Throup and Hornsby 1998: 47). Since the 1970s, the Kenyan health sector has been heavily dominated by the influence of the international community and its funding priorities.

From the 1980s onwards under the influence of the `health for all' agenda that emerged from Alma Ata and the structural adjustment demands of the World Bank, funders emphasised the need for decentralization of government services and accountability to users. Responsibilities for the delivery of health and other services were shifted to local government authorities (Barkan and Chege 1989, Semboja and Therkildsen 1996). Districts assumed responsibility for managing operational health services, subsidized through 'cost-sharing' (e.g. user fees for patients), which were legitimized through the narrative of community participation (Mwabu 1995, Mwabu, Mwanzia and Liambila 1995, Oyaya and Rifkin 2003: 115-6). District level implementation was further formalised in 1994 through the introduction of District Health Management Teams. Throughout the 1990s the attention to health systems reforms increased, as it did elsewhere (Therkildsen 2000), most notably with the implementation of what was termed the sector wide approach (SWAps) which was concerned with improving the co-ordination of aid funding through a single centralised structure of management (Walt, Pavignani, Gilson and Buse 1999).

By the early 2000s, the direction of these changes were consolidated through a preferential shift among influential donors towards sector based funding and budget support,

alongside integration of funded projects into the routine activities of government ministries (Craig and Porter 2006). Funding for health care in Kenya now consists both of government budgets (which are themselves sustained by multi-donor support) and vertical interventions supported by different funders. These programmes have highly complex organisational structures. The US-funded PEPFAR interventions that support the majority of HIV/AIDS care and treatment in Kenyan public hospitals are a case in point. US implementing agencies such as the Centers for Disease Control and USAID are responsible for managing the distribution of HIV/AIDS funding in collaboration with the US-run office of the Global AIDS Programme, based in Nairobi. Smaller managing agents (who include non-governmental organisations and research agencies) compete with one another to gain contracts from these larger agencies and deliver services in different geographical areas.[ii] Almost all service delivery takes place through Kenyan government structures (Brown 2015, Dietrich 2007, Ingram 2010).

Vertical interventions do not only target HIV/AIDS. They also include water and sanitation (WASH) projects, the national immunisation programme and tuberculosis and malaria control programmes. Each of these vertical programmes is supported by a different funding agency and each is concerned with different sets of development outputs. Funding from multiple donors and the implementation of projects inside the health system transforms the role of some staff working within it, who, in addition to delivering health services to users of their facilities have to deliver the outputs of projects to their various funders outside it. This particularly affects health managers within district or regional management teams whose responsibility is to represent their district as a deliverer of health services to users as beneficiaries of aid transfers, while reporting on what is delivered, and who has paid for it, to management and development partners further up the system. Managing in this context thus becomes more than the management of health facilities and outcomes. It is fundamentally concerned with the management of development relationships and expectations.

This is not a small undertaking. The district health managers whose work is described in this article worked with a total of 19 partner organisations of varying sizes at the time of fieldwork. The 'harmonization' of development activities within the health sector has had the paradoxical effect of increasing complexity as external projects are brought into the sector to be managed but remain separate in terms of their social relations, implementation and reporting processes. In these reconfigured health systems which incorporate vertical streams of donor funding, a key task of managers is to demonstrate responsibility for development. This is achieved through reporting and monitoring on project progress and through the demonstration of professionalism. Official meetings constitute the social fora where these responsibilities can be enacted and the demands of partnership can be managed.

Meetings and Management

In 2011 Hannah Brown spent around 8 months carrying out ethnographic fieldwork with a District Health Management Team in western Kenya.[iii] This group consisted of roughly 12 mid-level managers who worked within a tiered system of management. Above them were Provincial managers (with whom they interacted occasionally) and National managers (with whom they rarely or never interacted). Below them were the 'in-charges' of rural health facilities. In-charges in turn line-managed front line health workers and supervised the day-to-day running of health facilities of varying sizes.[iv] The managerial team that participated in this research managed health services across a rural District with a population of approximately 150,000. The District included 21 health facilities ranging in size from 2 to 15 staff members, each led by an 'in-charge'. Development funds and resources were distributed through these managerial structures, with monitoring and management required at each level.

