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Health justice for all: The development of alternative  
health system capabilities in the conflict-affected  
context of Shan State, Myanmar

A thesis presented in fulfilment of the requirements for the degree of

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Development Studies

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New Zealand

Sharon Margaret Bell

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## Dedication

“Do you know what I want? I want justice - oceans of it. I want fairness - rivers of it. That’s what I want. That’s all I want” (Amos 5:24, The Message).

This thesis is dedicated to my friend and research assistant, Nang Mo Kham,<sup>1</sup> and the community health workers and medics of the Shan Health Department, working tirelessly to bring health justice to their communities in Shan State, Myanmar.

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<sup>1</sup> Not her real name.



## Abstract

As the 2030 Agenda for Sustainable Development advances, it is vital to determine how conflict impacts on the achievement of the Sustainable Development Goals (SDGs) in conflict-affected contexts. The United Nations (UN) regards conflict as the leading risk to development progress as these contexts have high rates of poverty and limited access to crucial healthcare services. Shan State, Myanmar is one such context, facing a critical shortage in its health workforce, considered one of the building blocks of an effective health system. Approaches to building health workforce capabilities can meaningfully contribute towards meeting SDG 3 – ‘to ensure healthy lives and promote well-being for all at all ages’, and consequently, health justice for conflict-affected communities.

This research aims to understand how the approaches taken by an international non-governmental organisation (INGO) support the development of alternative health system capabilities in a conflict-affected context. A global development agenda of state- and peace-building has meant that INGOs have been criticised for undermining state legitimacy. Meanwhile, non-state armed groups (NSAGs) in areas like Shan State, Myanmar, have established alternative regimes which seek self-determination as well as attempting to provide for the social and economic wellbeing of their people. However, little is known about how a partnership between an INGO and a NSAG contributes toward enabling alternative health system development in these contexts.

This research contributes to new ways of understanding this through the development of a capabilities framework for health system development in conflict-affected contexts. This was used to analyse findings from the qualitative case study of an INGO’s health workforce training programme on the Myanmar-Thailand border. The research found that a positive partnership between the INGO and the NSAG has played a crucial role in enabling the workforce capabilities of the alternative health system, leading to promising improvements in health outcomes in communities. However, the effectiveness of the programme is restricted by the INGO’s reliance on volunteerism for staffing, where expatriate medical volunteers are selected based on their availability, rather than the appropriate skills and experience for this context. The international aid community has also reduced its funding for cross-border development programmes in Myanmar which has constrained the activities of the INGO and the NSAG. For Myanmar to achieve health justice and SDG 3, supporting health system development that focuses on improving health outcomes needs to be a priority for the international community.



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<sup>2</sup> Not his real name.

<sup>3</sup> Not her real name.

you were relentlessly confident in my abilities, even when I wasn't. Dr Sharon McLennan, aka Sharon Number 1: you were always available for coffee and conversation, importantly at times, about things other than my research. Your shared understanding of my research passions has been a huge encouragement. Professor Regina Scheyvens: I relied heavily on your expertise, wisdom, good humour, and continual encouragement. You all consistently advocated for the value of my research and for financial support for me to continue. I am forever grateful for your belief in me as it kept me going.

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---

<sup>4</sup> Crane, D. (Writer), Kauffman, M. (Writer), Junge, A. (Writer), & Burrows, J. (Director). (1996). The one with the prom video [Television series episode]. In M. Borkow (Producer), *Friends*. Burbank, CA: Warner Bros. Television.



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## Abbreviations and acronyms

ASEAN	Association of Southeast Asian Nations
CHW	Community Health Worker
ECBHO	Ethnic and community-based health organisation
HCCG	Health Convergence Core Group
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
INGO	International non-governmental organisation
IRC	International Rescue Committee
MDG	Millennium Development Goal
MoHS	Ministry of Health and Sports
MOU	Memorandum of understanding
MTA	Mong Tai Army
NCA	Nationwide Ceasefire Agreement
NLD	National League for Democracy
NSAG	Non-state armed group
OECD	Organisation for Economic Co-operation and Development
Partners	Partners Relief and Development
RCSS	The Restoration Council of Shan State
RI	Relief International
SDG	Sustainable Development Goal
SHTP	Shan Healthcare Training Programme
SLORC	State Law and Order Restoration Council
SSA-S	Shan State Army-South
SSDF	Shan State Development Foundation
UN	United Nations
UNDP	United Nations Development Programme

WHO World Health Organization  
WVNZ World Vision New Zealand



# **Chapter 1: Health justice for all: The development of alternative health system capabilities in conflict-affected contexts**

## **1.1 The genesis of the research**

My interest in health justice and health system development in conflict-affected contexts is deeply rooted in my experiences working for World Vision New Zealand (WVNZ), an international non-governmental organisation (INGO). In 1996, I travelled to Mozambique to visit a community development programme funded by New Zealanders. At that time Mozambique was in its post-conflict recovery phase following a long civil war. The evidence of conflict was still apparent as we had to travel on clearly designated roads to avoid landmine areas marked by ominous skull and crossbones signs. People who had been displaced by the conflict were slowly returning to their communities and were working hard to re-establish their lives. While there were various aspects to the community development programme, the component I was most drawn to was a community health worker (CHW) programme which trained community members to meet their primary healthcare needs. I was particularly excited about the transformative effect it was having on the community. What stood out was the positive local engagement with this initiative as it responded to a very real unmet need - particularly for women and children, who had experienced greater negative health impacts due to the conflict. It was apparent that the key to the success of the programme was that WVNZ enabled the capabilities of the CHWs to provide health services, rather than delivering them itself. My involvement in this programme triggered my ongoing interest in the connections between health and development in conflict-affected communities, and the importance of enabling the capabilities of those involved.

My continuing connection with the INGO sector led to my involvement with Partners Relief and Development (Partners; to be explained in detail in Chapter 5), and the Shan<sup>5</sup> Healthcare Training Programme (SHTP) that they were running on the Myanmar-Thailand border, and this helped crystallise the research topic. I saw an excellent opportunity to comprehensively explore the approaches that INGOs can take to support the development of community capabilities through health-related programmes in conflict-affected contexts. I was specifically interested in the role of INGOs as development actors because I could draw on my own knowledge and experience of INGOs

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<sup>5</sup> Throughout the thesis, 'Shan' is used where used officially in names and 'Tai' is used to describe the ethnic group and language.

to intersect with the research. I wanted to examine the relationship between Partners and the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), one of Myanmar's ethnic non-state armed groups as they sought to develop their own alternative health system to provide healthcare to underserved areas inside Shan State. Throughout this thesis I conceptualise 'alternative health systems' as those which are non-state, and operating in the absence of or parallel to state systems. In the Myanmar context, these include a number of ethnic and community based health organisations (Davis & Jolliffe, 2016, p. 1), such as the Shan Health Department (which will be introduced in Chapter 5, section 5.2.2).<sup>6</sup> This enquiry is particularly relevant in Shan State, Myanmar, where communities bear the adverse health effects of the protracted conflict between the state and various ethnic groups. Understanding the implications of these partnerships and programmes for health system development<sup>7</sup> in conflict-affected contexts is imperative in a global context where conflict continues to impact half of the world's population (OECD, 2016, p. 6). As such, research is needed in order to explore the transformative potential of these types of programmes to improve health outcomes and wellbeing for communities in conflict-affected contexts.<sup>8</sup>

## 1.2 The research problem

The current global context is one in which the United Nations (UN) identifies conflict as the "biggest threat to human development" (United Nations, 2015, p. 8), with the Organisation for Economic Co-operation and Development (OECD) estimating that, by 2030, more than 60% of the world's poor will be in 'fragile contexts' (OECD, 2016, p. 6). In the years since the 11 September 2001 terror attacks, the development agenda has

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<sup>6</sup> I note here that in the health and medical literature the term 'alternative' is not used in reference to health systems, but as a term which encompasses medicine, and medical/healthcare practices that are non-Western, traditional and/or complementary to Western medicine (see for example Micozzi, 2015).

<sup>7</sup> The thesis uses the World Health Organization's (WHO) definition of a 'health system' as consisting of "all the organizations, institutions, resources and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health-improvement activities" (World Health Organization, 2010, p. vi).

<sup>8</sup> It is important to briefly address the use of the name Burma or Myanmar for the country. Burma was the name given to the country by the British colonialists. In 1989, the military government renamed the country from Burma to Myanmar. Following that, many who rejected the legitimacy of that government, and supported ethnic minority demands for greater autonomy, chose to keep calling it Burma. Some governments, including the United States, continue to use Burma. However, academic researchers, and Partners Relief and Development, the organisation I am researching, now use the term Myanmar. In that regard, I use the term Myanmar, unless speaking of British colonial Burma or directly quoting someone who uses Burma.

increasingly focused on fragile and conflict-affected states.<sup>9</sup> Concomitant with this interest in conflict-affected states, the UN has developed the 2030 Agenda for Sustainable Development, which includes the Sustainable Development Goal 3 (SDG 3) to “ensure healthy lives and promote well-being for all at all ages” (United Nations General Assembly, 2015, p. 16). The negative effects of conflict on the health and wellbeing of communities, and the development of health systems more broadly, are already well established (Benton et al., 2014; Bouta, Frerks, & Bannon, 2005; R. J. Haar & Rubenstein, 2012; N. Howard, Hossain, & Ho, 2012; PLoS Medicine Editors, 2011; Waters, Garrett, & Burnham, 2007). It is also recognised that no conflict-affected states achieved the UN’s earlier Millennium Development Goals (Norris, Dunning, & Malknecht, 2015, p. 5; OECD, 2015, pp. 30–37; World Bank, 2011, p. 63), with Myanmar failing to meet the health-related Millennium Development Goals or address poor health outcomes in conflict-affected contexts (Norris et al., 2015, p. 31). This has elevated concerns about the ability of conflict-affected contexts, such as Myanmar, to meet the SDGs. Thus, there is a critical need to understand what is required for successful health system development in conflict-affected states if they are to achieve SDG 3.

The focus of much of the research on healthcare in conflict-affected contexts has been on the inability and unwillingness of conflict-affected states to provide essential services such as healthcare and education to their populations (D. W. Brinkerhoff, 2010; Feeny, Posso, & Regan-Beasley, 2015; Stewart & Brown, 2009), and on how various development interventions can bolster the legitimacy and capacity of these conflict-affected states (Batley & Mcloughlin, 2010; Commins, 2010; Newbrander, Waldman, & Shepherd-Banigan, 2011; OECD, 2007, 2008a). It is increasingly recognised that the connection between state service provision and improved state legitimacy is more complex than linear (Lemay-Hébert, n.d. paragraph 13; Mcloughlin, 2015, p. 347), with recent research evidencing that a strong causal link is not established (Slater & Mallett, 2017, pp. 4–5; Slater, Mallett, & Carpenter, 2012). While there is a growing body of policy and research that recognises the importance of health system development more generally (Adam et al., 2012; George, Mehra, Scott, & Sriram, 2015; George, Scott, Mehra, & Sriram, 2016; George, Scott, Sarriot, Kanjilal, & Peters, 2016; Hafner & Shiffman, 2013), and in conflict-affected contexts more specifically (R. J. Haar & Rubenstein, 2012; Kruk, Freedman, Anglin, & Waldman, 2010;

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<sup>9</sup> Although the terms ‘fragile states’ and ‘conflict-affected states/contexts’ are often used interchangeably in policy and literature, this thesis will use ‘conflict-affected contexts’ as a less value-laden term (this is explained in Chapter 2, section 2.1.3).

