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Partnerships for Universal Health Coverage in Myanmar: Power and Politics within 'Immunisation Encounters' in Kayah State and Kayin State

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ABSTRACT *The Sustainable Development Goals (SDGs) emphasise the importance of partnerships in achieving targets like Universal Health Coverage. But how can partnerships between non-state and state actors be established, and what development and political ramifications might they have, within protracted conflict situations? In Myanmar's Kayah State and Kayin State, decades-long conflict resulted in parallel health systems operating under Ethnic Armed Organisations. In recent years, non-state and state health workers in both areas have forged partnerships to implement an Expanded Programme on Immunisation (EPI). These endeavours demonstrate that partnerships are permeated with power relations and development programmes can become the site of political struggles in contested states. Linking national development plans with the SDGs can enhance non-state actors' positions in contexts where state and international actors have limited implementation capacity. Comparing Kayah State and Kayin State EPI activities demonstrates the importance of recognising political dynamics of partnerships in conflict situations. In Kayah State, when non-state actors were not recognised as leaders of development in their areas, EPI activities had negative impacts, fuelling local grievances. Conversely, in Kayin State, when state and international actors acknowledged political sensitivities and empowered non-state actors, EPI activities built a 'working encounter' with positive development and peacebuilding outcomes.*

1. Introduction

Adopted by United Nations (UN) member states in 2015, the Sustainable Development Goals (SDGs) establish a global development agenda focused on eradicating poverty, ensuring environmental sustainability, and achieving just, inclusive and peaceful societies (UN, 2015). With the SDGs being broader in scope and ambition than the Millennium Development Goals, there is increased emphasis on partnerships for development. SDG 17 is based on the premise that 'a successful sustainable development agenda requires partnerships between governments, the private sector and civil society' (UN, 2017). Moreover, not only is the formation of partnerships a foundational principle underpinning all of the SDGs, it is also identified as a key mechanism for their implementation (Haywood, Funke, Audouin, Musvoto, & Nahman, 2019).

While a number of academic studies have explored partnerships and the role of non-state actors in relation to the SDGs,[1] there is a paucity of empirical studies on state–non-state partnerships within

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contexts shaped by state-society conflict and where non-state actors have become key agents of development. Focusing on Myanmar's Expanded Programme on Immunisation (EPI), this article therefore explores how local and external actors can foster state–non-state partnerships that have positive development and peacebuilding outcomes, within a context shaped by protracted conflict and competing governance systems.

In Myanmar's Kayah State and Kayin State,[2] decades-long conflict resulted in the development of parallel health systems operating under the governance of Ethnic Armed Organisations (EAOs). In recent years, health workers who are part of these systems have worked with government health workers to implement Myanmar's EPI – a programme that aims to control preventable diseases by providing basic vaccination to children throughout the country. These joint interventions make crucial steps towards achieving Universal Health Coverage (UHC) in remote border areas, with UHC being one of the targets of the SDGs and a key aim of Myanmar's National Health Plan (NHP); and within the context of Myanmar's fledgling peace process, they have important political implications.

Exploring development and political ramifications of state–non-state partnerships in conflictual situations is all the more important in that partnerships inevitably entail power relations. Drawing on anthropological approaches, this article highlights the agency of non-state actors in shaping development partnerships and their outcomes. In so doing, it moves beyond structuralist and post-structuralist analyses that present development partnerships as mainly (re)producing systems of domination or regimes of national and global governance (for example, Abrahamsen, 2004; Fowler, 2009). Recognising that all actors exercise some kind of power and that '[a]ll forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors' (Giddens, 1984, p. 16), the article builds on actor-oriented approaches to development (for example, Long, 1990, 2001). While partnerships are permeated with power inequalities, less powerful actors can still exercise agency through 'development encounters' and by drawing on forms of capital made available to them by international and national development frameworks and programmes (Rossi, 2006).

After providing an overview of the research context and methodology, the article explores how partnerships between actors previously divided by conflict can be forged and how agency can be exercised through these partnerships. Drawing on Mosse (2004), it shows that development frameworks like the SDGs and NHP act as a 'narrative glue', providing the illusion of coherence and preserving a network of actors, while still allowing room for manoeuvre as these actors pursue different agendas. As highlighted by other analysts who have explored partnerships for development (for example, Bull & McNeill, 2019; Hayman, 2019), the linking of national development plans with the SDGs is shown to enhance the position of non-state actors in contexts where state and international actors have limited implementation capacity. Moreover, the analysis below demonstrates how 'development encounters' can involve but also move beyond 'working misunderstandings' (Watkins & Swidler, 2012) or processes of competition, negotiation, and compromise highlighted by anthropologists of development (for example, Li, 2007; Mosse, 2005; Rossi, 2006), in turn forging understanding and peaceful relationships between actors historically divided by conflict.

In the analysis of 'working encounters' created through EPI interventions in Myanmar, I draw upon Rossi's (2006) concept of the 'development encounter' and Watkins and Swidler's (2012) concept of 'working misunderstandings'. In her ethnography of a development project in Niger, Rossi (2006) conceptualises the 'development encounter' as an unequal field of power (in the sense defined by Bourdieu, 1990) which brings together diverse actors – donors, Non-Government Organisations (NGOs), community members, and so on – who advance their specific agendas by drawing upon the various forms of symbolic and other capital made available to them by international development programmes. Focusing on HIV/AIDS programmes in Malawi, Watkins and Swidler (2012) reveal how a common lexicon of health programming and standardised practices like trainings enable diverse and competing actors to come together. These 'work' because they satisfy the agendas of the different actors, even when the meanings that these actors give to shared terminology and practices diverge.