The District Health Management Team spent most of their time in meetings. The board outside their main offices listed planned activities for the month ahead, revealing a working life structured almost entirely around meetings of different kinds; monthly in-charges meetings

with health workers, budgetary planning meetings with NGO partners, weekly team meetings, quarterly review meetings for various projects, and stakeholder meetings that brought together providers, funders and recipients of health care in the District. Indeed, health managers spent so much time in meetings that it was hard, if not impossible, to imagine work without meetings. Managers used meetings to maintain working relationships with partner organisations. At meetings, they met the facility in-charges and gave formal updates about ongoing interventions while in-charges reported 'up' from their facility. Meetings were opportunities to demonstrate professional expertise in development and ensure the proper management of health systems, whilst engaging agendas of capacity building, partnership and participation. Meetings instantiated development as the delivery of projects within the health system. For district health managers as interstitial actors between development funders and service users, participation in health system meetings enhanced one's capacity as a manager and as an agent of development (cf. Pigg 1997, Watkins and Swidler 2013).

An 'in-charges' meeting

It is almost 9.30am and around fifty people have gathered for a meeting in a large hall in a small market town, little more than a cluster of buildings around the main road, approximately 70km from the regional capital Kisumu. The hall is a recent addition to a popular local hotel where people with disposable income, including wealthy men and those with salaried employment, come to drink beer and eat *nyama choma* (roasted meat), perhaps staying overnight in one of the small self-contained rooms. The hall was built specifically to capitalise on the growing business opportunities for hosting development meetings in the town but local residents also make use of the facilities for weddings and other events. Participants at the health meeting include the District Managers and other senior Ministry employees based at the nearby government hospital, representatives from 'partner organisations', and the 'in-charges' who manage the smaller health facilities in the District. Despite the hot weather, men are dressed in

jackets and ties. The women wear tailored suits and have salon styled hair, demonstrating professionalism and a business-like demeanour. The managers who lead the meeting are differentiated from attendees by their sitting positions at the front of the hall next to main part of the stage. Tablecloths and a display of plastic flowers next to them further emphasise the seniority of the managers and the special status of the meeting.

When participants arrive, they sign in using a form that will be used to organise the payment of transport and attendance allowances. They are provided with a copy of the agenda for the meeting, a bottle of drinking water, a notebook and a pen. Once the hustle and bustle of greetings has died down, and all participants have taken their seats, the meeting is formally opened. On the programme this task is allocated to the District Medical Officer, but she is late to arrive and a senior manager does this on her behalf, welcoming the participants and asking one of the female managers to lead a word of prayer before the meeting begins. The meeting starts with management presentations. Managers are in mostly in their 40s or 50s and consist of women and men who are trained in different areas of public health, clinical medicine and nursing. They are a confident and charismatic group. Managerial behaviour at meetings is a taken-for-granted set of high-status skills and experience, underlined by confidence and familiarity with the social conventions of meetings. Managers carry laptop bags or fabric cases branded with logos from higher level development meetings which they have previously attended. Meetings at this level are held in English and participants, particularly managers, employ a wide range of technical development terms. This month there is a presentation from the District Disease Surveillance Officer, who gives an update on epidemic reports and reminds in-charges of the alert protocol if they see cases suggestive of particular diseases, such as measles.

Then the Reproductive Health Manager takes the stage, “I don’t have a presentation for you today”, she says, “But I am requesting you all for something. Data on Family Planning is still a problem. We don’t reflect exactly what we are doing in the facilities. We have changed now to

a monthly reporting tool, however some of the reports are not complete. How am I expected to give my reports to Provincial level?", she complains, underlining how in-charges reports are embedded in a larger system of reporting that extends upwards. She brings up a copy of the reporting form on her laptop, which is projected onto the wall at the back of the hall, and explains how to complete it. "Let's make sure we are reporting properly," she emphasises.

