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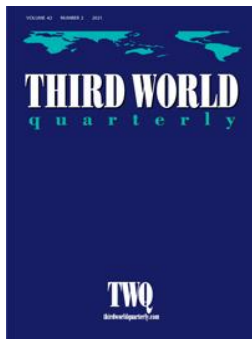
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Health as a bridge to peace in Myanmar's Kayin State: 'working encounters' for community development

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ABSTRACT

This article explores 'health as a bridge to peace' in Myanmar's Kayin State. It focuses on an Auxiliary Midwife training programme, which has created partnerships between actors historically divided by decades-long conflict. Drawing on ethnographic research, the article highlights the agency of community-level service providers, who are often overlooked in conventional approaches to peacebuilding. It demonstrates that community health workers are challenging top-down liberal approaches to peacebuilding and advancing an alternative approach to development and peace in their areas – one that emphasises systemic change and recognition of non-state governance systems. The shared lexicon and standardised practices of healthcare create 'working encounters' – encounters that 'work', because they enable actors historically divided by conflict to carve out an 'apolitical' space in an otherwise highly politicised context, while still allowing for different perspectives and agendas. These 'working encounters' in turn facilitate the development of understanding, trust and collaboration across conflict divides. Yet community-level actors face structural limitations, which are often underestimated by proponents of 'health as a bridge to peace'. Nevertheless, this case study highlights significant contributions that community-level 'working encounters' can make to wider peace processes, as well as the need for hybrid and emancipatory practices of peace formation.

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Introduction

The lives of communities in remote areas of Myanmar's Kayin State have been shaped by decades-long conflict and structural violence. In recent years, there was much hope that Myanmar was embarking on a 'triple transition' towards peace, democracy and inclusive development. However, by early 2019, national-level peace discussions had stalled and much of the earlier optimism about Myanmar's transition had eroded. Nevertheless, actors in Kayin State who were historically on opposite 'sides' of the conflict were continuing to build partnerships in order to improve health outcomes for their communities. These partnerships have significant implications, not only for long-term community development but also for

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Myanmar's fledgling peace process. Community health workers therefore maintain that health is a 'bridge to peace'.

This article focuses on an Auxiliary Midwife (AMW) training programme established by the Back Pack Health Worker Team (BPHWT), a community-based health organisation (CBHO) operating in areas historically controlled by armed non-state actors.¹ The article highlights the agency of community-level service providers, who are often overlooked in conventional approaches to peacebuilding. It demonstrates the importance of localised and emancipatory processes of peace formation, to achieve sustainable peace in contexts shaped by protracted conflict and structural violence.

After reviewing concepts and methods for exploring 'health as a bridge to peace', the article presents an ethnographic analysis of the AMW training programme, focussing on how it has created partnerships between non-state and state actors. The analysis demonstrates that community health workers are challenging top-down liberal approaches to peacebuilding and advancing an alternative approach to development and peace in their areas – one that emphasises systemic change and recognition of non-state governance systems. The article then reveals that a shared lexicon and standardised practices of health work can create 'working encounters', enabling those involved to carve out an 'apolitical' space in an otherwise highly politicised context, while still allowing for diverse perspectives and agendas. 'Working encounters' in turn facilitate the development of understanding, trust and collaboration across conflict divides. Yet the AMW programme also highlights structural limitations faced by community-level actors and which are often underestimated by proponents of 'health as a bridge to peace'. Finally, the article examines contributions that community-level 'working encounters' can nevertheless make to wider peace processes.

Concepts: from liberal peace to 'health as a bridge to peace'

In the past decade, the liberal peace framework that has dominated since the end of the Cold War has come under increasing criticism. While having universalist pretensions, this framework is closely linked to Western and liberal conceptions of the state, as well as top-down and often heavily externalised interventions (Mac Ginty 2014; Richmond 2009, 2014). These interventions generally focus on statebuilding, formal institutions, neoliberal economies and elite-level processes, to the detriment of more localised and alternative approaches.

Through its focus on statebuilding and elite processes, the liberal peace project risks reproducing political hierarchies and systemic inequalities, denying self-determination, and reinforcing anti-democratic and depoliticising processes (Pugh 2005; Richmond 2009, 2010, 2014). Liberal approaches to peacebuilding tend to produce 'negative' forms of peace – where structural violence remains – rather than 'positive' peace, 'where both structural violence (meaning inequality in terms of rights, needs and access to laws and institutions) and overt violence are overcome and emancipation becomes possible' (Richmond 2014, 3). By strengthening states and elites perceived as illegitimate by local populations and by failing to address local demands for justice, rights and equality, the liberal peace project often fails to prevent the recurrence of violence (Richmond 2009, 2014; Tadjbakhsh 2011). At the same time, the technocratic turn and valorisation of the 'expert' in mainstream peacebuilding approaches reinforces the portrayal of local actors as passive 'victims' who lack the agency to build peace in their own communities (Mac Ginty 2014).

Since the mid-2000s, the shortcomings of the liberal peace project have prompted analysts to turn towards more localised, hybrid and alternative approaches. This 'local turn' has engendered a more nuanced understanding of the role of civil society and other community-level actors in peacebuilding, and more focus on localised interpretations of peace (Bell and O'Rourke 2007; Christie 2013). For example, Mac Ginty highlights 'everyday diplomacy' by community-level actors, who build bridges between groups divided by conflict, thereby potentially undercutting political elites and positing alternative sources of legitimacy (Mac Ginty 2014). Such 'everyday diplomacy' can be conceptualised as part of what Richmond calls peace formation (to differentiate from top-down, liberal peacebuilding): 'relationships and networked processes where indigenous or local agents of peacebuilding, conflict resolution, development, or in customary, religious, cultural, social, or local political or local government settings find ways of establishing peace processes and sustainable dynamics of peace' (Richmond 2013, 276). The notion of peace formation moves beyond the narrow statist and elitist focus of the liberal peace framework, emphasising local agency as well as more emancipatory and hybrid approaches to peace (Mac Ginty 2014; Richmond 2014).