But although enabling joint health interventions, encounters between diverse actors remain 'working misunderstandings' – they do not result in the creation of greater understanding or of new positionalities.

In the ethnographic examples described below, 'immunisation encounters' created by EPI activities in Kayah State and Kayin State brought together non-state, state, and international actors. In both Kayah State and Kayin State, community-level actors drew on international and national development frameworks and programmes in order to increase immunisation coverage in their areas and to gain recognition for non-state health workers and systems. Moreover, in early EPI activities in Kayah State, the 'immunisation encounter' led to the creation of state–non-state partnerships that were comparable to Watkins and Swidler's 'working misunderstandings' – they enabled diverse actors to work alongside one another, albeit uneasily and while maintaining conflicting perspectives and agendas. In later EPI activities in Kayin State, when non-state actors were empowered to lead health interventions in their areas, an initial 'working misunderstanding' evolved into a 'working encounter' – an encounter that still involved diverse actors with different agendas, but that over time and through the creation of a more equal partnership built understanding and trust between actors historically divided by conflict.

The comparison between initial EPI activities in Kayah State and those later implemented in Kayah and Kayin States in turn reveals the extent to which the efforts of ethnic health workers to promote UHC in their areas are interlinked with aspirations for the political recognition of non-state health and governance systems. Analysing EPI activities in both areas then demonstrates the importance of recognising political dynamics of partnerships in conflict situations. In early Kayah State EPI activities, non-state actors were largely sidelined instead of being recognised as leaders of health and development programmes in their areas. The partnerships resulting from these activities were unequal and perceived by non-state actors as undermining local health and governance systems, as well as enabling the expansion of state power into areas previously under EAO control. This fuelled local grievances and risked impacting negatively on a fledgling peace process.

Conversely, in Kayin State, a different model of partnerships was developed, based on lessons learnt in Kayah State. In Kayin State EPI activities, political sensitivities were recognised and non-state actors were empowered to lead health interventions in their areas. Joint EPI activities in Kayin State then enabled state and non-state actors to move beyond a 'working misunderstanding' and to build a 'working encounter' that had positive development and peacebuilding outcomes. This demonstrates that, by taking into account political sensitivities and by recognising and empowering non-state actors, local and international actors can foster state–non-state partnerships that not only make positive steps towards achieving the SDGs but that also build peaceful relationships between actors on opposite 'sides' of a decades-long conflict.

2. Background and methodology

2.1. Conflict, parallel health systems and international aid in Myanmar

Myanmar is a patchwork of 135 officially recognised ethnicities, dominated by the Bamar, who have historically made up most of the ruling elite. Larger minorities include the Karen and Karenni, whom I focus on in this article and who primarily live in Kayin State and Kayah State, respectively.[3] Since decolonisation in 1948, non-Bamar groups have been largely marginalised from national politics, their aspirations for self-determination denied (Smith, 2007). From the late 1940s onwards, conflict broke out between state forces and EAOs. In 1949, the Karen National Union (KNU) – the main EAO in Kayin State – launched its struggle for self-determination.[4] In the early 1960s, following U Ne Win's coup and in response to the central government's denial of the EAOs' hopes for a federal model of government, conflict spread between state forces and other EAOs in the border areas.

Since the 1960s, a succession of Bamar-dominated military regimes attempted to extend control over ethnic communities[5] and resource-rich areas in Myanmar's borderlands, while also implementing policies of so-called 'Bamarnisation'/'Burmanisation', aiming to assimilate non-Bamar groups

into a unified Bamar and Buddhist nation (Callahan, 2003; Pedersen, 2008). The state's counter-insurgency efforts were accompanied by widespread and systematic human rights abuses targeting communities in areas classified by the state as 'brown' (contested) and 'black' (EAO-controlled) zones (Rae, 2007).

In recent years, Myanmar has undergone significant political changes. In 2010, the country held its first general elections in twenty years. After coming to power in 2011, U Thein Sein's government introduced sweeping political and economic reforms, and initiated ceasefire discussions with EAOs. In 2015, the government signed a Nationwide Ceasefire Agreement with eight EAOs; and to date, ten EAOs have signed. Later in 2015, the National League for Democracy won the general elections, ushering Daw Aung San Suu Kyi's party to power in 2016. Together, these changes engendered much hope at national and international levels that Myanmar was at last transitioning from decades of military rule to democracy, and from conflict to peace. However, in reality the military retained a great deal of control over the state; conflict and human rights abuses persisted in many border areas; and EAOs continued to demand self-determination through a federal government system.

In Myanmar's eastern border areas, decades of violence, displacement, and impoverishment had severe impacts on the health and welfare of local populations (Checchi, Elder, Schäfer, Drouhin, & Legros, 2003). Surveys conducted in the 2000s found that indicators such as child mortality rates and maternal mortality ratios were far worse in conflict-affected areas than suggested by Myanmar's national averages (BPHWT, 2006, 2010). Moreover, starved of funding, fragmented and lacking human resources, government health services neglected much of the remote and contested border areas (Duffield, 2008). In the past, the military state also restricted international humanitarian access to contested areas. Local communities therefore came to rely on services provided by Ethnic Health Organisations (EHOs) and Community-Based Health Organisations (CBHOs).

The EHOs were originally established under EAO governance systems. Indeed, in the past, larger EAOs set up their own civilian administrative systems and services in areas under their control. These effectively functioned as 'quasi "mini-states"' (TNI, 2018, p. 94). Larger EAOs ran departments for health, education, and so on, which they initially financed through taxation and control over trade routes (Smith, 2007). Over the years, as EAOs lost territorial control, EHOs like the Karen Department of Health and Welfare (health department of the KNU) established management bases in Thailand, where they could access international funding to support the provision of services inside Myanmar. Today, EHOs in different areas continue to support the delivery of health services by working closely with a network of CBHOs, including the Back Pack Health Worker Team, Burma Medical Association, and Mae Tao Clinic.