Witter et al., 2015), I argue for a shift in focus away from health system development as a function of state- and peace-building, and instead towards improved health outcomes (see also Philips & Derderian, 2015), and health justice as the goal (Venkatapuram, 2011, 2013).

In order to reach this goal, scholars have sought to identify knowledge gaps and establish a research agenda for health systems, identifying the need for specific research on health systems in conflict-affected contexts (Martineau, Woodward, Sheahan, & Sondorp, 2017; Woodward, Sondorp, Witter, & Martineau, 2016b). A significant aspect of health system development and the focus of much attention from scholars and international institutions is the education and training of the health workforce, considered by the WHO to be one of the six essential building blocks of an effective health system (de Savigny & Adam, 2009; World Health Organization, 2016a). Roome, Raven and Martineau (2014, p. 9) note that the lack of qualified trainers particularly impacts the health workforce supply in conflict-affected states and they advocate for more research into appropriate, sustainable approaches to supplying qualified trainers. This study seeks to contribute to the body of knowledge by also asking the question “how best [are we] to build an appropriate health workforce post-conflict[?]” (Woodward et al., 2016b, p. 9). While this research offers a specific case study, it is expected that some of these findings will have relevance to other conflict-affected contexts.

While the training of the health workforce is an important focus, some scholars maintain that health systems in conflict-affected states are not simply waiting to be filled by health workers in the absence of state provision, but already contain an assemblage of actors (P. S. Hill, Pavignani, Michael, Murru, & Beesley, 2014; Pavignani, Michael, Murru, Beesley, & Hill, 2013). One such group of actors are INGOs who have played an important role as gap-fillers in healthcare service provision in conflict-affected states (Bornemisza, Ranson, Poletti, & Sondorp, 2010), although there is concern that their work may undermine the legitimacy of these states (Batley & Mcloughlin, 2010). However, it is important to understand the contribution of INGOs and how INGO efforts can focus on fostering appropriate health systems that lead to improved health outcomes. An exploration of the mechanisms to hold INGOs accountable for their health systems strengthening activities is also paramount, with Woodward et al. (2016b, p. 9) emphasising the need to understand power relationships between different actors and processes of accountability.

Another group of actors in healthcare in many conflict-affected contexts are non-state armed groups (NSAGs). These groups have stepped in to provide health services to

communities where the state is absent (see for example Davis & Jolliffe, 2016, pp. 10–11; South & Joll, 2016, p. 169), often by initiating their own “humanitarian wings engaged in the provision of welfare services” (Podder, 2014b, pp. 1622–1623). NSAGs often work in partnership with other ethnic organisations and INGOs as is the case in this research. Indeed, the emergence of these assemblages of INGOs and non-state armed groups in a context such as Shan State, Myanmar provides rich ground in which to examine the factors that can enable the capabilities of alternative health systems in conflict-affected contexts. The adverse health consequences of conflict are clearly evidenced within Myanmar, deemed a conflict-affected context due to its continued conflict between the state and various non-state armed groups (Burke, Williams, Barron, Jolliffe, & Carr, 2017; Davis & Jolliffe, 2016; Davis, Mullany, Schissler, Albert, & Beyrer, 2015; N. L. Zaw & Pepper, 2016; P. P. T. Zaw, Htoo, Pham, & Eggleston, 2015). Myanmar is also currently facing a critical shortage in its health workforce (Low et al., 2014). However, in Shan State one NSAG, the RCSS/SSA-S, is working to address these health needs, in partnership with Partners INGO to develop the capabilities of a health workforce for an alternative health system to overcome these poor health outcomes. This relationship, and the development of the alternative health system, is the focus of this research.

The research is particularly important in the context of recent changes in Myanmar which have led to an increased focus on state-building aid, and a decrease in attention to conflict-affected areas such as Shan State. During the course of this research, the Nationwide Ceasefire Agreement was signed between the Myanmar government and eight of Myanmar’s non-state armed groups, including the RCSS/SSA-S. The first ostensibly democratic elections were held in November 2015, with Aung San Suu Kyi’s National League for Democracy winning a landslide victory. The civilian government was sworn into power in March 2016 as I completed my last fieldwork visit. High hopes were held in Aung San Suu Kyi to transform Myanmar from a pariah state to a peaceful and functioning democracy. However, despite the emergent democracy and the current peace process, conflict in many ethnic regions, including Shan State, has increased (Burke et al., 2017, pp. 11–17). Even with the lack of reliable statistics in Myanmar, it is clear that the wellbeing of all citizens has not been enhanced by the peace process, as shown in Figure 1.1 below.

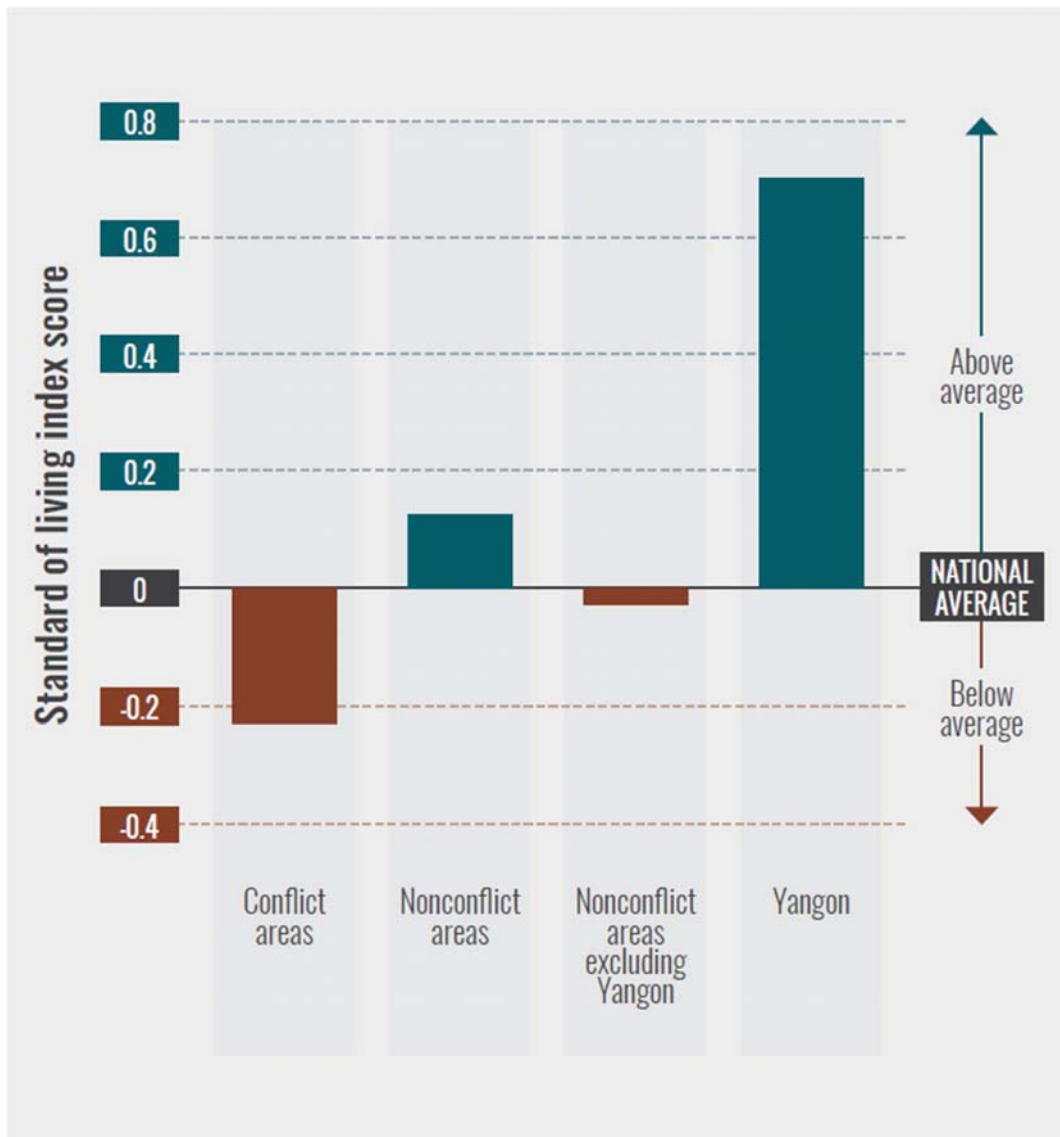


Figure 1.1: Standard of living index in conflict areas and nonconflict areas (Source: Burke et al., 2017, p. 30).

In light of this, this research seeks to provide new insights about health workforce training programmes of INGOs in conflict-affected contexts, and create better understanding of how these meaningfully contribute to alternative health system development in conflict-affected contexts, health justice, and the achievement of SDG 3.

### 1.3 Research aim and objectives

#### Research aim

This research aims to understand how the approaches taken by an international non-governmental organisation (INGO) support the development of alternative health system

capabilities in the conflict-affected context of Shan State, Myanmar. It does this by examining the case study of the Shan Healthcare Training Programme (SHTP), run by Partners Relief and Development (Partners) in partnership with one of Myanmar's non-state armed groups, the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S). I use 'approaches' as an umbrella term to encompass the ideological standpoint and ways in which Partners conceptualises development, as well as the types of programmes it implements, and the methods it uses within those programmes.

### ***Research objectives***

To meet this aim, three objectives are outlined below and will be achieved through a case study investigation of Partners' health workforce training programme on the Myanmar-Thailand border.

**Objective 1:** To explore the relationships of the different actors in the delivery of the Shan Healthcare Training Programme (SHTP), particularly Partners' partnership with the RCSS/SSA-S.

**Objective 2:** To examine the effectiveness of the approaches used by Partners in the SHTP in order to evaluate whether they support the development of health workforce capabilities.

**Objective 3:** To identify the impact of the conflict-affected context on the capability of the alternative health system to deliver primary healthcare.

## **1.4 Research design overview**

In order to achieve the research aim and objectives, a capabilities framework for alternative health system development in conflict-affected contexts (health capabilities framework) was developed and is positioned as the overall conceptual framework for this research. The framework is underpinned by Amartya Sen's (1999, 2005, 2009, 2013) and Martha Nussbaum's (2000, 2011) capabilities approaches. Their approaches include important components that have been assembled into a health capabilities framework developed as part of this research and will then be used to analyse the research findings. Central to my health capabilities framework is the examination of factors that enable the expansion and functioning of medic capabilities. Another core element is the availability of resources such as the SHTP itself, and the support structures provided by the RCSS/SSA-S to the medics. The actions of specific personal, social and environmental conversion

factors that were found during the course of this research, including the relationship between Partners and the RCSS/SSA-S, are also considered.

As mentioned, this research takes a case study approach to allow for the in-depth analysis of a bounded unit (Creswell & Poth, 2018, p. 98), within a specific context (Yin, 2013, p. 321). The scope of the research is delineated by the case study selected for this research. This is Partners' SHTP on the Myanmar-Thailand border, and includes examining the relationships between the key actors directly involved. This conflict-affected context is a key component in the health capabilities framework developed for this study. An analysis of the impact of that context on the realisation of medic capabilities is therefore necessary. Qualitative methods of semi-structured interviews, focus groups, observations and document analysis were chosen to provide an intricate understanding of participants' views and experiences.

## **1.5 Thesis outline**

**Chapter 1** introduced the research by outlining the research problem and context, including the key themes of health system development in conflict-affected contexts and the role of international non-governmental organisations. The research aim and three research objectives are also delineated along with the scope and intended contribution of the research, and a brief overview of the research design was also given.