There is a break for tea and snacks; hard-boiled eggs and small doughnuts. People move outside to enjoy the cool fresh air and collect their food. By now, the District Medical Officer has arrived, her late arrival giving the impression of busyness and her interruption to the meeting underlining the power and status of her position. She is not expected to queue for food and one of the younger female nurses is sent to fetch tea and snacks for her while she sits down next to the other managers. When people gather in the hall again she addresses them, discussing the overall strategy for the District, new facilities that will be opened and upcoming trainings and initiatives. She informs attendees that a partner organisation funding HIV care and treatment will be calling health workers to a training course on how to use their new reporting frameworks. In-charges are told expect invitation letters and to select appropriate participants from their facility. The following week there will be a refresher course on TB management as part of the national HIV/AIDS and Tuberculosis strategy. This will take place for three days in Lakeside Hotel in Kisumu. Both training events seek to educate health workers on the use of standardised modes of clinical practice and reporting. These training programs constitute evidence for the organizations contracted to deliver them – who also have to report back to their own funders – that they are 'working through government structures' and 'building capacity' (cf. Swidler and Watkins 2009).

The District Medical Officers' interruption to the meeting is followed by an update from the District Records Officer. He gives an extended presentation about the District's overall performance against health indicators for the District which are pegged against the millennium development goals for health. He points out areas where "we are not doing well" and selects

other targets for special attention, "Please can dispensaries [the smallest category of health facility] remember that you should be aiming to do 10 deliveries per month, and please everyone try hard with the measles vaccine as we are almost there on that target." As well as presenting data about the District performance he also uses the meeting as an opportunity to educate in-charges about their own data collection obligations. He tells participants, "With Voluntary Male Circumcision I have an issue, reports are not coming to the district and we agreed that facilities would forward circumcision reports alongside others."[v] He puts up a PowerPoint slide which shows the reporting responses of each facility. "It would be good to know the difficulties that hinder these reports", he says, diplomatically. The effect of his presentation is, again, to highlight the embeddedness of the health facilities within larger developmental systems and to show the importance of 'reporting up' in management practice, as well as to visibly demonstrate his own management of reporting processes. After he sits down his presentation is praised by a Japanese aid worker present at the meeting leading a national health-systems strengthening and capacity building programme, who takes the presentation as a chance to engage the agenda of his own project. Standing up he tells everyone, "Let me congratulate the District Records Officer on an excellent presentation! I encourage you to share it with the whole management team and to use it for planning so that they you can then visit the weak points".

By now it is lunchtime. People pile their plates high with chicken stew, roasted beef, fish, rice, chapatti and the Kenyan staple food *ugali* made from maize. They sip their favourite sodas as they engage in lively banter as they relax in the shade outside. In-charges presentations follow lunch. Unlike the senior managers, many of these presenters are nervous; some are visibly shaking when they take the stage, clearly worried about making mistakes. Meanwhile, managers train their junior colleagues in professional meeting comportment. As the facility in-charges are preparing to speak, the District Public Health Nurse gestures to the wall where the order of presentation is listed on a piece of flip-chart paper and says, "It is good that you people are organised because you can be each getting ready when the first one is

presenting". After the first presentation, which is a verbal report, another manager praises the presenter for his time-keeping but then says, "It would have been better if you had made a copy of your presentation on flipchart paper. Let those who have written on a flipchart paper go first, during which time others can be preparing", and the order of presentations is revised.