With support from international donors and NGOs, EHOs and CBHOs have worked together over the past decades to develop a strong network for the provision of health services in Myanmar's historically contested border areas. Together, they now support some 4,400 trained health workers, who provide services to about ¾ million people. The health workers are recruited from and work within ethnic communities in the border areas. Indeed, building local capacities for health is at the heart of the EHOs' and CBHOs' model – a model which EHO and CBHO leaders maintain makes for an effective and sustainable community-level health system. However, EHOs and CBHOs are not officially recognised in Myanmar, nor are they legally allowed to serve their communities. Meanwhile – like its government systems – official health systems in Myanmar are highly centralised, with decision-making power concentrated at the Union level. The EHOs and CBHOs therefore constitute parallel, parastate systems for health, which challenge the centralised model of the Myanmar state.

Meanwhile, international aid to Myanmar has boomed in recent years. Whereas historically Myanmar was an 'aid orphan', the period following 2011 saw dramatic increases in Official Development Assistance (ODA). Peaking at almost USD6 billion in 2013, this was almost a sixty-fold increase in ODA compared to 2005 (Carr, 2018). At the same time, major donor countries have increasingly 'normalised' aid relations with Myanmar, with this representing a significant shift from the past. Indeed, until the late 2000s, major Western donors prioritised humanitarian – rather than

development – aid to Myanmar; their isolationist policies typically meant bypassing a state that was widely perceived as illegitimate; and they generally channelled aid through international agencies in Myanmar or 'cross-border' organisations[6] like the EHOs and CBHOs (Décobert & Wells, 2020). With 'normalisation', donors have increasingly channelled aid through state-sanctioned systems inside Myanmar, while supporting the state's development plans.

In some respects, the 'normalisation' of aid relations in Myanmar has had negative impacts on EHOs and CBHOs. These organisations have lost the support of some donors and have had to tap into new funding streams, instead of relying on funding channelled through agencies located across the border in Thailand, as they did in the past. However, in recent years, international donors and INGOs working in Myanmar have also increasingly emphasised the importance of working with non-state as well as state actors (Décobert & Wells, 2020). In the eastern border areas, a number of donors and INGOs have tried to support interventions that not only promote UHC, but that also build state–non-state partnerships for health. These endeavours present significant opportunities for EHOs and CBHOs, as illustrated through EPI activities in Kayah State and Kayin State.

2.2. Research design and methods

The findings presented in this article are based on research conducted in 2019, during trips to Kayin State and Yangon (Myanmar), and Mae Sot (Thailand). Qualitative research methods were employed, since they generate detailed and contextualised information on people's experiences and perceptions, and on meanings attributed to different phenomena (Punch, 2012).

Interviews and focus group discussions were conducted in January-February 2019 with fifty members and representatives of: EHOs and CBHOs; the Myanmar Ministry of Health and Sports (MoHS); and Civil Society Organisations (CSOs), International NGOs (INGOs) and donor agencies. Follow-up interviews were then conducted in November-December 2019 with twenty members and representatives of: CBHOs and EHOs; MoHS; CSOs, INGOs, UN, and donor agencies. These discussions, like those in early 2019, focused on individuals' experiences and perceptions of state–non-state partnerships and health systems 'convergence' in Kayin State and Kayah State.

Research participants were selected on the basis of their involvement in health systems 'convergence' in Myanmar, including but not limited to EPI activities. In practice, this meant selecting participants who, through their work for the diverse organisations listed above, were involved in the implementation and/or management of joint health programmes and 'convergence' activities in Kayah State and/or Kayin State. Participants were recruited through the 'snowball' method (Lewis-Beck, Bryman, & Liao, 2004), drawing first on initial connections that I had developed during previous work and research in the area (which is described further below), and then reaching out through secondary contacts and networks on the ground. This approach enabled me to reach a wider and more diverse 'pool' of participants and to explore different perspectives on state–non-state partnerships for health.

Informed consent was sought from all participants prior to the conduct of interviews and focus group discussions. In order to protect participant confidentiality, names and identifying features of participants are not included in the analysis below. The names of EHOs and CBHOs have been included with the consent of the organisations' leaders and because information on their health programmes is already in the public domain.

Interviews and focus group discussions were transcribed before then being coded and analysed according to key identified themes. Qualitative analysis used the grounded theory method, where findings are analysed using emerging concepts and themes (Charmaz, 2008). Initial research findings were presented to EHO and CBHO leaders in November-December 2019, to obtain feedback prior to follow-up interviews and discussions. A draft of this article was also circulated to participants who had requested to review this prior to publication.

The findings presented in this article are also informed by previous research with CBHOs and EHOs conducted over several periods, from 2009 to 2017. From late 2009 to mid-2012, I undertook

in-depth ethnographic research with the Back Pack Health Worker Team (BPHWT) and partner organisations, while also working as a BPHWT volunteer. During this time, I conducted participant observation within BPHWT, as well as 120 semi-structured interviews with members of CBHOs and EHOs; UN and INGO representatives; donors; and other stakeholders. These interviews notably explored the development of parastate health systems and an evolving politics of international aid to Myanmar. Between 2012 and 2017, I worked as a consultant on the Thailand-Myanmar border, which enabled me to follow the work of EHOs and CBHOs. In April-May 2017, I conducted follow-up research with leaders of EHOs and CBHOs, including seven in-depth interviews focusing on 'convergence' with state systems. In this article, data from research conducted between 2009 and 2017 have been used to contextualise and add further information to data collected in 2019.