Even before the 'local turn' described above, analysts and practitioners had highlighted the roles of alternative sectors and actors in peace processes. The 'health as a bridge to peace' (HBP) framework originated in El Salvador in the mid-1980s, when UNICEF negotiated 'days of tranquillity' so that health workers could provide immunisation in conflict-affected communities (Rodriguez-Garcia et al. 2001). The resulting collaboration was widely believed to have generated significant, longer term positive impacts for the peace process; and HBP operations were then implemented in many other conflict situations across the world.

Proponents of HBP argue that health transcends political, economic, social and ethnic divisions, and can bring opponents together around supraordinate goals (Goldfield 2012; Rubenstein and Kohli 2010). Collaboration as part of joint health activities is claimed to result in humanisation of the 'enemy', trust building, and development of communication and cooperation channels (de Quadros and Epstein 2002; MacQueen and Santa Barbara 2008). Additionally, health interventions can potentially address social inequities that feed into conflict dynamics (Percival 2017).

Analysts like Santa Barbara (2005) note that local ownership of HBP endeavours is vital for their success, yet many HBP interventions have been initiated as part of top-down and/or international interventions. This reinforces the tendency for local actors to be seen as passive recipients of peacebuilding interventions. Additionally, studies have found that it is more difficult for health interventions to contribute to peace when health workers operate within a context shaped by profound structural inequalities (Percival 2017; Santa Barbara 2005). At the same time, analysts have critiqued overly optimistic proponents of the HBP framework for underestimating structural limitations faced by health workers in conflict situations (Percival 2017). Together, these various studies highlight the need for empirical investigation of cases where local health workers operating in situations shaped by structural violence are themselves attempting to promote 'health as a bridge to peace', as part of bottom-up peace formation endeavours through which they are challenging systemic drivers of conflict. As outlined in this article, BPHWT's attempts to build partnerships for health in Kayin State present a valuable example of such an approach.

At the same time, the assertion that health transcends politics needs to be examined critically. In international norms and discourse, health workers and interventions are defined as 'apolitical', their medical neutrality forming the basis for their protection under International

Humanitarian Law (Percival 2017). Yet health workers are often deliberately targeted in conflict situations; and health interventions frequently become intertwined with political agendas and endeavour. More generally, health systems and outcomes are the product of political decisions and structural processes (Farmer et al. 2006). So if health is shaped by political factors as well as being a domain of political contestation, how can it become a 'bridge to peace'?

Drawing on long-term research in Malawi, Watkins and Swidler (2013) explore the creation of 'working misunderstandings' through AIDS interventions, which bring together a wide range of actors with diverse worldviews and agendas. Their detailed analysis reveals how a common lexicon of health programming and standardised, even ritualised, practices like trainings enable actors to come together. These 'work' because they satisfy different actors' agendas, even when the meanings that these actors give to shared terminology and practices differ. Building on this analysis, I suggest that the concept of a 'working encounter', created through a shared lexicon and routinised practices, helps to elucidate how health programmes in Myanmar can build partnerships between actors historically divided by conflict. As described below, 'working encounters' enable these actors to navigate the political minefields of health work, bringing them together around shared, 'apolitical' goals and activities, even when they originally have diverging perspectives and political agendas.

Research methods

This article draws on ethnographic research conducted over a decade-long period, from 2009 to 2019. From late 2009 to mid-2012, I undertook ethnographic fieldwork with 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 BPHWT, other CBHOs and ethnic health organisations (EHOs); United Nations (UN) and International Non-Government Organisation (INGO) representatives; donors; and other stakeholders. Between 2012 and 2017, I worked as a consultant on the Thailand–Myanmar border, which enabled me to follow BPHWT's work. In April–May 2017, I conducted follow-up research with leaders of BPHWT and partner CBHOs, focussing on their attempts to promote 'convergence' with state health systems.

In January–February 2019, I returned to Kayin State and Yangon (Myanmar) and Mae Sot (Thailand). During this time, I conducted semi-structured interviews with 50 research participants: AMWs from different areas of Kayin State²; CBHO and EHO members; trainers from the Myanmar Ministry of Health and Sports (MoHS); and civil society organisation (CSO), INGO and donor representatives. In November–December 2019, I then returned to Hpa An (capital of Kayin State) and Mae Sot, where I conducted semi-structured interviews with a further 20 research participants: leaders and members of BPHWT and partner CBHOs and EHOs; government health workers and senior representatives of the MoHS in Kayin State; and CSO, INGO and donor representatives. These discussions, like those in January–February 2019, focussed on local-level attempts to promote peace and equitable development through health.

My previous role as a BPHWT volunteer and my decade-long professional and personal involvement with CBHOs operating in Myanmar's border areas mean that this article inevitably presents a 'positioned interpretation' (Mosse 2006, 941). Working as a volunteer with BPHWT while conducting my PhD research in 2009–2012 was what initially enabled me to earn the trust of the organisation's members, who were at the time targeted as 'enemies'

of the Myanmar state and had legitimate concerns about a foreign researcher operating in their midst.³ My role as a 'participant insider' operating in a fieldwork context shaped by structural violence and conflict in turn exacerbated more general methodological and ethical challenges of anthropological research. To me, it became clear that 'there is no neutral or uninvolved knowledge' (Mosse 2006, 950).

Nevertheless, I have endeavoured over the years to gain a more holistic understanding of health and development systems in Myanmar, recognising the diversity of actors and perspectives involved. As the country opened up over the past decade and as I developed a wider network of contacts, I was able to meet with actors in the Myanmar state health system. By late 2019, I was able to have open discussions with senior MoHS representatives in Kayin State about their growing partnerships with non-state health workers – something unimaginable to me when I first began working with BPHWT.