**Chapter 2** reviews the literature on 'fragile states' and highlights how it has been operationalised globally. It explains the use of the term 'conflicted-affected contexts' as a less value-laden alternative for this research. The chapter moves on to consider essential issues for health system development in conflict-affected contexts, including the need to reorient health system strengthening efforts towards the goal of improved health outcomes rather than state- and peace-building. International non-governmental organisations, non-state armed groups and community health workers are presented as some of the key actors involved in health system development in conflict-affected contexts, and in this research.

**Chapter 3** explores the literature describing the capabilities approach established by Amartya Sen and Martha Nussbaum. In doing so, the essential elements of the capabilities approach: functionings, capabilities, resources and conversion factors are presented. Critiques and limitations of the capabilities approach are first addressed, and then its operationalisation in research is detailed, demonstrating its appropriateness for this

research. The capabilities approach's connection to the notion of health justice, central to exploring medic capabilities to provide healthcare is established. The capabilities approach forms the basis of the conceptual framework developed for this research: the capabilities framework for health system development in conflict-affected contexts. The various elements in this health capabilities framework will then be used to analyse and discuss the research findings later in Chapter 8.

**Chapter 4** outlines the methodology and design employed in this research, linked closely to the capabilities approach described in Chapter 3. The chapter starts by explaining the adoption of a case study approach before detailing the research focus and location, and unpacking the specific ethical considerations related to doing research in the Myanmar-Thailand border context. Fieldwork considerations, including issues of positionality and reflexivity are then attended to. The research methods used for data generation and analysis are recounted. The chapter ends with a brief discussion of the limitations of this research.

**Chapter 5** establishes the research context for the case study which is the Shan Healthcare Training Programme (SHTP). It begins by giving the socio-political and historical background to Myanmar, and lays out the antecedents of the conflict in Shan State. The description of the negative impacts of the conflict on healthcare in rural communities in Shan State is necessary to highlight the need for the SHTP. The key actors involved in the SHTP are introduced: The Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), the Shan State Development Foundation (SSDF), and the Shan Health Department. The chapter then provides an account of the emergence of Partners, as a provider of cross-border aid and development programmes. The chapter ends by sketching out the history of the SHTP, including the involvement of expatriate medical staff and volunteers.

**Chapter 6** is the first of two chapters that compile key findings from the field. The first research objective, to explore the relationships of the different actors in the delivery of the SHTP is addressed. The partnership between Partners, the SSDF, and the Shan Health Department, and its establishment through a memorandum of understanding (MOU) is examined. The chapter identifies some of the issues that the SHTP medics experience which are linked to their lack of certification to practise inside Shan State. The chapter goes on to contrast Partners' support for the convergence of the Tai health system with the Myanmar system against Tai desires to see the two systems remain separate. Finally,

the chapter looks at Partners' relationship with the RCSS/SSA-A as a non-state armed group, and summarises some of the limitations the research found in establishing a civilian health system within the military structures of the SSA-S.

**Chapter 7** assembles research findings regarding the views and experiences of different actors related to Partners' approaches in the SHTP. First, an account of the medic's experiences and views of the SHTP, and as healthcare providers in their communities, is provided. The chapter then shifts to catalogue findings about the volunteerism approach that Partners employed in the SHTP. Problems experienced because of the lack of a monitoring, evaluation and learning culture, difficulties with language, and the need for practical workshops in the curriculum to overcome these language difficulties are explained. The chapter concludes by describing the positive developments that Partners has made in the SHTP.

**Chapter 8** uses the capabilities framework for health system development in conflict-affected contexts to analyse and discuss the collective research findings from Chapters 6 and 7 in order to understand how the approaches taken by Partners support the development of an alternative health system in Shan State, Myanmar. It does this by analysing each of the factors of the health capabilities framework developed in Chapter 3. The discussion first pays attention to the impact of the conflict-affected context on the Tai organisations' ability to support the functioning of medic capabilities. Second, it moves to discuss the two key resources of the SHTP and the support structures provided to the medics by the RCSS/SSA-S. Third, it examines the enabling or hindering actions of the various personal, environmental and social conversion factors identified by this research.

**Chapter 9** reflects how the thesis has met the research aim and achieved the three research objectives. Five contributions to knowledge made by this research are detailed. The chapter concludes by offering some recommendations and implications for health system development in conflict-affected contexts in the wider global context. The contribution of the thesis to the health justice body of knowledge, and to understanding what approaches enable the capabilities of alternative health systems in conflict-affected contexts to effect better health outcomes and the achievement of SDG 3 is made clear.

## Chapter 2: Conflict-affected contexts and health system development

### Introduction

The research aims to understand how the approaches taken by an international non-governmental organisation (INGO) support the development of alternative health system<sup>10</sup> capabilities in the conflict-affected context of Shan State, Myanmar. This chapter examines the literature on ‘fragile states’ and health system development in conflict-affected contexts to situate the research within the current agenda that prioritises “health systems research in fragile and conflict-affected states” (Martineau et al., 2017; Woodward et al., 2016b). In doing so, it partially addresses the third research objective, to identify the impact of the conflict-affected context on the capability of the alternative health system to deliver primary healthcare. The chapter begins by tracing the history of the definition and measurement of ‘fragile states’ and addresses the use of ‘fragile states’ discourse to frame the development agenda of Global North governments and international development organisations for self-interest, state- and peace-building. Myanmar is defined as a ‘fragile state’ on all international measures, although as noted in Chapter 1, the less pejorative term of ‘conflict-affected contexts’ is used in this research. The turn to regarding local and hybrid orders as legitimate political arrangements for development interventions is also explored in this chapter, which then moves on to address the critical issue of health system development in conflict-affected contexts, and to identify the need to prioritise improved health outcomes over state- and peace-building. The chapter concludes by interrogating the roles of the three different groups of actors in the process of health system development that this research investigates.

### 2.1 The ‘fragile state’: A new development agenda

#### 2.1.1 Defining and measuring ‘fragile states’

International interest in ‘fragile states’ as a development problem increased during the early 2000s, in the period following the 11 September 2001 terror attacks (Nay, 2014, p. 211), when there appeared to be an increase in the number of states that were supposedly failing/failed (D. W. Brinkerhoff, 2014). During this time, sites of conflict shifted from largely between states to non-conventional and intra-state violence (Briscoe, 2013, p. 2;

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<sup>10</sup> As explained in Chapter 1, section 1.2, I define ‘alternative health systems’ as those which are non-state, and operating in the absence of or in parallel to state systems.

World Bank, 2011, pp. 2–3). The global development agenda also deviated away from poverty alleviation towards the security-development nexus (N. Banks & Hulme, 2012, p. 15; Fowler, 2011; Overton & Murray, 2016; Ware, 2014a, p. 3), concerned with state- and peace-building functions (OECD, 2008a; Rocha Menocal, 2011). The global community labelled states as ‘fragile states’, and they were identified as:

...an ideal breeding ground for domestic and international terrorism, organised crime (eg human and drug trafficking), violent conflict and regional instability, emphasising the potential threats to a fragile state’s neighbours and the wider global community. (Grimm, 2014, p. 255)

The ‘fragile states’ development agenda led to aid policies that were “a product of donor hegemony and coercion, (in)security and self-interest” (Nair, 2013, p. 636), and about “the securitization of dangerous poverty on the periphery” (Mosse, 2013, p. 237).

While it appears that consensus exists on the ‘fragile states’ phenomenon as worthy of investigation (Lemay-Hébert, 2009, p. 21), there is no widely agreed definition of the term. As the discourse on definitions drives policy direction (Woolcock, 2014, p. 3), policy makers, development organisations and practitioners alike tend to utilise the definition that best suits their paradigmatic and policy purposes. However, there is some overlap in the definitions currently employed by organisations such as the Organisation for Economic Co-operation and Development (OECD) and the World Bank, who are the predominant global influence on the ‘fragile states’ development agenda. They, along with the governments of the United States and United Kingdom, drive policy interventions that are centred on state-building interventions to enhance state legitimacy (Lemay-Hébert, 2009; Lemay-Hébert & Mathieu, 2014; Nay, 2013, p. 328, 2014).

Generally accepted definitions of ‘fragile states’ broadly encompass three factors: first, a ‘fragile state’ is unwilling or unable to provide essential services, such as healthcare; second, it does not provide security for its citizens; third, it lacks legitimacy. Table 2.1 below collates some of the definitions used by those organisations leading the ‘fragile states’ agenda: the United Kingdom’s Department for International Development (DFID), the OECD, and the World Bank.<sup>11</sup> Two definitions are given from the OECD as it has

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<sup>11</sup> Similar definitions have been offered by others (D. W. Brinkerhoff, 2010, p. 66; Feeny et al., 2015, p. 1073; Kaplan, 2014, p. 52).

evolved from focusing on “when state structures lack political will and/or capacity to provide the basic functions” (2007, p. 2), to a more nuanced understanding of “the accumulation and combination of risks combined with insufficient capacity by the state” (2016, p. 6).

*Table 2.1: Definitions of 'fragile states'*

<b>Definition</b>	<b>Reference</b>
“...where the government cannot or will not deliver core functions to the majority of its people, including the poor. The most important functions of the state for poverty reduction are territorial control, safety and security, capacity to manage public resources, delivery of basic services, and the ability to protect and support the ways in which the poorest people sustain themselves.”	DFID, 2005, p. 7
“...when state structures lack political will and/or capacity to provide the basic functions needed for poverty reduction, development and to safeguard the security and human rights of their populations.”	OECD, 2007, p. 2
“...the accumulation and combination of risks combined with insufficient capacity by the state, system, and/or communities to manage it, absorb it, or mitigate its consequences. This situation of exposure to risk can lead to negative outcomes, including violence, conflict, protracted political crises, and chronic underdevelopment.”	OECD, 2016, p. 6
“...when states or institutions lack the capacity, accountability, or legitimacy to mediate relations between citizen groups and between citizens and the state, making them vulnerable to violence.”	World Bank, 2011, p. xvi

*(Source: Author)*

In addition to there being no commonly shared definition, there is also little agreement on how to measure state fragility, what factors contribute to fragility, and which countries exhibit those factors. Despite this, various lists are maintained to measure and rank ‘fragile states’. Three of the principal lists are the Fragile States Index (The Fund for Peace, 2016); the Uppsala Conflict Data Program (UCDP Conflict Encyclopedia, 2016); and the most widely used – the World Bank’s harmonized list of fragile situations (World Bank, 2016).<sup>12</sup> These organisations have analysed states according to sets of normative, often inconsistent, criteria that mask the multidimensionality and complexity of their problems (Ferreira, 2016, p. 10). Instead, a more context-specific approach that investigates “underlying sociopolitical and institutional structures and dynamics” is warranted (Kaplan, 2014, pp. 60–62),<sup>13</sup> so that policy responses take account of the specific factors that have led to that state’s fragility (Feeny et al., 2015, p. 1079). Similarly, Gisselquist (2015, p. 1277) maintains that “systematic thinking about the varieties of fragility and the sorts of policies that have worked and could work in each” is necessary so that policy approaches are adapted to each context.<sup>14</sup>

In this regard, the OECD has made recent advances to incorporate multidimensionality in its States of Fragility Framework (2016), shown below in Figure 2.1. The framework uses five dimensions to measure both the exposure to and management of risk factors of fragility, on a scale of moderate to extreme risk. These are political, societal, economic, environmental, and security dimensions (OECD, 2016, p. 37). Myanmar is shown to exhibit extreme risk in the political, societal, environmental and security dimensions. The OECD claims that the framework will help policy makers and practitioners design more context-specific programmes to address the different dimensions of fragility, and promote greater collaboration among different development actors (OECD, 2016, p. 44).