It is important to clarify that this article does not intend to present a systematic evaluation of the Kayah State and Kayin State EPI activities, in terms of long-term community development outcomes. Such an endeavour would require a different methodology and longer-term research with a wider range of actors. Instead, this article aims to explore partnerships developed between state and non-state actors through these programmes, and perspectives on successes and challenges to date.

3. Findings: partnerships, power and politics in the Expanded Programme on Immunisation in Kayah State and Kayin State

3.1. The National Health Plan and Universal Health Coverage in Myanmar

In the past, conflict, structural divides, and lack of trust made it very difficult for non-state and state health workers to collaborate. As a CBHO leader stated, 'Before the ceasefire, we could not meet and talk because there were many barriers … We could not work as one community for the people.'[7] But the changing political situation and aid economy in Myanmar have presented new impetus for non-state and state actors to build partnerships. So too has Myanmar's National Health Plan (NHP).

The NHP aims to achieve Universal Health Coverage (UHC) by 2030 and provides a national-level roadmap for the development of Myanmar's health systems over 2017–2021 (MoHS, 2016). The NHP refers explicitly to the SDGs and aligns with Target 3.8 – to 'Achieve universal health coverage, including … quality and affordable essential medicines and vaccines for all.' Additionally, it highlights the involvement of international and national partners in the plan's development and implementation; and it declares that 'partnerships will need to be strengthened with the private sector, NGOs, CSOs, EHOs, and [international] development partners' (MoHS, 2016, p. 11). However, while state–non-state partnerships are posited as central to achieving UHC, there is significant debate about what role non-state actors should play in Myanmar's current and future health systems.

The NHP acknowledges EHOs as 'service providers' in Myanmar's 'ethnic areas' (MoHS, 2016, p. 8). The fact that these actors are mentioned at all indicates the state's recognition that UHC is not achievable without collaborating with the EHOs. However, all decision-making power effectively remains in the hands of the state, at the Union level.

EHO and CBHO members have varying views of the NHP. Many mention that EHO leaders were invited by the MoHS to participate in consultations as part of the plan's development; and they perceive this as a tangible demonstration of increased recognition by state actors. The NHP's development was arguably a relatively inclusive process within the Myanmar context (Si Thura & Schroeder, 2018). However, EHO and CBHO leaders generally contest the designation of EHOs as mere 'service providers', arguing instead that EHOs need decision-making power.[8] As one CBHO leader explained:

> The Ethnic Health Organisations and the ethnic groups have for such a long time been dealing with their own health issues. You need to respect the ethnic groups, you need to give a chance, you need to give the self-determination for their own rights, their own health issues. We don't see that in the National Health Plan![9]

Since 2011, within the context of Myanmar's fledgling peace process, EHO and CBHO leaders have endeavoured to increase communication and collaboration with state actors, as part of efforts at promoting health systems 'convergence'. However, in their vision, convergence does not mean integration into the centralised state system. Instead, the leaders are advocating for a devolution of powers and for the official recognition of their health workers and systems as part of a federal governance system. For them, the EHOs should be recognised as State-level systems for health, with decision-making power in their respective areas; and CBHOs should work under these systems.

The quest for recognition of parastate health systems is therefore interlinked with the political aspirations of EHO and CBHO members for the establishment of a federal system of government in Myanmar. So it was that another leader told me:

> This is in line with the political goal, because every Ethnic Organisation want to manage themselves, for the organisation and administration. So that's why our health convergence also wants the self-administration and self-determination.[10]

So while, on one level, the NHP acts as a 'narrative glue' (Mosse, 2004), bringing together a network of actors and providing the appearance of coherence in working towards the common goal of UHC, there are in reality conflicting visions for the future of Myanmar's health systems. The vision endorsed by the Myanmar state is one where power remains centralised at the Union level. In contrast, EHO and CBHO members are working towards an alternative vision – one where power is devolved and non-state health systems are recognised as part of a decentralised, federal governance system. These visions and the differing agendas that they entail are key to understanding the dynamics of partnerships created through EPI activities in Kayah State and Kayin State.

3.2. The 'immunisation encounter' in Kayah State

The evolving 'immunisation encounter' in Kayah State demonstrates the negative impacts of ignoring political sensitivities when forging development partnerships within protracted conflict situations. In early EPI activities in Kayah State, non-state actors were not recognised as leaders of health and development programmes in their areas. Instead, their role was reduced to facilitating EPI interventions led by state actors. Partnerships resulting from these activities were unequal and perceived by non-state actors as undermining local health and governance systems, as well as enabling the expansion of state power into areas previously under EAO control. This undermined trust and fuelled local grievances. Over time, however, partnerships were renegotiated. EPI activities in Kayah State became increasingly successful when state and international actors recognised the key role played by non-state health workers and empowered these workers to lead EPI activities in their areas. The evolving 'immunisation encounter' in Kayah State was the result of an ongoing struggle by non-state actors for recognition; and of compromises by state actors who had a responsibility to 'deliver' on Myanmar's EPI yet lacked implementation capacity in remote border areas. These dynamics are described in detail in the rest of this section.

In 2012, after over fifty years of armed conflict, the Myanmar state signed a ceasefire with the Karenni National Progressive Party (KNPP). The ceasefire paved the way for joint immunisation interventions involving health workers from the MoHS and from the Karenni Health Department (KnHD) and Karenni Mobile Health Committee (KnMHC). The KnDH is the health department of the KNPP. In 1997, the KnHD formed the KnMHC to provide emergency healthcare to Internally Displaced Persons in KNPP-controlled areas; today, KnMHC continues to provide services in hard-to-reach areas, including Hpasawng, West Hpruso, and Shadaw Townships (TNI, 2018).