However, this article inevitably remains coloured by my positionality and personal relationships with BPHWT and other CBHO members. At the same time, the article is not intended as a systematic evaluation of BPHWT's AMW programme, in terms of long-term community development and peace outcomes. Such an endeavour would require a different methodology and longer term research with a wider range of actors. Instead, the article aims to explore how and why community health workers have tried to operationalise 'health as a bridge to peace'; what peace and development mean to them; and local perspectives on successes and challenges to date.

The AMW programme and 'health as a bridge to peace'

Over the past decade, Myanmar has embarked on a difficult transition from authoritarianism to democracy and from conflict to peace. These changes form the context within which BPHWT medics have attempted to build partnerships with state actors. This section contextualises BPHWT's work before presenting an ethnographic analysis of the AMW programme, its links to an alternative vision for development and peace in Myanmar, and its successes and limitations as a 'bridge to peace'.

From conflict to peacebuilding and 'convergence'

Health systems in contested areas of Kayin State, in south-eastern Myanmar, are the product of a history of conflict, structural violence and competing claims to socio-political legitimacy. Myanmar is home to over 100 ethnic groups. The Bamar, the majority group, have historically made up most of the ruling elite. Since decolonisation in 1948, groups like the Karen (officially known as Kayin)⁴ have been largely marginalised from national politics, their aspirations for self-determination denied (Smith 2007). In 1949, the Karen National Union (KNU) and its armed wing, the Karen National Liberation Army (KNLA), launched a struggle for self-determination.⁵ In the early 1960s, following U Ne Win's coup and in response to the state's denial of demands by Ethnic Armed Organisations (EAOs)⁶ for federalism, conflict spread between state forces and other EAOs in border areas.

For decades, communities in areas where EAOs were active were subjected to attacks, forced displacement and human rights abuses by *Tatmadaw* (Myanmar Army) forces. A succession of military regimes implemented a policy of 'Bamarnisation', attempting to

assimilate non-Bamar groups into a unified Bamar and Buddhist nation, while also extending control over the resource-rich borderlands (Callahan 2003). At the same time, conflict and human rights abuses had severe impacts on the health and welfare of local communities (Checci et al. 2003). Historically starved of funding, fragmented and lacking human resources, government health services neglected much of the remote and contested border areas (Duffield 2008). To this day, communities in many remote areas of Kayin State have little or no access to official health services and rely instead on para-state systems.

In the past, groups like the KNU established parallel 'mini-states', with their own governance systems and services in border areas under their control (Brenner 2019). The KNU ran departments for health, education and so on, which were financed initially through control over trade routes and taxation, and then – from the mid-1990s onwards, when the KNU/KNLA lost much territorial control – through international donor funding. Over the years, the Karen Department of Health and Welfare (the Ethnic Health Organisation of the KNU) developed a strong system for the delivery of health services in Karen State, working closely with a network of CBHOs, including BPHWT.

BPHWT was created in 1998 by health workers from Kayin, Mon, Kayah and Shan States. Their vision was to develop a community-level system that could provide health services in remote and conflict-affected areas. At the same time, the leaders aim to create sustainable health systems for ethnic communities⁷ in a future, peaceful Myanmar. With international funding and technical support, BPHWT builds community-level capacities for health. The organisation now supports over 450 health workers who are recruited from and work within ethnic communities in Myanmar's border areas.

Decades of conflict and structural violence contributed to the world of the BPHWT health workers being one divided into friends and foes. Many senior medics were originally part of and/or trained by EAOs. But even if they were never themselves part of groups like the KNU/KNLA, BPHWT members share an 'embodied history' of violence, as defined by Fassin (2007).⁸ For them, the Bamar-dominated state was the source of their personal and communal histories of suffering. Agents of the state were, as medics often told me, 'the enemy'. In contrast, EAOs like the KNU were seen as having the legitimacy and authority to govern local populations.

In the past, there was much distrust amongst the medics towards government health staff. Conversely, in a context where state forces historically drew no distinction between civilians and armed combatants, and where BPHWT medics worked in partnership with groups like the KNU/KNLA, state actors perceived the medics as 'illegal insurgents' (Décobert 2016, 147–78). Conflict and structural divides therefore made collaboration across state and non-state health systems extremely difficult. As a CBHO leader stated, 'We could not work as one community for the people.'⁹

In recent years, however, Myanmar has undergone significant political changes. After widely criticised elections in 2010, U Thein Sein's reformist government came to power, introducing broad programmes of economic and political liberalisation, and initiating cease-fire discussions with EAOs. In 2012, a preliminary ceasefire agreement was signed with the KNU/KNLA. In 2015, Daw Aung San Suu Kyi's party, the National League for Democracy, won the national elections by a landslide, ushering the party to power in 2016. Between 2015 and now, 10 EAOs have signed a Nationwide Ceasefire Agreement with the state.

Yet by the time I returned to Kayin State in early 2019, much of the initial euphoria about Myanmar's long hoped-for transition to democracy and peace had been replaced by

scepticism. The military still retained a great deal of control over the state. There was ongoing conflict, human rights abuses and displacement in border areas, including parts of Kayin State. The peace process had been marred by numerous setbacks. And top-down, national-level peace negotiations had not yet addressed underlying political and structural drivers of the decades-long conflict. As one BPHWT leader stated, 'there has not been much progress on talking about the political system, especially for the ethnics'.¹⁰

Myanmar's 2008 constitution denies the aspirations of EAOs and of members of groups like BPHWT for a federal government system. In the eyes of BPHWT's leaders, ongoing injustices can only be remedied through political reform and the establishment of federalism. One leader explained:

Until now, even the people vote to get the democratic government, the international people thought, 'Oh, Burma already get democracy!' – something like that. Not like that! We are facing a lot of difficulties to get democracy and Federal Union. ... We need to make less discrimination. We need to share the power between the Union government, State government.¹¹

BPHWT's leaders maintain that the national peace process will fail if it does not address issues of federalism, justice and the rights of ethnic groups to self-determination. More generally, there is increased recognition that the peace process in Myanmar must move beyond liberal statebuilding approaches and recognise the role of EAO governance and service delivery systems (South 2018).