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<sup>12</sup> It is worth noting that the United Nations (UN) endorses the development agenda for ‘fragile states’, but does not measure or list countries that it considers ‘fragile’. This is probably to allay the risk of causing diplomatic concerns between the UN and member states, as allocation to the list may be considered demeaning.

<sup>13</sup> Kaplan develops this further in his Country Fragility Assessment Framework which builds on the work of the g7+ (Kaplan, 2015).

<sup>14</sup> Grävingholt, Ziaja and Kreibaum (2015, p. 1293) also support this view and present a multidimensional typology based on a definition of state fragility as “deficiencies in one or more of the core functions of the state: authority, capacity and legitimacy” linked to context-specific, and appropriate indicators.

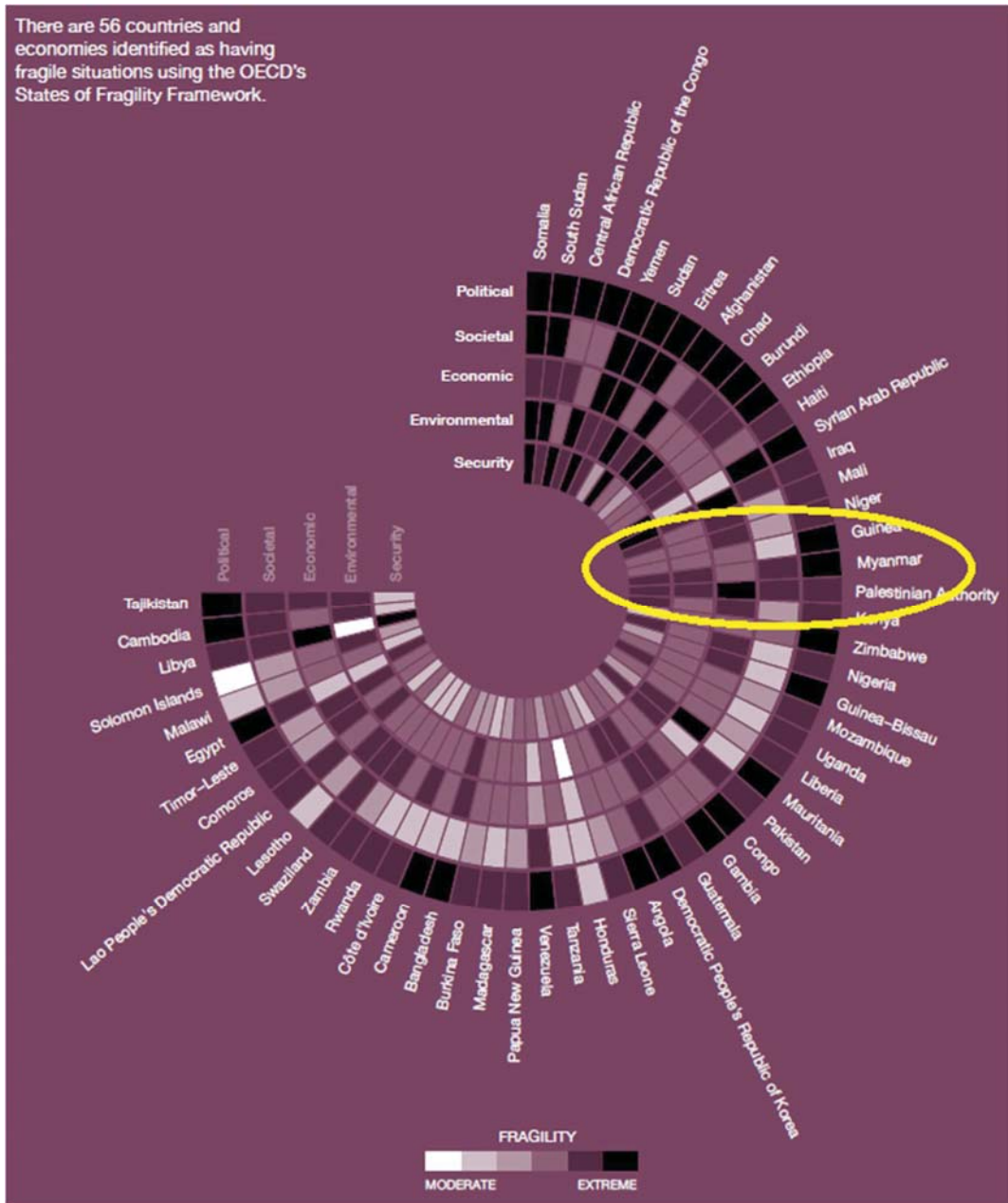


Figure 2.1: OECD States of Fragility Framework (Source: adapted from OECD, 2016, p. 36).

Moving on from an account of the definition and measurement of 'fragile states', the following section addresses how the 'fragile states' concept underpins the new development agenda.

### **2.1.2 The use of the ‘fragile states’ concept by the international aid community**

#### ***International aid interventions in self-interest***

What is clear from the diversity in definition and measurement discussed in section 2.1.1, is that an internationally coherent response to ‘fragile states’ is difficult to achieve (Faust, Grävingholt, & Ziaja, 2013; Grimm, 2014). Much of the criticism of the ‘fragile states’ concept has centred on its operationalisation in the strategic self-interest of the Global North (Barakat & Larson, 2014, p. 22; Nay, 2013, p. 330). These increased concerns about global security in the 2000s coalesced in the security-development nexus which guided aid allocations (Leader & Colenso, 2005), and assumed that ‘fragile states’ posed a global security risk (Nay, 2013, p. 327). The World Bank exemplified this outlook in its seminal report on “conflict, security and development” (2011), which explicitly linked fragility to a lack of development:

Yet, insecurity not only remains, it has become a primary development challenge of our time. One-and-a-half billion people live in areas affected by fragility, conflict, or large-scale, organized criminal violence, and no low-income fragile or conflict-affected country has yet to achieve a single United Nations Millennium Development Goal (UN MDG). (World Bank, 2011, p. 1)

Aid is allocated to ‘fragile states’ as part of larger strategic policies that incorporate political and military agendas as well (Barakat & Larson, 2014, p. 32; OECD, 2008a, p. 13, 2015, p. 61). These policies are framed around interventionist approaches, ostensibly to “strengthen capacity and find a path from fragility to socio-economic progress” (D. W. Brinkerhoff, 2010, p. 66; D. W. Brinkerhoff & Morgan, 2010). International development efforts are thus grounded in an ideology that security, or addressing the problem of ‘fragile states’, is an essential precursor for development to occur (Grimm, Lemay-Hébert, & Nay, 2014, pp. 199–200; Lemay-Hébert, n.d.). Barakat and Larson (2014) argue that international interventions in ‘fragile states’ operate by identifying geographically bounded places that are a threat to international security, and then applying simplified responses to complex situations, without either context-specific analysis or recognising the contribution of those external interventions to ‘fragility’.

Much of the literature that critiques the concept of ‘fragile states’ pays particular attention to the universal policy prescriptions and interventions of the Global North. These

interventions address internal factors of fragility without considering external determinants, such as structural inequities caused by the former colonisation of these states (Feeny et al., 2015, p. 1074), and existing external dependencies (Nay, 2013, pp. 333–334). A number of authors are critical of the Global North’s characterisation of ‘fragile states’ as lacking in internal capabilities (J. Hill, 2005, p. 149), as it ignores the interconnectedness with the impacts of colonisation and excludes the contribution of the Global North to state failure (see Barakat & Larson, 2014; B. G. Jones, 2008). Indeed, by overlooking the structural roots of social, economic and political problems, the characterisation of states as ‘fragile’ has permitted interventions by the Global North to function as reproductions of these colonial structures (B. G. Jones, 2008, p. 184).

### ***International aid interventions for state-building and peace-building***

International interventions by development organisations and governments have paid particular attention to efforts developing the capacity of states to provide services as a means of bolstering state legitimacy (Batley & McLoughlin, 2010; Carment, Landry, Samy, & Shaw, 2015, p. 1328; Newbrander et al., 2011; OECD, 2007, 2008a). The OECD explicitly determined a connection between state legitimacy and capacity when it prioritised state-building as one of its central objectives, stating:

International engagement will need to be concerted, sustained, and focused on building the relationship between state and society, through engagement in two main areas. Firstly, supporting the legitimacy and accountability of states by addressing issues of democratic governance, human rights, civil society engagement and peacebuilding. Secondly, strengthening the capability of states to fulfil their core functions is essential in order to reduce poverty. (OECD, 2007, p. 2)

However, the main weakness with approaches designed to increase state legitimacy is that they have failed to establish the evidence for a strong causal link between this and the development of state capacity to provide services (Lemay-Hébert, n.d. paragraph 13; see McLoughlin, 2015; Slater & Mallett, 2017; Slater et al., 2012). Further to this, Krasner and Risse (2014) argue against external engagement in state-building altogether, contending that:

...international organizations and the foreign aid community should critically evaluate their organizational templates for state-building and

service provision, and should cease orienting themselves toward consolidated statehood. (Krasner & Risse, 2014, p. 564)

Organisations such as the United Nations Development Programme advanced the security-development nexus further by combining the two tasks of state-building and peace-building into a “state building for peace” agenda (Rocha Menocal, 2011, p. 1716). However, state- and peace-building interventions may not reinforce one another as intended due to four reasons: 1) State building won’t necessarily contribute to peace; 2) peace-building efforts may undermine state effectiveness; 3) peace-building efforts undermine state-building if they bypass state institutions. Finally, 4) local, non-state forms of authority and legitimacy are often overlooked by state-building efforts (Rocha Menocal, 2011, pp. 1727–1731).

A principal goal of this research is to examine the roles of actors such as the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), a non-state armed group (NSAG) in Myanmar, and Partners Relief and Development (Partners), an international non-governmental organisation (INGO). The problem with viewing the statehood model of the Global North as the norm is that ‘fragile states’ are viewed through a deficit lens, which ignores how actors such as NSAGs and INGOs “support, undermine or explicitly challenge these states” (Bøås, 2017, p. 150). In a similar vein, Nay (2013, p. 337) advocates that policy solutions should incorporate the analysis of “traditional authorities, community-based groups, tribal structures and clans, social classes, religious and ethnic solidarities, and informal economy networks”, in doing so a better understanding of the contribution of NSAGs to state- and peace-building in Myanmar should emerge. Likewise, Ware’s research (2012, 2014b, pp. 264–266) provides evidence that development initiatives in Myanmar during the 1990s and 2000s were effective despite not engaging with the state-building paradigm for ‘fragile states’.

The paradigm of state-building through strengthening health systems will be addressed in section 2.2.2.

### ***What is the appropriate role for international actors in ‘fragile states’?***

Rather than concluding that international actors should abandon ‘fragile states’, many scholars argue that the international community should engage in less top-down and more “highly contextual” interventions (Ware & Ware, 2014, p. 30). For example, Call (2010, p. 304) maintains that “external actors require smarter approaches through more refined

analytic frameworks and more contextualized responses”. He proposes a conceptual lens of three different, but interrelated, gaps: 1) capacity gaps, 2) security gaps, and 3) legitimacy gaps. This enables a more appropriate response depending on where countries are located in the framework, as shown in Figure 2.2 below. He acknowledges that this still categorises countries on the basis of a set of externally imposed characteristics, even though it allows for more refined approaches (Call, 2010, p. 316). Although Call’s figure did not include Myanmar, I have included it in the framework as sharing the characteristic of ‘weak states’. Also pertinent to Myanmar is Call’s (2008, p. 1498) warning of problematic international engagement in state-building that may shore up repressive, corrupt and discriminatory regimes (as described in Chapter 5, section 5.1).