The first joint EPI activities in Kayah State began in 2014. Health workers from the MoHS and the Karenni EHOs travelled together to Shadaw Township, in eastern Kayah State – area historically classified as a 'black zone' and previously inaccessible to MoHS staff. There, MoHS and EHO health workers provided immunisation and primary health care services to local villagers. An INGO

facilitated discussions between MoHS and EHO leaders, and supported operation costs. Vaccines were provided by UNICEF to the MoHS, as part of the international agency's support for Myanmar's national immunisation programme.

In late 2014, the INGO published an article entitled 'Former enemies join forces for health care' in The Irrawaddy, an online news magazine.[11] An MoHS representative in Kayah State was quoted as saying: 'The joint health missions are good for everyone. … Health services are better and more effective.' The article also highlighted the political significance of the mission, in terms of building collaboration and trust between health workers historically divided by conflict. A senior INGO staff member was quoted as follows:

> This is a ground-breaking and unique moment, one many here never thought they would see. … This is the first time that government and ethnic health organisations have joined forces, overcoming decades of mistrust borne of conflict.

The Shadaw Township mission was in many ways ground-breaking. This was the first major intervention bringing together MoHS and EHO health workers; and collaboration between these actors enabled Myanmar's EPI to be rolled out to communities with previously little or no access to vaccines.[12] The EPI activities created the type of 'working misunderstanding' described by Watkins and Swidler (2012). The shared lexicon and routinised practices of health work enabled state and non-state actors to come together around a shared, 'apolitical' goal. An INGO representative thus told me, 'they both [that is, MoHS and EHOs] have the common goal in terms of the health service provider.'[13] Yet at the same time, actors brought together through this 'immunisation encounter' had diverging perspectives and agendas.

In reality, the perceptions of Karenni medics and of members of partner EHOs and CBHOs differed significantly from the jubilant perspective presented in the Irrawaddy article. When I met with them in early 2019, Karenni EHO leaders stated that the Shadaw Township mission was far from the type of partnership they had envisaged. They explained that their medics were not allowed to deliver vaccines themselves. In Myanmar, only doctors, nurses, and midwives accredited through the MoHS system are legally entitled to deliver vaccines. Karenni EHO members therefore felt that MoHS actors saw them not as professional health workers but as inferior 'volunteers' with 'no right to hold the needle.'[14]

Instead, the Karenni medics were tasked with leading MoHS staff to remote villages, gathering the villagers, and providing information about the benefits of vaccination. As such, many EHO and CBHO members described the Karenni medics as having been treated like 'a porter for the government staff', drawing a deliberate parallel with the Myanmar Army's practice during the conflict of forcibly conscripting ethnic villagers to work as porters.[15] EHO and CBHO members also felt that the medics' roles had been reduced to facilitating access by MoHS staff to what were labelled by state and international actors as 'unreached populations' – with this label ignoring the fact that Karenni medics had provided services to communities in these areas for many years. A senior Karenni EHO member could barely contain their anger when they told me about the mission:

> We learned a big lesson from this. [The INGO] went to one of our areas, and they take in the government staff. And they asked our medics to come with them, but our medics had to carry their stuff for them! And when they reached there, they talked to our people and it looked like we were just there as their translator. … We had been providing health services there since 1997. … But they said, in terms of health, it's the first time people were able to hear about it. Whereas that is totally not true![16]

EHO and CBHO members also expressed concerns that joint immunisation activities, as implemented in the Shadaw Township mission, could impact negatively on the relationship between EHOs and local communities. A leader of a CBHO that works closely with the Karenni EHOs was amongst

those who felt that the joint mission had potentially undermined the EHOs in the eyes of community members:

> How did they feel in the community? 'Wow, a long time we never saw this government staff, now they are coming to us and they are very pretty, they bring us the vaccine!' – and their community recognise that. But our staff, the Karenni staff here, our ethnic staff, they do more long time for this community, but now they have become like a volunteer. … So, that's very dangerous for the organisation as well. Because they separate the community from the organisation.[17]

Such concerns are interlinked with fears that health and development programmes may enable the expansion of central state control over border areas. One Karen EHO leader thus described the initial joint mission in Kayah State as facilitating the state's efforts to 'Burmanise' and extend control over ethnic communities through development rather than military interventions[18] – even if international partners had never intended such outcomes.

Over time, however, the Karenni health workers negotiated a different working relationship with their MoHS counterparts, in the process redefining the Kayah State 'immunisation encounter'. Since 2016, the MoHS has trained Karenni medics to deliver vaccines themselves. According to Karenni health workers, this shift was the result of concerted negotiations with MoHS authorities – 'Because we fight for it!', one EHO leader declared.[19] Karenni health workers also described the new arrangement as a compromise made by the MoHS, in a context where state actors had limited implementation capacity and where MoHS authorities came to realise that EHO medics were better placed to convince local villagers of the benefits of vaccination – since, unlike MoHS health workers, EHO medics spoke the local languages and had existing relationships with community members.[20]

The evolving 'immunisation encounter' in Kayah State therefore demonstrates that development partnerships are permeated with power inequalities; yet less powerful actors can nevertheless exercise agency through these partnerships. The initial Shadaw Township mission provoked strong reactions from non-state actors, as the partnership involved was seen as fundamentally unequal, as well as potentially acting as a type of 'anti-politics machine' – depoliticising development and enabling the expansion of centralised state control under cover of a neutral, technical project (Ferguson, 1990). This mission fuelled local grievances, highlighting the importance of recognising the power dynamics and political sensitivities of development partnerships in conflictual situations.