Despite the lack of significant progress in national-level peace discussions, BPHWT's leaders have been building state–non-state partnerships for health and promoting the recognition of their health workers and systems. Indeed, CBHOs, EHOs and their staff are not officially recognised in Myanmar nor are they legally allowed to provide services in their areas; and their para-state systems challenge the centralised model of the Myanmar state. In recent years, leaders of these organisations have embarked on efforts at 'convergence' with state health systems. They describe these efforts as promoting understanding, trust and reconciliation, with health being a 'bridge to peace'. Yet for BPHWT members, 'convergence' should not mean integration into state systems but instead requires systemic change and an alternative vision for development and peace in Myanmar's border areas.

An alternative vision for development and peace

The AMW programme has brought together actors historically divided by conflict, while at the same time being shaped by a particular vision for development and peace. The programme was established in 2013 by BPHWT, in partnership with the Phlon Education Development Unit (PEDU), and with the support and involvement of representatives of the Myanmar MoHS in Kayin State. PEDU is a faith-based CSO, which supports community development projects in Kayin State and was founded by Sayadaw Ashin Pinnyar Tharmi, the Abbot of the Taung Galay Monastery in Hpa An.

The first part of the AMW training is held in a centre near the Taung Galay Monastery. 20 young women from different areas of Kayin State – including government-controlled, KNU/KNLA-controlled and mixed-administration areas – stay in this training centre for three months. There, they attend classes delivered by senior BPHWT medics, as well as former and current MoHS staff. The second, practical part of the training is held over three months at

the Mae Tao Clinic (MTC), in Thailand.¹² By 2019, 160 AMWs had been trained through the programme.

The immediate aim of the AMW programme is to develop local health capacities in remote communities that lack access to mother and child health services. A PEDU member explained:

People in rural areas have a lot of difficulty to reach the hospital and clinic when they are sick or have to give birth. Sometimes, they die in childbirth because they cannot reach the hospital. Currently, there are not enough midwives supported by the government. Also, midwives cannot reach every rural area. That's why we must do the AMW training to develop our community.¹³

BPHWT leaders also explain that they wanted to develop local health capacities in a way that would facilitate 'convergence' with state systems and recognition of non-state health workers. The role of AMW already existed in the human resource structure of the Myanmar MoHS. In the MoHS system, AMWs are assistants to accredited midwives; they are volunteers and do not receive formal positions or salaries, yet they are legally entitled to provide health-care in their communities.

BPHWT therefore aligned its AMW training programme with the existing MoHS curriculum, deliberately adopting the lexicon of the MoHS. However, the BPHWT AMW training is more extensive than that of the MoHS. Firstly, while MoHS AMWs are trained to *assist* midwives, the BPHWT AMWs are trained to be able to work alone in providing mother and child healthcare. Additionally, BPHWT AMWs learn to treat the infectious diseases that drive high mortality rates in border areas. During their practical training at MTC, the AMWs also learn to give vaccines – whereas in the state system only officially accredited midwives, nurses and doctors are allowed to deliver vaccines. For BPHWT's leaders, training their AMWs to a higher level than the MoHS AMWs is vital to address systemic inequalities in healthcare systems and access for communities in remote areas, with these inequalities being a product of and feeding into conflict dynamics.

The second aim of the AMW programme, BPHWT's leaders explain, is to foster peaceful relationships between non-state and state actors. Echoing proponents of the HBP framework, they maintain that health can transcend politics, bringing together actors historically divided by conflict. As one leader put it: 'My opinion is that, as a bridge for peace, health is coming together for the people. ... Even if we have political opinions that are different, we need to focus on the people.'¹⁴

However, BPHWT's attempts to build partnerships with state actors and to promote 'convergence' with state systems are far from being apolitical. For BPHWT members, peace formation through health is interlinked with a quest for the political recognition of non-state health workers and systems, showcasing the extent to which health interventions can become intertwined with political agendas and endeavours (Percival 2017). A senior medic, whom I met when visiting a BPHWT clinic in early 2019, expressed this clearly:

Health can be a bridge to peace because health workers can access the community and work with the community. And if government side see that ethnic health workers can serve their communities, they will respect and recognise them more, which will improve the situation and build peace.¹⁵

At the same time as they are developing partnerships with state actors, BPHWT's leaders are seeking recognition for their health workers and systems, as part of what they

hope will become a decentralised health system. For them, EHOs should be legally recognised as State-level authorities for health, with decision-making power in their target areas; and CBHOs like BPHWT should function under these State-level systems. 'Convergence' is therefore inextricably linked with a struggle for the devolution of powers through a federal government system: 'Our convergence vision is based on our political goals ... 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.'¹⁶

Through their efforts to build local health capacities in Kayin State and to operationalise 'health as a bridge for peace', BPHWT's leaders are therefore advancing an alternative model for development and peace in Myanmar's border areas. For one, BPHWT's model aims to foster equity in health systems and access for ethnic communities. In remote and historically contested areas of Kayin State, health systems and outcomes are the product of structural violence, of the type described by Paul Farmer et al. (2006). The design of BPHWT's AMW programme takes into account and attempts to redress structural drivers of poor health systems and outcomes, thereby addressing some of the underlying inequalities and injustices that have shaped a decades-long conflict.