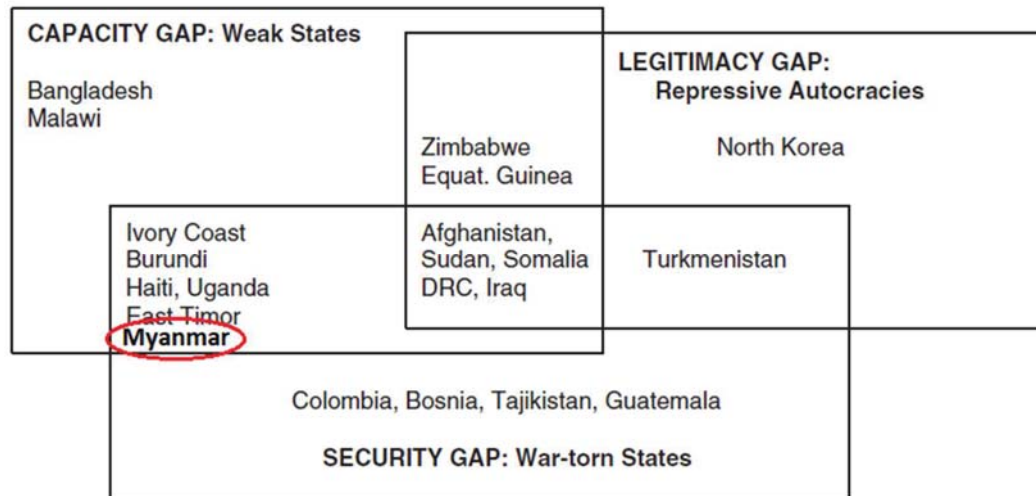


Figure 2.2: Fund for Peace 'fragile states index' from 2007 with selected countries sorted by gaps (Source: adapted from Call, 2010, p. 310).

Lemay-Hébert (2009, p. 41) does not dismiss a role for international actors either, but rejects top down approaches to state-building in favour of “local ownership...as a vital constitutive element of the process”. Likewise, Bøås (2017, p. 152) advocates for the continued involvement of the international community in ‘fragile states’ as a key development agenda, particularly “in the peripheral provinces”, a critical focus of this research on the Myanmar-Thailand border. Rocha Menocal (2011) further makes the case for the engagement of international actors, but cautions:

...rather than imposing institutions and blueprints from the outside, they need to start with the local context. This implies building on what is already there, and focusing their engagement in fragile states on accompanying

and facilitating domestic processes, leveraging local capacities, and complementing, rather than crowding out, domestic initiatives and actions. (Rocha Menocal, 2011, p. 1732)

Given all these words of caution, it would seem that there is a role for the international community. However, there then becomes a risk that the international community could overlook the legitimacy of the RCSS/SSA-S as a development actor (see section 2.3.2 and Chapter 5, section 5.2.1 for further discussion of their role).

### **2.1.3 'Conflict-affected context': An alternative term**

As this chapter has shown, the term 'fragile states' tends to emphasise the use of top-down, external solutions proposed by international organisations. In addition, some authors contend that the discursive use of 'fragile state' lacks any explanatory utility. As such, Call (2008, 2010) argues for the term to be wholly abandoned as the "concept contains culturally specific assumptions about what a 'successful' state should look like and groups together disparate sorts of states with diverse problems" (2008, p. 1494). In this section, alternative typologies to 'fragile states' are offered which show how more precise and impartial terms could be used. These include collapsed, weak formal institutional capacity, war-torn, or authoritarian states/regimes (Call, 2008, pp. 1500–1504), or "resilient states" (Nay, 2013, p. 338), as an even less pejorative term. Norris, Dunning and Malknecht (2015) also recommend "rebranding", explaining that:

...it might be more helpful for the international community to label these states as *priority strategy countries* or *strategic priority countries*. This would be both more palatable politically for leaders in these countries while at the same time making clear that significant resources would need to be brought to bear if a country is to change course. (Norris et al., 2015, p. 22)

In this research, the less stigmatising term of 'conflict-affected contexts' is used, in its broadest sense as a direct alternative to 'fragile states', except when quoting authors who have used the term 'fragile states'. What is clear is that using the term 'conflict-affected context' places emphasis on the conflict, rather than deficiencies in the state itself. However, it has proven difficult to source a working definition of 'conflict-affected' as the term is commonly conflated with 'fragile states'. The definition of armed conflict used by the Uppsala Conflict Data Program (UCDP) is used here to "...distinguish between various

forms of organized violence at a greater level of precision than previously thought possible (Strand & Dahl, 2010, p. 2).

An **armed conflict** is a contested incompatibility which concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths. (Uppsala Conflict Data Program, n.d.)

The UCDP differentiates between state and non-state armed conflict, where non-state armed conflict is “between two organised armed groups, neither of which is the government of a state” (Uppsala Conflict Data Program, n.d.). What is useful about the term ‘conflict-affected context’ is that it captures the reality that conflict between the state and non-state armed groups is a dynamic lever that shapes the research context in Myanmar, and has recognised effects upon health outcomes and health systems as will be outlined in section 2.2 (for further details see Bornemisza et al., 2010, p. 81).

The following section considers local and hybrid responses to conflict-affected contexts, in contrast to the top-down approach of international organisations presented thus far in this chapter.

#### **2.1.4 A turn to local and hybrid approaches**

An alternative way forward in conflict-affected contexts is to situate state- and peace-building processes within local expressions of development and resilience, rather than as a function of top-down global interventions. Policy direction and aid intervention in ‘fragile states’ has been primarily driven by the large global organisations, so the emergence of the g7+ (<http://www.g7plus.org/>) in 2010 is a promising response for ‘fragile’ and conflict-affected states in the Global South “to cooperate and speak collectively to their ‘development partners’” (Fenby, 2013, p. 33). The g7+ is made up of 20 self-selected ‘fragile states’. Myanmar, the focus of this research, is not a member. The g7+ offers an alternative definition of state fragility as:

...a period of time during nationhood when sustainable socio-economic development requires greater emphasis on complementary peacebuilding and statebuilding activities such as building inclusive political settlements, security, justice, jobs, good management of resources, and accountable and fair service delivery. (g7+, 2013, p. 1)

The g7+ extends its alternative definition of ‘fragile states’ to provide its own wide-ranging and multidimensional assessment of state fragility using the menu of indicators developed for the g7+ fragility spectrum (g7+, 2013). Importantly, this assessment is:

...an **inclusive** and participatory **exercise carried out by national stakeholders** to assess a country’s **causes, features and drivers of fragility as well as the** sources of resilience within a country. In doing so, it takes a look not only at historical legacies but also at more recent and current drivers of fragility. (International Dialogue on Peacebuilding and Statebuilding, 2014, p. 1)

The g7+ advocates for localised ownership of international development programmes (Fenby, 2013, p. 37; Ware & Ware, 2014, pp. 36–37), and is critical of the high level of self-interest of the Global North (International Dialogue on Peacebuilding and Statebuilding, 2016b, p. 1). The group established “a new deal for engagement in fragile states”, concluding that the current development architecture must accommodate the context-specific challenges faced by these states (International Dialogue on Peacebuilding and Statebuilding, 2011, p. 1, 2016a). Two key achievements of the g7+ are the development of their own fragility assessments (International Dialogue on Peacebuilding and Statebuilding, 2014; Rocha De Siqueira, 2014, pp. 276–278), and fostering greater South to South cooperation (2016b, pp. 51–55). The fragility assessment is one way to transfer the accountability for ‘fragility’ to donors and the ownership of solutions to the g7+ nations themselves, which reverses the current direction of the ‘fragile states’ agenda (Rocha De Siqueira, 2014, p. 278). However, although the emergence of the g7+ is a hopeful advancement, its processes are still bounded by the dominant global aid architecture, limiting real opportunities for change (Fenby, 2013, p. 43; Kaplan, 2015, p. 2). In addition, its constituency remains limited to 20 conflict-affected countries.

At an even more localised level in conflict-affected contexts such as Myanmar, locally driven solutions create space for non-state actors and civil society organisations to provide services, such as healthcare and education. Instead of being primarily concerned with increasing state legitimacy, Clements, Boege, Brown, Foley and Nolan (2007, p. 48) argue that it is “more appropriate to focus on models of governance which draw on the strengths of social order and resilience embedded in community life”. Rather than underestimating the role of non-state actors, hybrid political orders are formulated between community level institutions, non-state actors and state structures (Boege, Brown, & Clements, 2009,

p. 14). Relevant to this research exploring the role of the RCSS/SSA-S, as a non-state development actor (see section 2.3.2), is the argument that:

The capacities and legitimacy of non-state providers of security and other public goods have to be acknowledged and integrated into processes of building political orders beyond the Western model of the state. (Boege et al., 2009, p. 20)

International problem-solving interventions in ‘fragile states’ tend to apply superficial fixes without understanding critical local processes for peace-building (Mac Ginty & Richmond, 2013, pp. 766–769). Alternatively, the lens of localism, and understanding processes at the local level, expands the possibilities for greater local agency in peace-building processes (Mac Ginty, 2014; Mac Ginty & Richmond, 2013), which are critical to Myanmar moving forward (Chapter 5 discusses the conflict-affected context of Myanmar). Mac Ginty and Richmond (2013, p. 775) maintain that the turn to locally appropriate approaches to peace-building is congruent to the similar turn to local participation and ownership in development. They argue that:

...local agency and its relationship with hybrid forms of peace [are] an attempt to redefine what peace and legitimacy mean in different contexts, to maintain everyday life, to gain autonomy, aspirations for social forms of justice, to express identity, and to engage with certain aspects of the liberal peace. (Mac Ginty & Richmond, 2013, p. 779)

Likewise, Brinkerhoff (2014, p. 339) emphasises that “[a]cknowledging local practices and institutions and hearing local voices are important prerequisites for an understanding of what is going on in post-conflict spaces”. Mac Ginty and Richmond (2016) also warn against the co-option of localised processes by organisations like the World Bank. They maintain that hope exists for radical and hybrid peace in support of local priorities (2016, p. 231). Indeed, in the context of Myanmar, Ware (2014b, p. 268) concludes that approaches that emphasise “working slowly but directly with communities, using highly empowering participatory models, [and] bypassing the state...” have been effective.

In sum, the first section of this chapter has provided a summary of the literature related to the ‘fragile states’ agenda, with the purpose of offering a critique of top-down instrumentalist interventions that aim to bolster state legitimacy. It has shown how the focus on ‘fragile states’ as a new development agenda increased during the early 2000s,

including efforts to define and measure these. The concept of ‘fragile states’ was operationalised in state- and peace-building interventions, primarily in the interests of the Global North. According to alternative notions of conflict-affected contexts, such as that determined by the g7+ group of states, an appropriate role for international actors in countries like Myanmar could be engagement in more context-specific approaches that accommodate organisations such as the RCSS/SSA-S. This literature locates the research in relation to the potential these more localised and appropriate responses offer for service delivery in a context such as Myanmar. Importantly, the term ‘conflict-affected contexts’ is used in the thesis as a less pejorative descriptor for these contexts. To conclude, hopeful possibilities of more localised and context-specific responses in conflict-affected contexts were introduced.

The chapter now turns to examine health system development in conflict-affected contexts.