In-charges presentations each follow a similar format. First, presenters remind the audience of the size of their health facility and the population they are serving. This information is fed into a formula that they use to calculate numerical targets for health service delivery in their facility. Like the District targets, these are informed by a national plan that relates to the global millennium development goals for health. Then they describe how they are performing against these health indicators, including, for example, the number of under-fives receiving immunisation, the number of women attending four antenatal appointments, the number of women having safe deliveries, etc, embedding their development work within a global knowledge economy centred on metrics and indicators (e.g. Adams 2016, Engle Merry, Davis and Kingsbury 2015, Rottenburg, Engle Merry, Park and Mugler 2015).

Once the in-charges have described their 'performance' in this way, they turn to a list of the 'challenges' that they face during the delivery of services. These usually include infrastructure and staffing issues, lack of equipment, and so on. One health centre mentions as challenges lack of funds due to an accounting error; lack of an ambulance; and high expenditure on non-pharmaceuticals. Finally, the in-charges list their 'achievements', which include the partnerships they have established, funds received, improvements to specific forms of service provision and the creation of strong and committed management teams. Sometimes in-charges use their description of achievements as a way to praise the management team or the District Medical Officer for their leadership. This format is typical of performance management cycles and development projects. Meeting presentations are therefore not only about presenting the outputs of interventions. They are also a presentation in aptitude and familiarity with modes of developmental governance and the technical language of development projects.

By now many participants are beginning to feel tired, because it is hot under the corrugated iron roof, even though the hall is large and the sides of the building are open to the breeze. This is not a high-status development meeting. The hall in this small District centre lacks the fans and air-conditioning found in the hotels in the Provincial capital where the more senior managers have their meetings concerned with higher tiers of the system. The relatively low-status surroundings indicate that this is a development event which is lower down the scale, a meeting that is itself reaching out into the even less-developed rural areas of the District. One of the District managers is currently engaged in a business venture to build a competing meeting hall and is convinced there is a potential in the town for something more upmarket, but that venue will not open until some months in the future. A generator rumbles loudly in the background, serving both the hall and, intermittently, the *posho* (an electric mill for grinding maize) in the building next door, which is also owned by the hotel proprietor, which further underlines the semi-rural nature of the location. In town, people don't grow maize that needs to be ground at the *posho*, they buy it ready-ground in the supermarket. Similar points of scale and understandings of how the developmental is constituted are reiterated in many of the community-level meetings held in the district, which take place not in hotels but in school classrooms or churches, with food cooked on open fires on the ground outside by local women's groups or community health workers. As one of the managers once jokingly put it, "There are those who can sit under a tree [for a meeting], and those who cannot". The physical surroundings of meetings reflects their imagined space in the developmental order.

The in-charges meeting is not yet over. There is afternoon tea, with more snacks, and then it is time to hear presentations from representatives of donor agencies. Development partners fund the in-charges meetings (as they do many of the meetings that are part of the managerial calendar). These contributions are agreed in the District's Annual Operational Plan (previously set out through its own process of meetings). Meetings therefore strengthen lateral relations with partners by integrating these external organisations in scaled and sector based development activities, in this case at the interface between District management and health

facility in-charges. When stakeholder representatives take the stage, without fail they emphasise the way that their project activities are nested within broader government strategies and structures, and their close working relations with the Ministry of Health.

At this meeting there is a presentation from a representative of a non-governmental organisation financed through the US government promoting male circumcision. Targets for male circumcision are part of the national HIV/AIDS strategy, and at the time of this fieldwork the District is working towards these targets through a partnership with this organisation. The partner group manages the project logistics, but circumcision operations are held in government health facilities and carried out by government health workers who have been trained as part of the programme. This is described by the presenter as 'working through government structures'. At this meeting, the project manager gives a presentation about the overall goals of the organisation, showing PowerPoint slides about their funding sources and intervention strategy. Then he presents the progress of the district against these population-based targets. Finally, he draws attention to difficulties in reaching targets across the district. He asks staff to be more committed, and emphasises that even small facilities could achieve success if the staff are dedicated to this project.