However, with the state having limited implementation capacity in historically contested border areas, Myanmar's commitment to achieving UHC created opportunities for non-state health workers to renegotiate state–non-state partnerships. The evolving 'immunisation encounter' in Kayah State was the result of a shifting politics of compromise, which over time led to a redefinition of partnerships. Ethnic health workers operating within what was initially a very unequal encounter capitalised on the support that international donors and development agencies were providing to the Myanmar state – and on the latter's requirement to 'deliver' on the basis of this support. One Karenni EHO member highlighted how international pressure could benefit those on the ground, with the Myanmar state obliged to demonstrate that it was working towards UHC, and with members of EHOs gaining bargaining power in a context where the state still could not access many areas:

> At the moment we can convince [MoHS] to do the vaccination. But this is because they know that they cannot do it, and the government has a responsibility to provide vaccination to all the country, because at the moment they are receiving some funding from the international [donors]. So if people do not get it and something happened, they would be in big trouble! So because of this, [MoHS] give us the opportunity to do it.[21]

International development programmes and frameworks therefore offer significant opportunities for local actors, in their attempts to achieve specific aims and to redefine development partnerships. And indeed, comparable dynamics can be observed within the 'immunisation encounter' in Kayin State.

Moreover, comparing the 'immunisation encounters' in Kayah State and Kayin State demonstrates the importance of acknowledging and empowering non-state actors, in order to move beyond 'working misunderstandings' and to foster 'working encounters' that have positive development and peacebuilding outcomes.

3.3. The 'immunisation encounter' in Kayin State

The 'immunisation encounter' in Kayin State demonstrates the benefits of recognising political sensitivities when fostering development partnerships within protracted conflict situations. In Kayin State, partnerships between non-state and state actors were negotiated over the course of three years. Through these negotiations, non-state actors were recognised as key agents of health and development programmes in their areas. The 'immunisation encounter' in Kayin State was again the result of a struggle by non-state actors for increased recognition; and of compromises by state actors within a context where they lacked implementation capacity yet needed to demonstrate achievements in implementing Myanmar's EPI. But in Kayin State, local as well as international actors took into consideration the learnings from Kayah State when planning EPI activities. From the outset, international actors set out to facilitate a more equal partnership between non-state and state actors and were more cognisant of compromises that could be brokered. Over time, the resulting 'working encounter' in Kayin State not only promoted positive development outcomes but also built peaceful relationships between actors historically divided by conflict. The following section details these processes.

A preliminary ceasefire agreement was signed between the Myanmar state and KNU in 2012, the same year as the KNPP ceasefire in Kayah State. Similarly to Kayah State, the ceasefire paved the way for joint immunisation activities in Kayin State – but these looked quite different from the initial joint mission in Shadaw Township, Kayah State.

The Kayin State EPI began in 2016, in Kyainseikgyi and Hlaingbwe Townships. Two INGOs facilitated discussions between the Kayin State Public Health Department of the MoHS, on the one hand, and the Karen Department of Health and Welfare (KDHW) and CBHOs working in Kayin State, on the other. Vaccinators were then selected from KDHW and the CBHOs, and they were given four weeks' training by Union- and State-level MoHS staff, as well as UNICEF staff. After the training, EHO and CBHO health workers delivered vaccines themselves in their target areas, with MoHS staff only supervising the first mission; the INGOs supported operation costs; and UNICEF provided technical support, as well as vaccines through the MoHS.

The shared and ostensibly 'apolitical' lexicon and practices of health programming enabled these different actors to come together. An international agency representative explained: 'Both sides have strict mindset but over time they can come together based on the shared goal. They can help the children, they have this common goal.'[22] Similarly, a Karen CBHO leader told me: 'The ideas [of MoHS and EHOs/CBHOs] are different, but for the health activities we can work together.'[23] At the same time, state and non-state actors had different underlying perspectives and agendas – making their encounter a 'working misunderstanding', in the sense defined by Watkins and Swidler (2012). But over time, interactions between non-state and state actors evolved into a 'working encounter', the outcomes of which went beyond misunderstanding.

KDHW health workers and partners with whom I met in 2019 explained that it took three years of negotiations to set up the joint immunisation activities. These negotiations, in their views, were successful for a number of reasons. Firstly, EHO and CBHO members explained that they had witnessed and learnt from the Karenni example. From the outset, one Karen EHO leader stated, 'We made it very clear that *we* do the work in our area.'[24] EHO and CBHO leaders were concerned that health programmes would enable the expansion of state control over ethnic areas, and the weakening of EAO governance systems. In their eyes, the initial immunisation mission in Kayah State acted as a sort of 'anti-politics machine' (Ferguson, 1990), enabling the expansion of state power under cover of a supposedly neutral, technical project. KDHW and CBHO leaders therefore deliberately set out to negotiate a different type of partnership to that created during the initial Shadaw Township mission.

Secondly, leaders of KDHW and CBHOs explained that the two INGOs played a key facilitating role, and that the personal connections that INGO staff had with MoHS authorities were instrumental in building the partnership. Thirdly, INGO staff themselves described having 'learnt' from the early Shadaw Township mission and having adopted a more politically sensitive approach, better involving KDHW and CBHO members in discussions and planning from the outset.[25]

As a result of these factors, EHO and CBHO members described the 'immunisation encounter' in Kayin State as more akin to how they would like to build partnerships with state actors – by 'sharing power between the government and the Ethnic Health Organisation.'[26] This greater sharing of power was the result of concerted efforts by KDHW and CBHOs to gain recognition for their health workers. In so doing, leaders of these groups capitalised on the Myanmar state's commitment to 'deliver', based on support received from international donors. Indeed, the leaders were very conscious of the sources of support for Myanmar's EPI – as one leader exclaimed: '[MoHS] do not have funds to buy medicine, to buy immunisations! It's from UNICEF, we know it!'[27] In a context where state actors had limited implementation capacity, international aid again became a valuable asset for non-state actors in their quest to not only improve development outcomes in marginalised areas but also to obtain political recognition.