Additionally, the health, development and peace formation activities of BPHWT members are intertwined with their political aspirations. In their views, devolution of power and recognition of non-state governance systems are integral to peace. For BPHWT members, political recognition – and their vision for health systems convergence – also amounts to the equality and autonomy that ethnic communities were historically denied by the centralised, Bamar-dominated state. As one leader explained, 'When we say convergence, we mean working as equal partners. So you have to provide opportunities or provide the chance to the people to manage their own health.'¹⁷

There are therefore conflicting – centripetal and centrifugal – visions for the future of health, development and peace in Myanmar. The Government of Myanmar's National Health Plan and National Development Plan put forth a vision where power remains centralised at the Union level (MoHS 2016; MPF 2018); to date, Myanmar's top-down 'transition' has not addressed underlying systemic inequalities and the concentration of power in the hands of the Bamar elite (Brenner and Schulman 2019); and increased international donor support for the state's national development plans and priorities is perceived by members of groups like BPHWT as bolstering centralised state control over border areas (Décobert 2020). In contrast, BPHWT's leaders and partners are working towards an alternative, more emancipatory vision for development and peace – one where non-state service delivery and governance systems are legitimate agents of development, and where peace entails systemic change.

'Working encounters' for health

Health systems and outcomes are therefore shaped by political and systemic factors, and health programmes can become intertwined with political aspirations. Nevertheless, health programmes can still bring together actors divided by conflict, in turn contributing to local-level processes of peace formation. Indeed, health programmes focus on problems that can be shared by diverse actors and on solutions towards which they can collaborate.

They do this notably by providing a common lexicon as well as routinised practices like trainings (Watkins and Swidler 2013).

BPHWT's AMW training brings together non-state actors as well as former and current MoHS staff in Kayin State. The programme's aims are expressed in public health terms: the purpose is to build local health capacities; the long-term aim is to reduce maternal and infant mortality; the target is to train one AMW per village; and the category of AMW borrows from the lexicon of the MoHS system. The aim, purpose, target and labels of the programme are ones that, in general terms, can be shared by actors from non-state and state systems. So it was that, before the first AMW training in 2013, BPHWT and PEDU leaders went to present their plans to the then-Director of the Public Health Department (PHD) – the highest-level MoHS representative in Kayin State. The director gave verbal permission for the training to go ahead. In effect, he agreed to 'themes that can make everyone happy' and 'practices that can make everyone happy' (Watkins and Swidler 2013, 201, 207) – even if the underlying agendas of actors brought together by these themes and practices differed.

In addition, former and current MoHS staff have been involved in the training design and activities. The curriculum was created by BPHWT programme managers, in partnership with three women who are now retired but previously held senior positions within the MoHS system in Kayin State.¹⁸ While in Myanmar in early 2019, I spoke with two of these women, who had by then trained eight cohorts of BPHWT AMWs; both emphasised public health benefits of collaboration between BPHWT and MoHS actors. Additionally, during the trainings, current technical staff of the Kayin State PHD deliver classes on topics such as immunisation.

Arguably, the fact that the programme focuses on maternal and infant health, aims to train young women, and has involved (some, if not all) female trainers may also contribute to the creation of a space perceived as more 'apolitical' and distinct from the typically male-dominated spaces of politics and militarised intervention in Myanmar – even if the individuals who initiated and continue to lead the programme are predominantly male.¹⁹ However, in explaining how the programme brings together actors historically divided by conflict, those involved emphasise the language and practices of health work, rather than gender dynamics. In particular, the framing of the programme within the 'apolitical' lexicon of health is described as bringing non-state and state actors together. So too are training activities – 'the ubiquitous social practice through which development aspirations are enacted jointly' by diverse actors (Watkins and Swidler 2013, 207).

The AMW trainings follow a common pattern, with routinised practices that enable the carving out of an 'apolitical' space and that mirror those found in many other development contexts across the world. These trainings inevitably include a graduation ceremony. To date, the director or deputy director of the Kayin State PHD has attended all AMW training graduation ceremonies. Together with leaders of BPHWT and PEDU, they stand on a podium at the front of a large reception hall in the Taung Galay Monastery. The graduates parade in front of the assembly, shake the leaders' hands, and pose for a photograph with their certificate. The certificate is signed by the directors of the Kayin State PHD, BPHWT and PEDU. The PHD representative also provides the AMWs with kits comprising medical supplies. Together, these various acts are perceived by BPHWT members as tangible indicators of a partnership that transcends conflict divides. At the same time, the graduation ceremonies can be read as a ritualised demonstration of the coming together of state and non-state actors. This is how one AMW trainer and former MoHS staff member described the training and graduation ceremonies:

It is important for the peace because they did not talk each other before and we can see clearly that [BPHWT], PEDU and government are working together now. It is like KNU and government are working together! [At the graduation] the government also supported the maternity kits [for BPHWT AMWs].²⁰

Together, a shared lexicon and common practices like trainings therefore create 'working encounters' between non-state and state actors. These encounters 'work' because they enable an 'apolitical' space to be carved out in an otherwise highly politicised context, while still allowing for diverse agendas and interpretations. For example, while the label of 'AMW' enables BPHWT and MoHS actors to come together, at a deeper level different actors have diverging interpretations of the AMW's role – with, for BPHWT members, the AMW training becoming a way to promote higher level healthcare access in ethnic communities and recognition of non-state health workers. Yet despite these different interpretations and agendas, the 'working encounter' created through the AMW training programme has enabled actors involved to develop relationships with those previously categorised as 'the enemy'.