Stakeholder meetings

In-charges meetings are an example of a form of meeting that can be classed as 'stakeholder meetings'. Stakeholders in development terms is a politically constituted category pertaining to those who have a stake in an intervention. Key stakeholders include representatives of powerful institutions with direct interests in a project as well as beneficiaries or their representatives, a position in the current constellation of development frequently accorded to community oriented civil society organisations (Mercer and Green 2013) . In development terms, although the stakeholder category includes funders, implementers and recipients of development aid, the practical inclusion of stakeholders necessitates a system of representation. In the Kenyan health context, all members of a beneficiary community were considered to be stakeholders in

development projects, but not all were invited to stakeholder meetings. Similarly, all health workers in the District were considered stakeholders in the delivery of health services, but again, not all were invited to meetings. At meetings, stakeholder categories became individual roles acted by people with the capacity to stand in for others either as managers, leaders or formal representatives of groups such as the recipient community. In stakeholder meetings in the Kenyan health sector, the abstract architecture of development represented as a matrix of sectors and scales of intervention was made real through individualised, interpersonal relations between development actors.

The form by which stakeholders were engaged through meetings was stylistically different depending upon the 'level' of development at which they took place. This further enacted the scaled architecture of development. For example, although there is a similar managerial aesthetics of planning and reporting in the District Record Officer's interaction with stakeholders at a Community stakeholders' meeting, consider the difference in style and tone;

He greets the participants in the national language, Swahili, "How are you? I don't have a lesson, but I want to discuss one or two things. This morning we started immunisation. Where is it done?", he asks rhetorically, "In the hospital. And where do those people being immunised come from? From the Community. And this meeting is called what? Stakeholders meeting…so you people have a stake in health services delivery. For that reason I would like to thank you for what you are doing, because you are doing something to promote health."

"Now, this is how we are doing in terms of service delivery performance," he says, as he tapes an indicator chart to the wall with masking tape. "What I'm showing is the data that we have from July 2010 to April 2011. Under one year vaccination against measles from those dates was expected to be 4830 and we achieved 3741. That is 77%. That means 23% have not been covered. Measles is one of the viral diseases which have no cure but luckily enough we have the vaccine. If this continues we by next month we will still have more who have not been covered and soon we will be attacked by a measles outbreak."

"My question is as stakeholders, how do you find these indicators? What do you say? Are we doing well? Are we not able to do something to improve this? *Wanyalo timo gimoro* [can we do something]?" he repeats in Luo, the local language, for emphasis. "Yes!" the participants shout back. "This is my appeal; please let us encourage community members to bring children for these services. Community members are not maximising use of the facilities."

Facilitation has assumed a special role within development practice as an instrument of training and community participation in which facilitators assume temporary positions of authority and leadership (Green 2003). These kind of skilled oratorical practices and facilitation skills realize the relationships that enable development systems to be produced in practice. In East Africa the directive practices of facilitators build upon a rich indigenous tradition in which public oratory is an important signifier of status in meetings of various kinds, ranging from political meetings to those organised by groups of kin and community groups, including funerals (e.g. Falk Moore 1977, Parkin 1978). In this context facilitation entailed assuming a leadership role, giving formal presentations, and educating others on how to act at meetings and carry out development activities, but also explaining key development concepts to participants, like the notion of the 'stakeholder'. The District Records Officer was a highly skilled facilitator, drawing upon different techniques and approaches in his work with stakeholders at different 'levels' of development architecture. His facilitation drew different significant actors into the structured order of development and built the relationships that were required to deliver development. His work was viewed as exemplary management. During a return visit in 2013 it transpired that he had been promoted to a senior position in the new County level administration. His colleagues described how proud they were of him and how deserving he was of this promotion.