The partnership developed through the Kayin State EPI activities was also the result of compromises. INGO representatives described facilitating discussions between KDHW/CBHOs and the MoHS, resulting in the former's acceptance to be trained and supervised by MoHS staff, and in the latter's acceptance to allow EHO/CBHO medics to provide immunisation themselves – in short, 'compromise from both sides'.[28] Significantly, when I met with MoHS authorities in Kayin State in late 2019, they also acknowledged the extent to which the Myanmar state's commitment to achieving UHC created the need for compromises that conferred increased recognition to non-state actors. One senior MoHS representative stated:

> Because the NHP says 'all inclusive', so we have to do. … You [that is, EHOs and CBHOs] have to be included, and you can manage your programmes in your areas. Like I say to [CBHO leader], you are the manager for your area, you do your model, we just support. … If just stay with the hard position, we cannot meet. We need to negotiate and compromise.[29]

Through a politics of compromise negotiated by international and local players, EPI activities in Kayin State then created a more equal partnership between non-state and state actors. Additionally, the 'immunisation encounter' in Kayin State went further than a 'working misunderstanding' in that, over time, it led to the development of greater understanding and trust. For example, one young KDHW medic, who attended the MoHS-run training and worked as part of joint EPI activities, felt that MoHS health workers developed a better understanding of her skills and experience. 'I feel that they recognised me through the EPI programme', she stated.[30] As KDHW and CBHO leaders interacted more and more with their MoHS counterparts, the leaders also described developing greater mutual understanding:

> So we work together and we come to understand each other. Because after meeting again and again, we come to realise: 'oh, this is the potential of these people, or this is the good heart of these people.'[31]

Similarly, a senior government health worker in Kayin State explained that, as a result of the joint EPI activities, 'We now build the trust between us.'[32] And one INGO worker involved in facilitating the joint EPI activities maintained that the trust built between state and non-state actors was even more important than the more immediate impacts of the programme:

> [There] is the number of children who have [been] immunised – that is the immediate success. It is like physical, you can touch this, you can show it. But long-term success, which is very important – more important than the number of children immunised! – is the trust, the trust between the government from the State level, from the Township level, and the EHO.[33]

The joint EPI activities in Kayin State therefore produced a 'working encounter', which over time built understanding and trust between actors on opposite 'sides' of a decades-long conflict. However, whilst these activities have already had a number of positive development and political impacts, there are also ongoing challenges. Although they receive training and vaccines from the MoHS (with the latter supported by UNICEF), EHOs and CBHOs still rely on support from INGO partners for operation costs and vaccinator stipends. One CBHO leader argued that, since the MoHS is not funding EHO/CBHO vaccinators, their health workers are still treated 'as volunteers.'[34] The inability of EHOs and CBHOs to pay salaries between missions also results in staff turnover and problems of sustainability at a local level. And the dependence of Myanmar's EPI on international donor funding poses further problems in terms of sustainability. Many actors with whom I met in 2019 therefore felt that the EHOs, CBHOs, and MoHS must build on the successes of the past and develop sustainable mechanisms for working together in the future. In particular, EHO and CBHO members and their INGO partners emphasised the need to institutionalise mechanisms for Myanmar's EPI to be funded nationally rather than internationally, and for EHOs and CBHOs to be fully recognised and supported as part of this system.[35]

4. Discussion and conclusions

The EPI activities in Kayah State and Kayin State created a new 'development encounter' – as defined by Rossi (2006) – bringing together diverse actors with unequal positions and differing agendas. To date, partnerships forged out of this encounter have had a number of positive development and political outcomes. However, these outcomes were not simply the result of the implementation of frameworks like the SDGs or NHP. Instead, development interventions and outcomes were shaped by strategic manoeuvring, negotiations, and compromises between actors at different 'levels'. However, this does not mean that international and national development frameworks were unimportant. Indeed, the SDGs and NHP acted as a 'narrative glue', as described by Mosse (2004), providing the appearance of coherence and bringing together diverse actors under a set of common, supraordinate goals. At the same time, these frameworks enabled significant room for manoeuvre and opportunities for leverage, as different actors pursued their specific agendas.

The comparison between early EPI activities in Kayah State and those later implemented in Kayah and Kayin States demonstrates the importance of understanding the different perspectives and agendas brought together in a particular 'development encounter'. In their efforts to build partnerships with state actors, EHO and CBHO leaders were also striving for a devolution of powers and for official recognition as part of a decentralised healthcare model. This was interlinked with the aspirations of members of these groups for the establishment of a federal system of government in Myanmar. This in turn highlights how health programmes – and development more widely – can become the site of struggles over political recognition and the terms of inclusion in contested states.

Moreover, and while they do not *determine* development outcomes, frameworks like the SDGs offer significant opportunities for community-level actors. Within a context where state and international actors had limited implementation capacity, Myanmar's linking of its NHP with the SDGs created a need for compromises by state actors. Non-state health workers capitalised on the impetus provided by Myanmar's NHP and commitment to the SDGs – and on the support provided by international actors for Myanmar to achieve these goals – in order to promote UHC in ethnic communities and to obtain greater recognition for non-state actors. International development frameworks and programmes can therefore provide community-level actors with leverage to advance political as well as development agendas. Through their focus on partnerships and their embodiment in national development plans, the SDGs provide openings for non-state actors to strengthen perceptions of their value added, to promote their roles, and to expand their operational space in previously hostile socio-political contexts (Hayman, 2019).