BPHWT's leaders explain that interactions with state actors through the AMW programme – interactions which can be conceptualised as a form of 'everyday diplomacy' (Mac Ginty 2014, 560) – have led to greater understanding and trust. One leader declared: 'We meet frequently, many times, many times... We can discuss more, so we can make more trust'.²¹ The leaders describe coming to realise that those they previously considered 'enemies' were also genuinely trying to improve the lives of communities in Kayin State. Similarly, former MoHS staff who are now working as BPHWT AMW trainers describe developing a better understanding of non-state health workers:

By working together, we can understand each other and we can see each other more clearly. ... Because when we are doing the health training, and doing awareness and treating the patients, we can start to trust each other and it becomes easier to collaborate after trusting each other.²²

AMWs themselves also perceive the training as leading to greater understanding between actors from different areas and different 'sides' of the conflict. As mentioned above, the young women trained through the programme come from different areas of Kayin State, including government-controlled, KNU/KNLA-controlled and mixed-administration areas. During the training, 20 young women study, eat and sleep in the training centre; and they spend many hours working with BPHWT medics, as well as retired and current MoHS staff. As a result, the AMWs describe creating friendships with and learning about the lives of people with whom they previously had no contact due to the conflict. One young AMW who had lived all her life in a government-controlled area told me: 'When I went to attend the AMW training, the [BPHWT] trainers explained to us about their experiences and also they explained about the people's living standard in [KNU-controlled] areas and I got to understand about the situation'.²³

Similarly, AMWs from KNU/KNLA-controlled areas describe developing a greater understanding of those living in state-controlled areas and/or working within the state system. More generally, as one young woman stated, 'Because different organisations and different people who come from different areas are working together, it creates unity'.²⁴

After graduating, the AMWs return to provide health services in their communities. In situations where there are government health workers based near their villages – which can be the case for government-controlled and mixed-administration areas, but generally not

for KNU/KNLA-controlled areas – the AMWs endeavour to build partnerships with these health workers. To date, some BPHWT AMWs in mixed-administration and government-controlled areas have developed strong working relationships with government health workers. One young AMW working in a small village in a mixed-administration area therefore explained that, since graduating from the AMW training, she has collaborated closely with a government midwife based in the nearest larger settlement.²⁵

BPHWT members, actors from the state system and the AMWs themselves therefore describe greater understanding and collaboration between state and non-state actors as a result of the AMW programme. A shared lexicon and routinised practices like trainings facilitate the creation of ‘working encounters’ between actors who may still have diverse agendas. ‘Working encounters’ generated from the State level down to the village level are, then, what enable health to become a ‘bridge to peace’. These encounters have led to the humanisation of those previously considered ‘enemies’, the development of trust and the opening of further channels for collaboration.

Structural limitations and transformative potential

‘Working encounters’ created through the AMW programme therefore have significant potential in terms of fostering state–non-state partnerships. In a context shaped by decades-long conflict, these localised processes of peace formation can make significant contributions to building the type of relationships and understanding that are conducive to long-term peace (Mac Ginty 2014; Richmond 2014). At the same time, the programme is linked to a more holistic and emancipatory vision of peace than that underlying the top-down, liberal approach, with this vision entailing a devolution of power and recognition of non-state governance systems. And to date, the programme has engendered small but significant steps towards the type of systemic change required for ‘positive’ peace in Myanmar.

For one, the programme has led to greater recognition of non-state health workers, at least at a local level. Many AMWs explain that the certificate signed by the Kayin State PHD Director means that state actors in their areas recognise their status. As one AMW stated:

We have more confidence after the AMW training because both sides have signed the certificate. If something happens in some situation, we can show the certificate to the government because it is already signed by EHO side and government side.²⁶

However, there remain significant barriers to building state–non-state partnerships for health and to obtaining recognition for non-state health workers. These barriers in turn highlight structural limitations that are often underestimated by proponents of HBP and that impact on the ability of local actors to realise their emancipatory vision of peace. In early 2019, I visited a BPHWT clinic in a remote, mixed-administration area of Kawkaeik District. There are 13 health workers in this clinic, including six AMWs who have tried to develop relationships with a government midwife based in a nearby village. The AMWs explained that, to date, their attempts have failed.

For the BPHWT Clinic-in-Charge, ongoing challenges in building partnerships with this midwife are linked with structural barriers. Like its government systems, the Myanmar state’s health systems remain highly centralised, with decision-making power concentrated at the Union level. Without higher level approval, local actors do not have the authority to initiate partnerships. Echoing the explanations provided by many other BPHWT members, the

Clinic-in-Charge told me: 'Actually, we should work together and we are the same ethnicity, but the government midwife doesn't cooperate with us. She doesn't get permission or order to cooperate with us'.²⁷

In reality, partnerships created through the AMW programme are based on arrangements between individuals brought together through informal encounters forged without central-level approval. Just like the partnerships between AMWs and midwives at the village level, the collaboration between BPHWT leaders and Kayin State PHD authorities is based on informal, inter-personal connections. Kayin State PHD representatives do not have official authority to legalise the AMW training. As such, BPHWT's leaders and partners acknowledge that the programme remains based on informal, local-level understandings – 'There's no written agreement, but they are doing with understanding'.²⁸

BPHWT's leaders also explain that there have been three new Kayin State PHD Directors since the AMW programme began. To date, they have been successful in obtaining successive directors' support; but the turnover in staff renders the partnership fragile, and the inter-personal relationships on which it depends must be continually rebuilt. The centralised nature of Myanmar's governance systems – which is precisely what non-state actors are contesting – therefore results in a situation where local-level 'working encounters' depend on informal and potentially fragile connections.

Another limitation of BPHWT's AMW programme is linked with the status of AMWs in the MoHS system. MoHS-trained AMWs are legally allowed to provide basic mother and child health services in their areas, but they are not allowed to register births or provide vaccines. So even if the BPHWT AMWs are recognised, they are still not legally entitled to provide the level of services for which they have been trained through the BPHWT programme and which the leaders maintain is essential for greater health equity in remote border areas. The fact that AMWs cannot legally register births also contributes to large numbers of children born in remote areas being unregistered and effectively stateless. Moreover, since AMWs are classified by the MoHS as volunteers, they receive no formal position, salary or other support. So whilst the shared lexicon and use of the AMW label enables non-state and state actors to collaborate, it also limits the ability of non-state actors to achieve their vision. BPHWT AMWs are still not recognised as professional health workers who can provide a high level of care, and systemic factors limit the agency of BPHWT members to achieve their vision of equitable community development.