## **2.2 Health system development in conflict-affected contexts**

### **2.2.1 The impact of conflict upon health and health systems**

This section commences by shifting from theoretical considerations of conflict-affected contexts to describe health system development, and the well-established negative impacts of conflict upon health outcomes and health systems. The World Health Organization’s (WHO) definition of ‘health systems’ is used and consists of:

...all the organizations, institutions, resources and people whose primary purpose is to improve health. This includes efforts to influence determinants of health as well as more direct health-improvement activities. (World Health Organization, 2010, p. vi)

Health systems have a goal of:

...improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources...[and] achieving greater access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety. (World Health Organization, 2007, p. 2)

Conflict-affected countries made little progress in achieving any of the United Nations' Millennium Development Goals, which it was hoped countries in the Global South would achieve by 2015 (Norris et al., 2015, p. 5; OECD, 2015, pp. 30–37; World Bank, 2011, p. 63), let alone those specifically related to health: Goal 4 to reduce child mortality, Goal 5 to improve maternal health, and Goal 6 to combat HIV/AIDS, malaria, and other diseases (Benton et al., 2014, pp. 20–21; Bryce, Black, & Victora, 2013). Myanmar either failed to achieve the six targets within the three health related MDGs, or was unable to furnish appropriate data to measure progress (Norris et al., 2015, p. 31).

The UN considers conflict to be “the biggest threat to human development” with conflict-affected countries having “the highest poverty rates” (United Nations, 2015, p. 8) and limited access to crucial services such as healthcare (2015, p. 23). The OECD stresses that understanding “the role of violence and fragility is crucial to realisation of the SDGs [Sustainable Development Goals<sup>5</sup>]” (OECD, 2016, p. 7). This is particularly so because populations in conflict-affected states “account for only 20% of the global population but 43% of the world's poor” (OECD, 2015, p. 35). D'Harcourt, Ratnayake and Kim (2017) draw attention to the fact that the SDGs contain insufficient direction on how to address the impacts of conflict. They argue that SDG 16, which aims to resolve conflict and promote peace, must:

...translate into specific action points for other SDGs, such as SDG 3, which focuses on health...[as unless] we learn how to achieve the targets in conflict settings, the benefits of the SDGs will not reach many of the people who need them most. (d'Harcourt et al., 2017, p. 157)

Despite the difficulty of obtaining data in conflict-affected contexts (N. Howard, Hossain, et al., 2012, p. 29; Woodward, Sondorp, Witter, & Martineau, 2016a, pp. 2–3), it is widely accepted that these populations carry a large burden of extremely poor health related outcomes, including for life expectancy, maternal mortality and vaccination rates (PLoS Medicine Editors, 2011, p. 1; World Bank, 2011, p. 63). It is known that children “are twice as likely to be malnourished and twice as likely to die by the age of five years in low-income countries affected by conflict compared with similar but stable countries” (d'Harcourt et al., 2017, p. 157). Within these populations, groups that are already “politically, socially and

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<sup>15</sup> Detail on the 17 Sustainable Development Goals (SDGs) may be found here: <https://sustainabledevelopment.un.org/sdgs>

economically marginalized” (Craig, 2012, p. 17) are also disproportionately vulnerable to the impacts of conflict.

The relationship between conflict and poor population health encompasses a number of challenges including the exacerbation of already poor health, increased susceptibility to communicable diseases, and further vulnerability of groups already marginalised due to food insecurity and poor reproductive health (Waters et al., 2007, pp. 2–3). The destruction or lack of healthcare facilities, absence of healthcare workers due to death or displacement, and the cessation of immunisation programmes is prevalent (Bouta et al., 2005, p. 111). Conflict leads to “high direct and indirect mortality, lack of governance, health system collapse and infrastructural breakdown” (N. Howard, Hossain, et al., 2012, p. 32), and “increased burden of disease, conflict, scarcity of health care workforce, financial limitations, fragile governance or weak institutional leadership” (Benton et al., 2014). The strain upon already weak health systems has led to questions about how to rebuild systems in the most appropriate way to reach conflict-affected and vulnerable populations, and these are considered next.

### **2.2.2 Strengthening health systems: State- and peace-building**

Having discussed the negative impacts of conflict upon health outcomes, this section considers the literature on the development of health systems in these contexts. Over the past few decades there has been a transition from conceptualising public health through vertical, disease-specific programmes to the current concern with horizontal health systems strengthening (HSS) in global health (see Brown, Cueto, & Fee, 2006; Koplan et al., 2009). WHO, as the predominant international organisation shaping the global focus on health systems strengthening, provides a framework to enable a shared understanding of what HSS is. This is assembled upon six building blocks, as shown in Figure 2.3 below, that lead to the four outcomes of a functioning system on the right of the figure. The scope of this research is to examine factors involved in the second building block, the ‘health workforce’. The WHO defines a “well-performing health workforce” as “one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances” (2007, p. 3). This research sets out to better understand the role that resources and the socio-political context play in the effective development of a health workforce in a conflict-affected context.

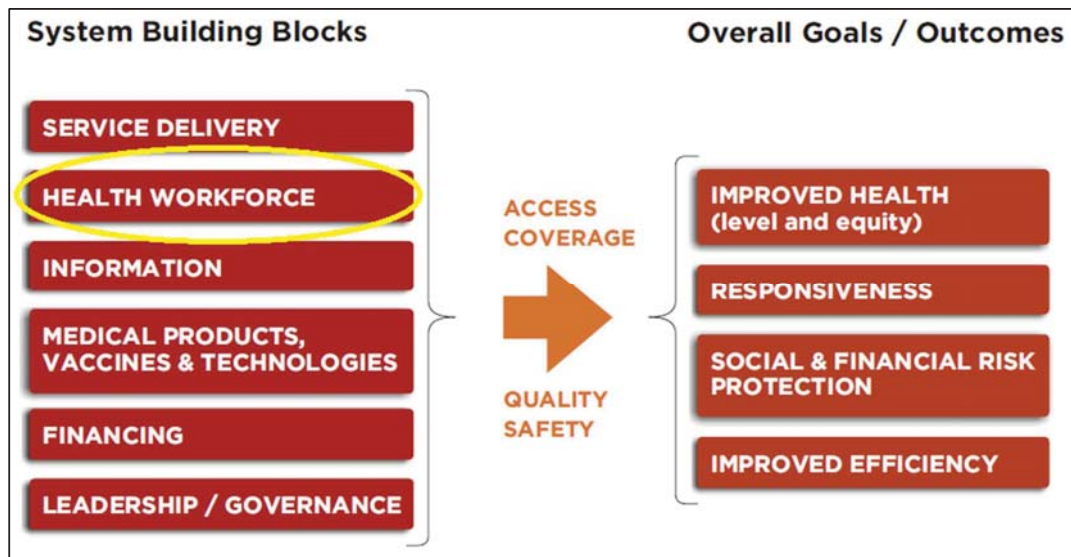


Figure 2.3: The WHO health system framework (Source: adapted from de Savigny & Adam, 2009, p. 31).

Hafner and Shiffman (2013, pp. 46–47) explain that the recent shift in attention, away from a disease-specific focus towards HSS in global health, was prompted by concerns about the poor headway being made on the health-related MDGs, as outlined in section 2.2.1. This concern was articulated in statements such as this from the World Health Organization:

It will be impossible to achieve national and international goals – including the *Millennium Development Goals* (MDGs) – without greater and more effective investment in health systems and services. (World Health Organization, 2007, p. v)

However, Hafner and Shiffman (2013, p. 48) caution against over stating the current level of attention that is being paid to health systems, as this is not yet supported by the appropriate levels of global funding or a shared perspective that understands health systems strengthening (HSS) to be the most advantageous strategy to achieve better health outcomes for the poor.

Much of the current literature on HSS in conflict-affected contexts is concerned particularly with the contribution of these systems as a means of state- and peace-building, by increasing the legitimacy of states (as discussed in section 2.1.2). The WHO (2007, p. 8) advances this view, acknowledging that the tensions involved “between saving lives and

livelihoods and starting the process of re-building the state” pose a singular challenge to conflict-affected contexts. The idea that HSS holds the potential to enhance state-building, as well as improving health outcomes, is maintained by some who argue that it promotes social cohesion, restores state accountability, and strengthens government capacity (Kruk et al., 2010, pp. 92–94). Similarly, Rocha Menocal (2011, p. 1726) notes that the achievement of state legitimacy is problematic due to weak governance and a lack of capacity. However, she cautions against circumventing state involvement in these processes, despite the difficulties, as this may negatively impact upon state legitimacy (Rocha Menocal, 2011, p. 1729).

The notion that HSS has a role in state- and peace-building is further reinforced by Sondorp, ter Veen and Howard’s (2012, p. 166) claim that “effective health system strengthening contributes to state building” although they moderate this by stating that the role between health systems and state- and peace-building is not yet clear (2012, p. 168). They suggest that the ‘Health as a Bridge for Peace’ framework<sup>16</sup> is one argument for HSS to play a role in peace-building (2012, p. 167). Similarly, Newbrander, Waldman and Shepherd-Banigan (2011) make a case for international engagement in HSS in conflict-affected contexts because of:

...the humanitarian imperative to act in the face of crises that result in high rates of disease and death and in the destruction of food sources, people’s homes, and other basic survival needs...[and because] health service delivery also can be a good entry point for tackling the causes of fragility because health services can lead to involvement with both the government and civil society. (Newbrander et al., 2011, pp. 641–642)

The dual approach of providing relief services while building the capacity of state systems supports the accepted wisdom that there is a linear continuum of relief through to development programmes (Mendenhall, 2012, pp. 7–8). Commins (2010, p. 599) describes this as a ‘two track approach’, with one focused on state-building, and the other on rapid service delivery. Waters, Garrett and Burnham (2007, p. 6) propose a three part framework for rehabilitating health systems in ‘fragile state’s: “(1) an initial response to immediate

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<sup>16</sup> “Health as a Bridge for Peace (HBP) is a multidimensional policy and planning framework which supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peace-building. It is defined as the integration of peace-building concerns, concepts, principles, strategies and practices into health relief and health sector development” (<http://www.who.int/hac/techguidance/hbp/about/en/>).

health needs; (2) the restoration or establishment of a package of essential health services; and (3) rehabilitation of the health system itself”. Endorsing this view, Brinkerhoff (2008) offers a model, in Figure 2.4 below, that illustrates the transition from humanitarian relief and service delivery, through to the sustainable development of health systems in cooperation with the state. Importantly, he and others recognise that transition strategies for HSS are “not sequential but iterative” (2008, p. 8) and are “complex, context-specific process that needs to address all the independent building blocks” (ter Veen & Commins, 2012, p. 161).