At the same time, the comparison between initial EPI activities in Kayah State and those later implemented in Kayah and Kayin States reveals the need to understand political and power dynamics

of partnerships in contested development situations. At all levels from the international level down to the village level in eastern Myanmar, there are individuals who have a genuine 'will to improve' conditions for remote and impoverished villagers – to borrow Li's (2007) turn of phrase. Yet whether development programmes are perceived as a 'will to improve' or as a 'will to control' depends on the perspectives of different actors, on their position within a particular 'development encounter', and on issues of trust and understanding. In the eyes of Karenni and Karen non-state health workers, the first joint immunisation mission in Kayah State was seen as a type of 'anti-politics machine' (Ferguson, 1990) – a mechanism through which central state control could be extended over border areas, and through which health and development inequities could be depoliticised. This mission fuelled local grievances, potentially undermining a fledgling peace process.

Lessons learnt from earlier EPI activities in Kayah State then prompted international actors to take into account political sensitivities and to facilitate more inclusive discussions between non-state and state actors from the outset. Partnerships developed through later EPI activities in Kayah State and Kayin State entailed more equal relationships and greater recognition for non-state actors. These more equal partnerships not only enabled better collaboration around development goals, but also built trust between state and non-state actors. As such, this study also demonstrates how, when they entail more equal partnerships, health programmes can create 'working encounters' – encounters that not only enable different actors to come together and at-times conflicting agendas to rub against one another, but that also, over time, build greater trust and mutual understanding.

The 'immunisation encounters' in Kayah State and Kayin State therefore illustrate the importance of taking into account power and political dynamics of development partnerships in situations of protracted conflict and competing governance systems. They show that such partnerships are more effective when non-state actors who have become key agents of development in their areas are empowered to lead collaborative development interventions. International actors should learn from successful examples of state–non-state partnerships in conflictual situations and use the leverage gained through donor support for national development programmes in order to promote genuine inclusion and greater recognition of non-state actors. By listening to the perspectives of non-state actors and by taking seriously issues of power and politics in 'development encounters', international actors can then better promote partnerships that not only contribute to achieving the SDGs but that also build peaceful relationships between actors historically divided by conflict.

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Notes

1. See for example: Beisheim & Ellersiek (2017); Bull and McNeill (2019); Hayman (2019); Haywood et al. (2019).
2. In this article, I use 'state' to refer to national government and 'State' to refer to sub-national geographic units (for example, Kayin State, Kayah State, and so forth) or sub-national authorities.
3. In 1989, the military state changed the name of the country from the colonial-era 'Burma' to 'Myanmar'; names used for ethnic nationalities and their respective 'Ethnic States' were also officially changed – 'Karen' becoming 'Kayin', and 'Karenni' becoming 'Kayah'. However, members of ethnic groups in eastern border areas still commonly use the colonial-era names, this being linked with their rejection of the central Bamar-dominated state. In this article, I use Kayin State and Kayah State to refer to the official sub-national territorial units of the Union of Myanmar; but I use 'Karen' and 'Karenni' to refer to the ethnic groups, out of respect for the terminology preferred by EHO and CBHO members whose perspectives are portrayed in this article.
4. The KNU initially aimed for secession and the creation of an independent Karen State. After 1976, the KNU changed policy and called for a federal system of government.
5. Members of EHOs and CBHOs commonly refer to their communities as 'ethnic communities', in contrast to the label of 'ethnic minority communities' generally used by international actors. This is linked with their rejection of the portrayal of their communities as 'minorities' within a predominantly Bamar nation.
6. 'Cross-border' organisations have a management and logistics based outside the country, often in Thailand, and provide assistance and services to communities inside Myanmar. EHOs and CBHOs discussed in this article were historically labelled 'cross-border' organisations.
7. CBHO leader, Mae Sot, 17/1/19.
8. CBHO member, Mae Sot, 6/04/17.
9. CBHO leader, Mae Sot, 17/01/19.
10. CBHO leader, Mae Sot, 17/1/19.
11. https://www.rescue-uk.org/article/former-enemies-join-forces-health-care – accessed 11/06/20.
12. In the past, some communities in areas of Kayah State and Kayin State that are close to the border were provided with vaccines through cross-border programmes coordinated out of Thailand. However, only a small proportion of communities in these areas could be provided with vaccines in this way, due to logistical challenges.
13. INGO representative, Hpa An, 29/01/19.
14. EHO member, Yangon, 28/01/19.
15. CBHO leader, Mae Sot, 17/01/19.
16. EHO member, Yangon, 28/01/19.
17. CBHO leader, Mae Sot, 17/01/19.
18. EHO leader, Mae Sot, 19/01/19.
19. EHO member, Yangon, 28/01/19.
20. EHO leader, Yangon, 28/01/19.
21. EHO leader, Yangon, 28/01/19.
22. International agency representative, Hpa An, 29/11/19.
23. CBHO leader, Mae Sot, 20/11/19/.
24. EHO leader, Hpa An, 26/01/19.
25. INGO representative, Yangon, 29/01/19.
26. CBHO leader, Mae Sot, 17/01/19.
27. CBHO leader, Mae Sot, 19/01/19.
28. INGO representative, Yangon, 1/02/19.
29. MoHS representative, Hpa An, 27/11/19.
30. EHO member, Hpa An, 21/01/19.
31. EHO leader, Hpa An, 26/01/19.
32. MoHS worker, Hpa An, 28/11/19.
33. INGO representative, Yangon, 29/01/19.
34. CBHO leader, Mae Sot, 17/01/19.
35. INGO representatives, Hpa An, 23/01/19; Yangon, 29/01/19; Yangon, 1/02/19.

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