There is therefore a risk that, by mobilising an 'apolitical' lexicon and standardised practices, 'working encounters' depoliticise and re-inscribe systemic inequalities. Health workers in historically contested areas of Myanmar continue to operate in a context shaped by structural violence. Within these areas, not only are health systems and outcomes impacted by systemic and political factors, but health workers and programmes are still negatively affected by violence and conflict dynamics – as demonstrated, for example, when *Tatmadaw* troops attempted to remove KNU COVID-19 checkpoints in May 2020.²⁹ As highlighted by BPHWT members themselves, attention to local-level 'working encounters' therefore should not detract from the ongoing need for systemic change, and the relationship between health and peace can go both ways – 'peace is also a bridge to health'.³⁰

Nevertheless, and while community-level actors face significant structural constraints, 'working encounters' created through community health programmes do have significant transformative potential and implications for wider peace processes. For one, the development of understanding, trust and collaboration at a local level is essential for long-term

peace. Communities in Kayin State have been torn apart by over 60 years of conflict. Developing mutual empathy and humanising those long considered ‘the enemy’, while still recognising differences, is an integral part of the longer term process of reconciliation, which is essential for ‘positive’ peace (Richmond 2014).

Secondly, community-level ‘working encounters’ can path the way for higher level ‘working encounters’, which can in turn feed into wider processes of change. Acknowledging the limitations described above, one BPHWT leader described the AMW programme as ‘an entry point for working with the government system.’³¹ When I met with them in late 2019, BPHWT leaders as well as senior MoHS representatives in Kayin State explained that relationships forged through the AMW programme had paved the way for a joint polio immunisation campaign after an outbreak was detected by local medics in Hpapun/Mutraw District.³² This campaign is significant in that BPHWT medics were trained by MoHS staff to deliver oral polio vaccines themselves; and the campaign was approved by central-level MoHS authorities, who channelled resources to BPHWT workers on the ground. This second ‘working encounter’, which grew in part out of partnerships forged through the AMW training, therefore implies a higher level of formality and recognition of non-state actors.

Finally, ‘working encounters’ like that created through the AMW programme can build greater support for the type of systemic change required by an emancipatory, ‘positive’ peace. When I met with them in late 2019, senior MoHS representatives in Kayin State who have worked closely with BPHWT leaders as part of the AMW training expressed support for non-state actors to manage their own health systems. And one senior MoHS representative told me: ‘If just stay with the hard position, we cannot meet. We need to negotiate and compromise.’³³

Although Myanmar’s centralised system means that State-level MoHS authorities lack decision-making power, they can nevertheless influence central-level decision makers – as was demonstrated by the Hpapun/Mutraw polio campaign, when Kayin State MoHS authorities convinced central-level authorities to support activities implemented by BPHWT. Building support at the State level for recognition of non-state health systems can then potentially feed into greater understanding and support at more central levels. More generally, everyday diplomacy and ‘working encounters’ created through health programmes can ‘send important signals to political elites’, undermining narratives of irreconcilable difference, encouraging alternative thinking, and suggesting to these elites that their constituencies are prepared for and supportive of change (Mac Ginty 2014, 560).

Conclusion

This ethnographic study reveals how actors who are often neglected by conventional peace-building approaches nevertheless develop agency to build bridges and improve relationships on a smaller, often limited, scale. BPHWT’s AMW programme highlights the agency of community health workers in promoting peace and equitable community development in their areas. This programme challenges the top-down liberal peace approach and highlights the importance of understanding what peace and development mean for those on the ground. Through this programme, BPHWT’s leaders are advancing an alternative model for development and peace in Myanmar’s border areas. By attempting to address structural drivers of dire health outcomes in these areas, the BPHWT programme is also confronting underlying inequities that have shaped a decades-long conflict.

At the same time, the health, development and peace formation activities of BPHWT members are intertwined with their aspirations for political change and recognition, revealing the extent to which community-level health and development programmes can be interlinked with political agendas. The type of peace that BPHWT's members are working towards is a more emancipatory vision of peace than that typically implied in the top-down, liberal approach. Here, structural change, devolution of power and recognition of non-state governance systems are integral to peace.

As illustrated in this article, BPHWT's AMW programme has led to the development of understanding, trust and collaboration across historical conflict divides. This shows that there is truth to claims that health programmes can foster relationships that are conducive to longer term peace. However, and while health can indeed be a 'bridge to peace', health systems and programmes are at the same time deeply embroiled in politics. As revealed through this ethnographic study, the shared lexicon of health programming and routinised practices like trainings enable local actors to navigate the tensions presented by health programming in conflict-affected areas. 'Working encounters' created through community health programmes then allow diverse actors to collaborate towards shared goals, while still having diverse perspectives and political agendas.

At the same time, community-level actors face significant structural constraints. Myanmar's centralised governance system – which is precisely what non-state actors are challenging – acts as an ongoing impediment to the agency of non-state actors, as they strive to achieve equitable community development and political recognition. Nevertheless, actors in non-state and state systems are trying to navigate structural constraints and to utilise the space that has been created by the recent ceasefires to build partnerships that can improve the lives of ethnic communities. Again, this highlights the agency of local actors in fostering equitable development and in building peace in their areas.

Additionally, while the type of systemic change required by a 'positive' peace remains the domain of political and military elites, community-level 'working encounters' do have significant transformative potential. For one, developing understanding, trust and collaboration at local levels is a vital part of the reconciliation process required for longer term and sustainable peace in communities ravaged by decades of conflict. Moreover, local-level 'working encounters' can lead to the development of higher level 'working encounters', as well as fostering greater support for the type of systemic change required by a more emancipatory version of peace.