Internal Meetings:

Unlike the in-charges meetings and stakeholder meetings, which often had large audiences and were more public events, the Monday Morning Brief was a team meeting for members of the District Health Management Team that took place in the privacy of the District Medical Officer's office. This was a small room in a dilapidated building that had once served as staff accommodation, which was repurposed to hold the management team offices when the district was formed as a breakaway from a larger district in 2009. Unlike better-appointed offices in other Districts, the poor repair and size of this office underlined the relative youth of this hospital as a centre for health administration and the lack of financing for material infrastructure that had followed the introduction of new management structures and the arrival of a new managerial class of staff. The room was empty apart from the District Medical Officer's wooden desk and a large plastic table that has been pushed up alongside it, around which chairs were placed for the meeting. The room was so small that there was barely enough space for all the team members to sit comfortably.

This internally facing meeting was in many respects more informal than most other meetings that the managers attended or facilitated. The office cleaner made tea, boiled eggs and buttered bread with margarine, which she sold to those present for a few shillings each. These were consumed during the meeting itself rather than in a designated break. There was a sense of camaraderie during these meetings as people caught up with each other's personal news and lives. Nevertheless, these meetings were pre-planned and formally minuted. In the minutes, health workers were referred to by their office rather than by their personal names. These weekly meetings were an important feature of managerial work.

At one meeting, the agenda was as follows:

1. Feedback and planned activities
2. Select participant for JICA meeting on quality service management
3. Planning for supportive supervision

4. Select Community Strategy focal person

5. Date for stakeholders meeting in August.

The primary focus of the Monday morning brief was communicating among the team and organising managerial activities. Each member shared with the others what she or he had been doing in the previous week, and any problems they were having. Managers verbally documented shortages of supplies that had affected their work. Problems encountered during visits to health facilities were discussed at these meetings, including absenteeism or disagreements between health workers. Managers requested fuel to travel to specific health facilities if there was a situation that required their attention. These discussions were important. However, much of the work of these weekly meetings involved reporting on meetings which staff had attended and making plans for future meetings. This included deciding when other meetings would take place and who would attend them.. Because it was minuted and formally reported, this meeting demonstrated that the managers who participated in it were part of a functioning health system within which people with different kinds of professional expertise performed appropriate functions. A key feature of these weekly internal meetings was that they allowed managers to organise their work and representation within a larger system of meetings.

Meeting Development Expectations

Both kinds of meetings described above - participatory/stakeholder meetings and team meetings - have a double (and somewhat paradoxical) role within development architectures that has become typical of development meetings; they are at one and the same time part of processes of delivering development and also demonstrative evidence of developmental outputs (see also Green 2003: 134). The format of the in-charges meeting centred on its role in demonstrating the devolution of management from the District to the health facility level and in

nesting the activities of health workers within broader development targets and activities. It was an important site for making this devolution of development work visible through the public demonstration of outputs linked to different health systems priorities, highlighting the managerial expertise of those who were positioned at different levels of the health system and demonstrating the delivery of development outputs. The presentation from the external agency organising a male circumcision intervention mirrored exactly the presentations by government managers and in-charges. This alignment of reporting and organisational forms enabled discrete development project to be practically and representationally folded into state structures through a shared aesthetics of development reporting. These kinds of stakeholder meetings rendered participatory and managerial relationships visible and tangible, and were thus able to act as proof that development was being delivered through appropriate relationships, maintaining and legitimating the social architecture of development organisation.

Development projects have evolved as sets of bounded activities and procedures that combine modes of accountability and predictability in attempts to intervene upon society (Rottenburg 2000). Under both previous and contemporary aid regimes, project success has been measured as much through the proper execution of procedures as by the actual effects of projects (Ferguson 1990, Mosse 2005). Particular tools such as the 'logical framework' (Green 2003, Krause 2014: 70-91) and other forms of development practice and reporting have become of central importance to development implementation. Meetings take on a similarly central role in the delivery of contemporary development projects because of their capacity to instantiate projects and development relations.