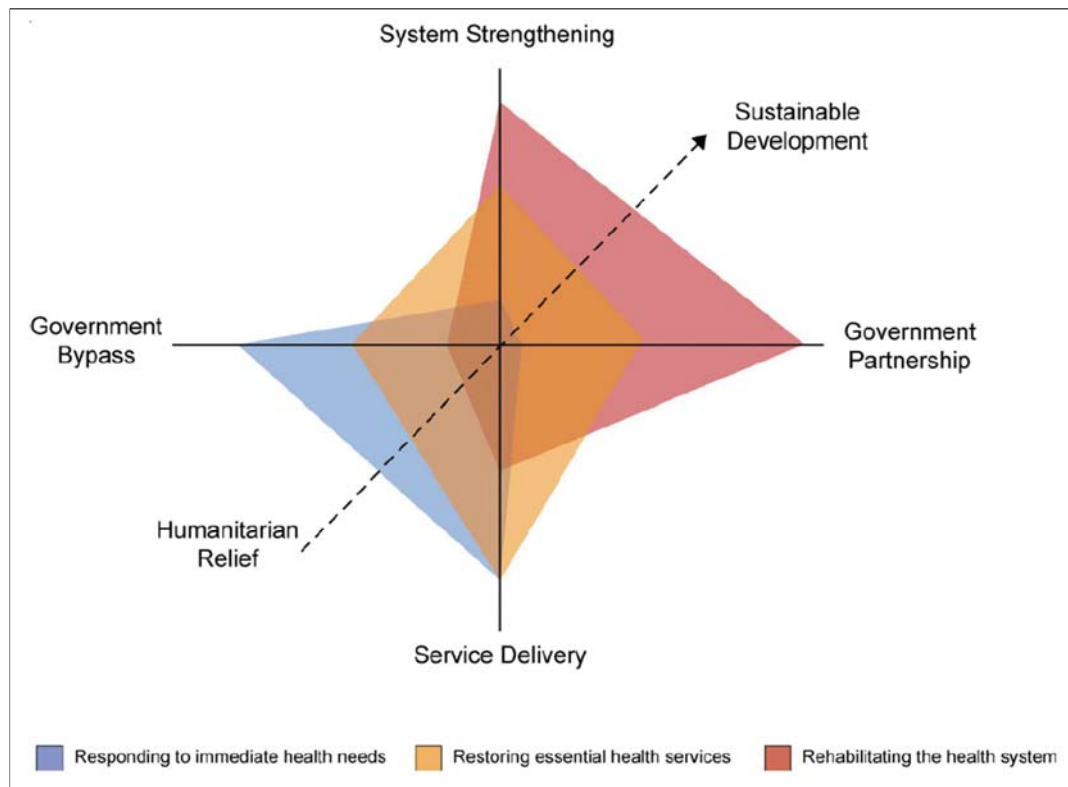


Figure 2.4: Transitions to sustainable health system development (Source: D. W. Brinkerhoff, 2008, p. 3).

In contrast to the state- and peace-building discourse, others have concluded that more evidence is required to support the causal connection between HSS and increased state legitimacy (Slater & Mallett, 2017, pp. 4-5; Slater et al., 2012, p. 4). The next section examines an alternative view of HSS as an end in itself.

### **2.2.3 Strengthening health systems: Improving health outcomes**

This section now turns to argue that the goal of health systems strengthening must primarily be improved health outcomes for communities in conflict-affected contexts. Krasner and Risse (2014, p. 546) contend that “we know surprisingly little about the effectiveness of external efforts at state-building, or public service provision in areas of limited statehood”, arguing that international actors need to reorient their efforts away from state-building. They consider that an essential element in the success of non-state service provision has to be whether the local community considers that they are legitimate or not (2014, p. 555). Further to this, Barma, Levy and Piombo (2017) maintain that there is a problem with conflating the two concepts of state-building with peace-building, as they see them as two separate but interrelated processes. They propose research into the role of aid dynamics upon state legitimacy pointing out that what is known currently is that international interventions tend to weaken state capacity to provide services, rather than strengthen it (Barma et al., 2017, p. 200). Mcloughlin (2015, p. 353) also draws a distinction between service delivery to meet political objectives of state-building and service delivery with the primary goal to meet population needs, and presses for a greater understanding as to whether international approaches can claim that they meet both objectives.

Without conclusive evidence of a strong causal relationship between service delivery and state legitimacy (Slater & Mallett, 2017, pp. 4–5), as discussed in section 2.1.2, it is necessary to reject the instrumental and dual roles of these tasks. Instead, it is useful to see undertakings such as HSS as an end that contributes to improved health outcomes. This would also overcome the limited emphasis on “whether nonstate provision undermines state legitimacy” (Mcloughlin, 2015, p. 352). Further research might usefully recognise “the potential relevance of alternative actors, which often form part of the state in their own right” (Denney, Mallett, & Benson, 2017, p. 31) so HSS efforts are more context-specific and able to advance substantive health outcomes. Along these lines, Philips and Derderian (2015) raise concerns that:

...state and peace building objectives might transform the strategic choices, the modalities and perception of health responses for people in precarious health and living conditions...strategic choices geared towards health care support for patients and effective delivery models, might increasingly be

influenced by the political framework of state ownership, state building and stabilization. (Philips & Derderian, 2015, p. 6)

They propose that the current state-building paradigm should not allow the international community to lose sight of a critical focus on health and wellbeing (Philips & Derderian, 2015, p. 6). This would reorient international efforts towards improving health outcomes.

In light of the fact that conflict-affected states failed to improve health outcomes and to achieve the MDGs, the SDGs have recognised the constraints that conflict places upon these states. As previously noted, the SDGs include goal 16, to “promote peaceful and inclusive societies for sustainable development” (United Nations General Assembly, 2015, p. 28). SDG 3, to “ensure healthy lives and promote well-being for all at all ages” (2015, pp. 18–19), retains the MDGs’ strong focus on health. These two goals are recognised as interconnected but having separate ends. However, concern has already been signalled that the 17 SDGs, with their 169 targets, place an extraordinary burden upon conflict-affected states in terms of implementation (Buse & Hawkes, 2015, p. 5; Norris et al., 2015, p. 59); and that any efforts to achieve SDG 3 need to be specifically addressed to conflict-affected contexts (d’Harcourt et al., 2017, p. 157).

The achievement of SDG 3 recognises the centrality of the health workforce building block (see Figure 2.3 on page 27) to the process through HSS. It has been long recognised that there is a dire shortage of health workers in conflict-affected countries (Doull & Campbell, 2008; Roome et al., 2014, p. 6), therefore what is needed is a global strategy for workforce development (Sidibé & Campbell, 2015, p. 3). The WHO have outlined such a strategy to “accelerate progress towards universal health coverage and the UN Sustainable Development Goals by ensuring equitable access to health workers within strengthened health systems” (2016a, p. 8). Buse and Hawkes (2015, p. 8) are concerned that “the health workforce itself needs to be retooled and brought closer to communities if health-as-a-way-of-life is to be achieved”.

Recognising that improved global health is a critical component to achieving sustainable development enables the international community to refocus development efforts on this goal as an end in itself, rather than as a means to political outcomes in conflict-affected states. The following section examines the roles of different actors in the process of HSS in more detail.

## **2.3 The different development actors in health system development**

### **2.3.1 International non-governmental organisations: Capacity builders**

The first objective for this research is to explore the relationships of the different actors in the delivery of the Shan Healthcare Training Programme (SHTP). Three crucial development actors are discussed in this section to help gain a better understanding of their involvement in health system development more generally. These are INGOs, non-state armed groups (NSAGs) and community health workers (CHWs). The fundamental question as to the most appropriate role for INGOs in conflict-affected contexts is a highly contested topic.

While recognising that definitions of INGOs are both widely varying and disputed due to their variety in form and function, Lewis (2014) provides a very basic definition as:

...‘third sector’, not-for-profit organizations concerned with addressing problems of global poverty and social justice and working primarily in the developing world...NGOs tend to go about their work either directly through the provision of services to people in need, or indirectly through partnerships, campaigning work and policy advocacy to bring about wider structural change that will improve the position of people living in poverty.  
(Lewis, 2014, p. 3)

It may be helpful to further categorise what type an INGO is when examining where they may be most usefully involved in development interventions. One useful conceptualisation is Korten’s (1990) typology of four generations of INGO strategies, as shown in Table 2.2 below. These are based on how INGOs define and assess the problems they are addressing and the timeframes they are operating to. Second generation INGOs are limited by their inability to address structural, institutional and policy constraints to activities such as health systems strengthening.

Table 2.2: Four generations of development NGO strategies

<b>Four generations of NGOs</b>				
	<b>First</b>	<b>Second</b>	<b>Third</b>	<b>Fourth</b>
	Relief and welfare	Community Development	Sustainable systems development	People's movements
<b>Problem definition</b>	Shortage	Local inertia	Institutional and policy constraints	Inadequate mobilising vision
<b>Timeframe</b>	Immediate	Project life	Ten to twenty years	Indefinite future
<b>Scope</b>	Individual or family	Neighbourhood or village	Region or nation	National or global
<b>Chief actors</b>	NGO	NGO plus community	All relevant public and private institutions	Loosely defined networks of people and organisations
<b>NGO role</b>	Doer	Mobiliser	Catalyst	Activist/educator

(Source: adapted from Korten, 1990, p. 117; Lewis & Kanji, 2009, p. 15)

Service delivery INGOs proliferated in the 1980s and 1990s in response to the impacts caused by the neoliberal development agenda implemented through policies such as the

International Monetary Fund and World Bank's structural adjustment programmes (N. Banks & Hulme, 2012, p. 5; Lewis & Kanji, 2009, pp. 85–89). During this time INGOs functioned as gap fillers to state provision of services such as healthcare (J. M. Brinkerhoff, 2003, p. 106; Eade, 2007, p. 634; Lewis & Kanji, 2009, p. 86; OECD, 2008a, 2008b), with some arguing that this limited their ability to be involved in more political advocacy activities (Hayman, 2016, p. 672; Mcloughlin, 2011, p. 247). This is arguably the case with Korten's four generations of INGOs.

As the 'fragile states' agenda developed in the 2000s, there was tension between the gap-filling role of INGOs to provide essential lacking services, and the state-building agenda of the Global North (see earlier discussion in section 2.1.2). Concern, particularly from the OECD (2007), was that:

...non-state services in fragile states may delegitimise the state in the eyes of citizens, [as] 'state-building' depends on governments' engagement in service management...what is good for service delivery may not be good for state-building. (Batley & Mcloughlin, 2010, pp. 131–132)

There were also unintentional side effects of INGO service provision including:

...unsustainable operational standards and facilities; lack of upward and downward accountability of service providers; the failure of humanitarian agencies to develop sustainable local capacity; and the tendency for service providers to attract hostility from the state. (Batley & Mcloughlin, 2010, p. 132)

However, as already outlined in section 2.2.3 there is yet no convincing causality between a state's provision of services and its concomitant legitimacy. A place still exists for INGOs to provide services that do not undermine state-building, but there may be more appropriate ways to cooperate with the state (Mcloughlin, 2015).

A significant characteristic of many INGOs is their use of volunteers to staff their programmes, particularly those that require technical skills that may not be locally available, such as in health-oriented programmes. However, although the use of skilled

volunteers to fill gaps and build capacity<sup>17</sup> is central to fostering local ownership in many development efforts (Devereux, 2008, p. 357), it is not without its contradictions. Key to these is the contention that volunteerism recreates neo-colonial and paternalistic practices (Baillie Smith & Laurie, 2011, p. 546; J. Howard & Burns, 2015, p. 6; McLennan, 2017, p. 884), which can lead volunteers to inhabit the role of ‘white saviour’<sup>18</sup> (Straubhaar, 2015). There is evidence that rather than volunteerism being driven by a demand for volunteers by organisations in the Global South it is often directed by a supply of international volunteers (Perold et al., 2013). This has led to structurally unequal relationships where recipient organisations “do not necessarily need or value the particular skills that [the volunteers] bring” (J. Howard & Burns, 2015, p. 9).