To date, Myanmar's national-level peace process has not addressed the structural violence and injustices that have fed into decades-long conflict in the border areas. Ultimately, the current, top-down liberal approach to peace in Myanmar is doomed to fail if it does not accommodate the demands of the country's diverse ethnic groups for political recognition and self-determination. As such, this ethnographic study also highlights the need for more hybrid and emancipatory approaches, which acknowledge systemic change as essential to long-term, sustainable peace in countries like Myanmar.

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During 2009–2012, the author worked as a volunteer for BPHWT, while also conducting research into the organisation's work. In 2013, the author then worked as a consultant for Mae Tao Clinic.

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Notes on contributor

Anne Décobert is a Development Studies Scholar and Anthropologist whose research focuses broadly on the intersections between development, conflict, justice and the struggles of Indigenous and marginalised populations for self-determination. Myanmar is her main country specialisation, but she has also worked elsewhere in Asia and with Indigenous communities in Australia. In addition to her academic research, she previously worked as a Development Practitioner and Consultant with local and international aid agencies in Southeast Asia. Her publications include *The Politics of Aid to Burma: A Humanitarian Struggle on the Thai–Burmese Border* (Routledge, 2016).

Notes

1. In this article, 'state' refers to national government; 'State' refers to sub-national geographic units (e.g. Kayin State).
2. Many AMWs were interviewed in Hpa An, as it remains difficult for foreigners to travel to some of the more remote and contested areas.
3. For a discussion of my PhD fieldwork and the ethical challenges this entailed, see Décobert (2014).
4. In this article, I use 'Karen' to refer to the ethnic group, out of respect for the terminology used by CBHO members. While the Myanmar state uses the term 'Kayin', many members of ethnic groups in border areas continue to use 'Karen', highlighting their rejection of the Myanmar state's legitimacy. Similarly, many members of these groups continue to use the country name 'Burma' instead of 'Myanmar'. The article also distinguishes between 'Kayin State' and 'Karen State'. The former is the territorial designation used by the Myanmar state; the latter refers to the territory identified by the KNU, which includes areas within state-defined Kayin State and adjacent areas of Mon State and Bago Division.
5. The KNU initially aimed for secession and the creation of an independent Karen State. After 1976, the KNU began calling for a federal system, with Karen State to become part of a hoped-for Federal Union.
6. The term 'Ethnic Armed Organisations' is commonly used to refer to armed non-state actors in Myanmar. However, this often leads to a reduction of EAO governance systems to their armed forces. Members of groups like BPHWT instead see the EAOs as legitimate governance systems, which cannot just be reduced to their armies.
7. Members of BPHWT and partner organisations commonly refer to their communities as 'ethnic communities', in contrast to the label 'ethnic minority communities', which is used by many international actors. This terminology is interlinked with BPHWT members' rejection of the legitimacy of the Bamar-dominated state and of the portrayal of their communities as 'minorities' within a predominantly Bamar nation.

8. In *When Bodies Remember*, Fassin (2007) analyses how a history of violence and injustices is embodied in the lives of the present, becoming the framework within which individuals and communities act and interpret the world.
9. CBHO leader, Mae Sot, January 17, 2019.
10. CBHO leader, Mae Sot, January 17, 2019.
11. BPHWT leader, Mae Sot, April 8, 2017.
12. MTC was set up in 1989 by Dr Cynthia Maung and fellow student demonstrators, who had escaped to the Thailand–Myanmar border after Myanmar's 1988 democracy uprisings. MTC is now a key provider of health services for displaced and migrant communities from Myanmar, and a training hub for medics working in Myanmar.
13. PEDU member, Hpa An, January 21, 2019.
14. BPHWT leader, Mae Sot, January 17, 2019.
15. BPHWT medic, Kawkaik District, January 20, 2019.
16. BPHWT leader, Mae Sot, January 17, 2019.
17. BPHWT leader, Mae Sot, April 2, 2017.
18. Health staff of an INGO also provided technical support.
19. While it is beyond the scope of this paper to explore gender dynamics in detail, it is worth mentioning that the programme's focus and aims, and the involvement of some female trainers (although others are male), can lead to it being read as an example of the type of localised peace building led by women, which is described by Cockburn (1998) and other feminist analysts. However, this risks oversimplifying more complex gender and power dynamics. The BPHWT leaders who established and continue to lead the programme are predominantly senior male health workers whose ability to lead health programmes in Myanmar's contested border areas depends upon their strong links into local (male-dominated) political and military hierarchies; and leaders of PEDU and MoHS who were central to the programme's establishment were also mostly male, even if the former MoHS staff members who designed and implemented training sessions were women.
20. AMW trainer and former MoHS worker, Hpa An, January 23, 2019.
21. BPHWT leader, Mae Sot, January 19, 2019.
22. AMW trainer and former MoHS worker, Hpa An, January 23, 2019.
23. AMW, Hpa An, January 24, 2019.
24. AMW, Hpa An Township, January 22, 2019.
25. AMW, Hpa An Township, January 22, 2019.
26. AMW, Kawkaik District, January 20, 2019.
27. BPHWT Clinic-in-Charge, Kawkaik District, January 20, 2019.
28. CBHO leader, Mae Sot, January 17, 2019.
29. <https://www.irrawaddy.com/news/burma/skirmish-breaks-myanmar-military-karen-rebels-covid-19-checkpoints.html> – accessed May 22, 2020.
30. BPHWT leader, Mae Sot, November 23, 2019.
31. BPHWT leader, Mae Sot, November 23, 2019.
32. Hpapun District is the official name used by the Myanmar state; Mutraw District is name used by the KNU.
33. MoHS representative, Hpa An, November 27, 2019.

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