The management work that takes place in meetings makes development relationships visible. The causal relationship of development projects, between spend and output, is demonstrated through meetings as much as through reports. Whereas reports are documentary acts of closure that 'sign off' a development intervention, meetings are active modes of report*ing*. Meetings demonstrate the relationship between spend and output whilst it is in

process, as an ongoing and controlled set of activities. Meetings act as validations of project spending because they are calendared occasions marking the temporal progress of projects, where participants visually and verbally present development outputs and achievements. Moreover, because meetings are nodes of interface that bring together actors situated in different organisational positions with developmental architectures, these outputs and achievements can be reported 'up' to higher levels of the state and made visible and tangible to funders. Meetings thereby programmatically situate development projects within national sectors and in terms of lateral relations with donors.

The capacity of meetings to situate development actors within a network of relations is key to understanding the importance of meetings in engaging agendas of partnership and participation. Literature on participatory meetings in development studies and in the anthropology of development has focused primarily on engagements between community recipients of development and project or agency employees (e.g. Marsland 2006, Mosse 2005). In recent years, as seen in our ethnographic description, meetings have become a visible demonstration of participation, idealised as stakeholder partnership and enacted at all scales of development architecture. The participation of actors who are positioned as stakeholders validates partnership relations. It is only when embedded in the professional spaces that are created by meetings that developmental capacity can be demonstrated.

Meetings also engage development agendas of capacity building. The smaller weekly internal meetings described above helped to enact development as a system of meetings by planning and organising future meetings. The very existence of these meetings was translated into a performance of good management and evidence of increased managerial capacity. The management of meetings (through smaller internal meetings) had become a demonstrable output of a strengthened health system, and was used as evidence of increased managerial capacity.

Development meetings are in this respect embedded within processes of "responsibilation" (Rose 1996, Rose 2007) which involve handing over some managerial responsibilities for the delivery of development from funders to national managers. In practice, as Rose and others have argued, this entails reduced levels of governmental control over the detail of implementation. Monitoring and evaluation, including a range of reporting mechanisms, come to be significant domains of development practice in such systems.

We agree with others who have analysed processes of `governing at a distance' that indicators and targets are central to systems of meetings-as-development, that these forms of audit can act as proxies for the achievement of policy visions (Harper 2000, Power 1997, Strathern 2000), and that they play a key role in extending networks of developmental governance as standardised objects of inscription that can travel back to funders' 'centres of calculation' (cf. Latour 1987, Miller and Rose 1990). However, we argue that because meetings are also sites for enveloping the participation, partnership and capacity building agendas, this particular form of 'governing at a distance' can only be achieved through the enrolment of new forms of intimacy, professional connection points and interpersonal spaces. Distance from one perspective necessitates closeness from another. Meetings rely upon people who become development actors and agents, 'stakeholders' who have professional relationships with one another. It is these relations which enable development projects to be instantiated within existing organisational structures.

Health management is not only about managing the delivery of health care. Managers are also responsible for managing development relations and sustaining relationships between different parts of development infrastructure. These are extremely important roles in sustaining impressions of capacity and effective implementation. This mode of governing is therefore linked to the emergence of new forms of professionalism, including a figure which conflates the roles of the civil servant/government manager and development professional. It also includes figures such as the 'volunteer' who works at the interface of formal organisations

and local communities (Brown and Green 2015, Prince and Brown 2016, Prince 2015). These professionals take on the roles of managers or leaders at different 'levels' of development systems. Development meetings, in Kenya and elsewhere (Harper 2000, Mosse 2005, 2011, Riles 2000) therefore highlight the professional competencies and capacities of managers responsible for achieving project objectives in the areas under their control. Professionalism is demonstrated in part through proper meeting behaviour, which has become synonymous with the effective delivery of development.

Conclusion: Governing at a distance

Meetings are not the same everywhere. Moreover, whilst meetings are certainly productive in their capacity to enact particular kinds of organisation (e.g. Boden 1994, Law 1994, Schwartzman 1987) they are also to some degree responses to particular administrative and governmental regimes. Meetings have proliferated in their current forms within the health sector in western Kenya because of intersections between the historical legacies of health systems reforms and the specific social forms of contemporary development funding and implementation. Development cannot be proved or enacted simply through projects, documentation and reports. It requires the new social relations of meetings. The ethnographic material presented in this article highlights that although meetings are widespread and familiar forms of contemporary organisation, there is important diversity in their form which partly relates to the nature of the administrative systems and context in which they emerge.

Our ethnographic material highlights a paradox at the centre of the neo-liberal responsibilitisation agenda. Theorists such as Nikolas Rose see the kind of devolution of responsibility that is assumed in the involvement of representatives of recipient governments as stakeholders and partners in the delivery of development aid as central to advanced liberal forms of governmentality (e.g. Rose 1996, 2007). In such processes, Rose and others have argued that managers become part of the new authorities for supervising the conduct of conduct within systems which explicitly seek to utilise and create the vertical relations which

enable the devolved responsibilities essential to 'governing at a distance'(Miller and Rose 1990). . In the Kenyan health system, funders aim to make implementing governments and their representatives key actors and partners in development. National managers and other actors placed in significant spaces of interface within organisational infrastructures are viewed as able to represent recipients of development aid by virtue of their office. Capacity building and delivering development through government structures means that development is devolved to people who can be given managerial responsibility for monitoring development. In-charges of rural health facilities who mediate between the district health management team and the staff and clients at these health centres, and managers who mediate between higher and lower levels of the health system become highly significant roles in these kinds of systems.

However, while this creates a system where responsibilities for governing are handed down and internalised by managers at different levels of the health system, these actors are at the same time not trusted to deliver development effectively without careful oversight and monitoring. What is performed at stakeholder meetings are therefore relations with other development actors and managerial capacity. Because this is achieved through meetings, meetings proliferate. Whilst it is true that from the perspective of the funders implementation is taking place at greater 'distance', the requirements for monitoring the delivery of development have the effect of folding this distance back in upon itself from the perspective of managers. This causes a proliferation of management, as managers must make their expertise in managing development constantly visible to funders, managing 'up' as well as 'down', whilst also enrolling those whom they manage (e.g. in-charges and community leaders) into the networks that make management work visible.

In development architectures then, the paradox of 'governing at a distance' is that it requires more diverse involvement of stakeholders and the creation of new organisational structures. This allows those positioned as distant governing actors (such as international agencies) not only to act as enabling partners in development but also provides opportunities

for them to see the effective implementation of others. Performing management at meetings becomes a means of delivering development by proxy. Whilst our analysis has focused on meetings in the Kenyan health sector, such effects may well not be limited to African contexts. Theorisations of neo-liberal governmentalities and modes of governing at a distance risk conflating theorisations of governance with models of the systems that governmental bodies seek to achieve. What Rose and others describe are primarily visions of governmental agencies and their rationalisations for particular forms of intervention and control. Ethnographic analyses of how such systems operate show the unpredictable effects and contradictions of such governmental forms. In development architectures where results must be proven and outputs made visible, meetings operate as a kind of performance of oversight where management professionalism and participation can be displayed as a proxy of effective oversight and implementation.

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[i] http://data.worldbank.org/indicator/DT.ODA.ALLD.CD accessed 26th April 2016

[ii] For an example of how development contracting relations play out further upstream, see Roberts, S.M. 2014. Development Capital: USAID and the Rise of Development Contractors. Annals of the Association of American Geographers 104, 1030-51.

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[iv] The organisation of health care delivery and other public services has undergone a major revision in Kenya since this fieldwork was undertaken, with the introduction of the County system. This has devolved larger amounts of funding to x areas of the country. Mid level managers remain important actors in the new system.

[v] Voluntary Male Circumcision was part of a suite of HIV/AIDS interventions introduced after research undertaken nearby showed that male circumcision greatly

reduced the risk of HIV transmission. In Western Kenya this intervention was funded by an NGO that was a spin-off from the original research consortium that carried out the original study.