Of particular concern to this research is the increasing use of expatriate medical volunteers in the Global South, facilitated by INGOs. Scholars have examined some of the concerns that have arisen in the shift from appropriately trained and experienced medical professionals deploying with INGOs longer term, to the growth in short-term medical volunteerism (see Asgary & Junck, 2013; Lasker, 2016; McLennan, 2014; Rozier, Lasker, & Compton, 2017). This shift is linked to wider scrutiny about volunteerism more generally and concerns about the deployment of volunteers without the appropriate preparation, experience and skills for the context (Asgary & Junck, 2013, pp. 625–626), and the harm that this may cause (detailed by Wilson, Merry, & Franz, 2012, p. 614). In the health field, this can mean that regardless of good intentions, volunteers can encounter ethical difficulties including operating “beyond the scope of their training and expertise based on the limited resources and the lack of other options for health care available to patients” (Stone & Olson, 2016, p. 239). Some argue this could be mitigated by the use of ethical and best practice guidelines (Crump, Sugarman, & Working Group on Ethics Guidelines for Global Health Training (WEIGHT), 2010). Some of the limitations of medical volunteerism (see McLennan, 2014, p. 168) specific to this research are discussed more fully in Chapter 8.

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<sup>17</sup> Capacity building endeavours more specifically in conflict-affected contexts have also been critiqued for their focus on technical issues and their failure to consider the centrality of power and politics to those efforts. Crucially, they have overlooked “alternative’ capacities” (Denney et al., 2017, p. 2).

<sup>18</sup> “The term “white saviours” refers to the idea that it is the role of outsiders - particularly white Westerners - to help the poor and oppressed in developing countries, an idea that recurs frequently in literature and film (Straubhaar 2015; Vera and Gordon 2003)” (McLennan, 2017, p. 883).

INGO contributions to health system development have been studied at length due to the essential nature of healthcare provision in 'fragile states'. Schäferhoff (2014, pp. 675–676) reports that INGOs can be providers of collective goods such as healthcare most effectively “when their task is simple... and their activities are perceived as legitimate”. He found that:

...the concept of acceptance - cultivating relations with local actors and communities - is increasingly recognized as an appropriate and effective approach to providing services in insecure settings. (Schäferhoff, 2014, p. 686)

In addition, Bornemisza, Ranson, Poletti and Sondorp (2010, p. 86) explain the appropriateness of external actors fulfilling functions in a particularly dysfunctional sector, but maintain that there is a need “to initiate capacity building at an early stage” Critically for this research, they identify the importance of providing a space for collaboration with non-state actors.

Some authors challenge the characterisation of healthcare in 'fragile states' as an “empty void” left by a lack of state service provision (P. S. Hill et al., 2014; Pavignani et al., 2013). They explore the provision of healthcare by a multiplicity of actors beyond the state, including “trans-border health provision in response to demand” (P. S. Hill et al., 2014, p. 23), which is reflective of the research context on the Myanmar-Thailand border. These lead to emergent local and international healthcare networks, often linked to “small-scale philanthropy” in local clinics and “health services patched together by rotations of visiting international professionals or through “twinned” institutional support from linked religious organisations” (P. S. Hill et al., 2014, p. 25). Rather than seeing the emergence of these health systems as a negative, these scholars argue that more is needed to understand the context in which they develop, the actors involved – including INGOs, and the quality and effectiveness of approaches taken. Pavignani et al. (2013) maintain that change is needed in:

...the framing of analysis of these contexts; an acknowledgement that the state is only one of many actors in health; a recognition that current time-frames, and the current expectations that shape them, are unrealistic; and a preparedness to rethink development engagement in ways that will allow effective harnessing of the diverse actors that currently provide services. (Pavignani et al., 2013, p. 58)

Pavignani et al. (2013) reinforce the contention that more in-depth analyses will provide ground for the global community to ensure that these complex adaptations have the ends of improving health outcomes and contributing to the achievement of the SDGs in conflict-affected states.

### **2.3.2 Non-state armed groups: Legitimate development actors**

Another significant aspect of health system development in conflict-affected states is the part played by non-state actors, and in the context of this research, the role of non-state armed groups (NSAGs). Like conflict-affected contexts, pinning down a conclusive definition for non-state armed groups is difficult owing to their variety. Hofmann and Schneckener (2011a) offer the following:

...non-state armed groups are defined as distinctive organizations that are (i) willing and capable to use violence for pursuing their objectives and (ii) not integrated into formalized state institutions such as regular armies, presidential guards, police, or special forces. They, therefore, (iii) possess a certain degree of autonomy with regard to politics, military operations, resources, and infrastructure. (Hofmann & Schneckener, 2011a, pp. 604–605)

Likewise, Podder (2012, p. 6) defines them as “groups that possess a hierarchical organisation, use violence for political ends, are independent from state control and have some degree of territorial control over a geographic area”. This research investigates the partnership between Partners, an INGO, with the RCSS/SSA-S, one of Myanmar’s NSAGs that controls territory inside Shan State (see Chapter 5, section 5.2.1 for more detail).

Much of the criticism that NSAGs attract is centred on their role as ‘spoilers’ because they “disturb, undermine, or completely truncate processes of peace- and state-building, leading violence to flare up again” (Hofmann & Schneckener, 2011a, p. 604). This can lead to further conflict that impacts upon the work of INGOs. However, Podder (2012, 2013, 2014a, 2014b) disputes this wholesale judgement and instead posits that NSAGs may fulfil a role as legitimate representatives of marginalised groups, such as ethnic groups, within

repressive states. She offers a typology to further understand the sources of NSAG support and legitimacy in Figure 2.5 below.<sup>19</sup>

Core Support Base	Resource Base	Relations with Civilians	Domestic Support	International Support	State-building Potential
Ethnic/ Tribal	Community Taxation/ Natural Resources	Protective/ Cooperative	High	Low	High
Ideological/ Religious Diaspora/ Displaced	Community Taxation/ Natural Resources Remittances/ Weapons/ Bases/Communications/ Capital-Based Exchange Systems	Protective/ Cooperative Abusive/ Conflicting	High Low	Low High	High Low
Regional/ International	Cash/Weapons/Bases/ Intelligence/ Capital- Based Exchange Systems	Abusive/ Conflicting	Low	High	Low
Majority Population (Local as well as diaspora)	Mix of Community- Based and Capital Exchange Systems	Cooperative	High	High	High

Figure 2.5: NSAG support base, resources, relations with civilians, and state-building potential (Source: adapted from Podder, 2013, p. 28).

Podder (2014a, p. 222) provides valuable insight into NSAGs use of humanitarian aid to “bolster popular perceptions about their commitment and capacity”, in other words to increase their own legitimacy. This is done when these groups expand from providing security to local communities into service provision such as healthcare. They do this two ways: first “by establishing control over the distribution of basic services (healthcare, water, food, education, sanitation), channelled through third-party providers such as NGOs and aid agencies into territories under their control”; and second, they establish “their own NGOs or humanitarian wings engaged in the provision of welfare services” (2014b, pp. 1622–1623). Podder distinguishes between “bottom-up” systems that are “indigenous, locally developed responses to contingencies and gaps in the provision of services or state presence”, and “proxy arrangements” that are propped up by external support such as from INGOs (Podder, 2014b, pp. 1629–1630). She concludes that these indigenous non-state systems have a better chance of sustainability when they connect with state institutions.

<sup>19</sup> Based on this typology, the RCSS/SSA-S is an NSAG with an ethnic support base, that enjoys “stronger social and political legitimacy in the post-war period” (Podder, 2013, p. 28), as marked in red in Figure 2.5 above.

Whichever way NSAGs are characterised, they are a reality in conflict-affected states, so the international community must find appropriate ways to deal with their emergent role in health system development.<sup>20</sup> The following section turns to the role of community health workers (CHWs) in these systems.

### **2.3.3 Community health workers and medics: The foundation of health systems**

At the time of writing there has been renewed attention to the critical role of CHWs as part of effective localised efforts to strengthen health workforces to improve health outcomes and meet SDG 3. INGOs and international organisations like the World Health Organization are now paying serious attention to CHWs as they emerge as the critical element in health systems that will ensure that health services are provided to poor and marginalised communities (Walker, Downey, Crigler, & LeBan, 2013, p. 3). This interest is reflected in the development of guidelines and resources to better support the training and practise of CHWs to strengthen health systems (Cisney, 2016; United States Agency for International Development, 2015; World Health Organization, 2016b).

‘Community health worker’ is a term frequently used, but with little consensus as to a common definition due to wide ranging roles, irregular naming practices, and a great deal of heterogeneity in CHW training processes (Olaniran, Smith, Unkels, Bar-Zeev, & van den Broek, 2017, p. 1). The systematic review by Olaniran et al. (2017) does not provide a universal definition but differentiates CHWs from other health workers as having less than three years preservice training, and as:

...individuals with an in-depth understanding of the community culture and language, have received standardised job-related training which is of shorter duration than health professionals, and their primary goal is to provide culturally appropriate health services to the community. (Olaniran et al., 2017, p. 8)

Recognising the significant contribution of CHWs to improving health outcomes (Perry, Zulliger, & Rogers, 2014; Schneider, Okello, & Lehmann, 2016), there is a greater interest in exploring the complexities faced by them in their role. It is now acknowledged that while CHWs are urgently required to meet desperate health needs, their importance is still

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<sup>20</sup> These authors have addressed partnerships with non-state armed groups more specifically in Myanmar (Lall & South, 2014; South & Joll, 2016; South & Lall, 2016).

unrecognised and marginalised within these systems, meaning they are unable to reach their full capabilities (The Lancet Global Health's Editors, 2017, p. e467).

Kok et al. (2015, p. 11) highlight a number of factors that influence how CHWs perform, including: "contextual factors related to community (most prominently), economy, environment, and health system policy and practice". Research already indicates that:

When CHWs are appropriately selected, trained, and supervised, and when they are provided with appropriate supplies, medicines, and equipment, CHWs can improve key health-related behaviors, extend the accessibility of key services, and strengthen linkages between communities and health services [therefore] CHWs should become an integral part of health systems as they strive to improve their quality, coverage, and impact on population health. (Perry et al., 2014, p. 412)

As such, the research aims to understand the factors and context that influence CHWs, as well as the personal characteristics of CHWs (see also Kok, Dieleman, et al., 2015, p. 1213), as this can enable better programme planning and implementation for improved healthcare outcomes.

## **Conclusion**

The chapter aimed to locate this research within two bodies of literature: that on 'fragile states' to provide the wider context, and the growing body of work on health system development in conflict-affected contexts. It showed that the process of defining, measuring, and then operationalising the 'fragile states' paradigm operates largely in the self-interest of the Global North and that the international aid community's new development agenda on 'fragile states' is embedded in the security-development nexus due to global security concerns, and because these states failed to achieve the Millennium Development Goals. This has led to the international community prioritising state- and peace-building development initiatives over poverty alleviation efforts. The OECD has developed a more nuanced analysis of state fragility as encompassing political, societal, economic, environmental, and security dimensions (OECD, 2016, p. 37). Myanmar is classified as at extreme risk in the political, societal, environmental and security dimensions. Although the terms 'fragile states' and 'conflict-affected states' are often conflated, I have proposed the term 'conflict-affected contexts' as a more useful, and less pejorative description of Shan State, Myanmar for this thesis. This research examines the

role of non-state actors such as INGOs and non-state armed groups in a development programme, so the turn to more localised and hybrid responses to state- and peace-building in these contexts was also explored. This approach offers space for these development actors to engage in bottom-up, locally appropriate responses to development issues (Boege et al., 2009, p. 20).

The chapter then explained the impact that conflict has upon health outcomes for marginalised communities and explored the question of whether improving state provision of services, such as healthcare, leads to state legitimacy (Slater et al., 2012). The chapter argued that the goal of health systems strengthening in conflict-affected contexts should centre on improving health outcomes (Philips & Derderian, 2015, p. 6), rather than increasing state legitimacy. The key actors in health system development were introduced, and non-state armed groups were affirmed as a legitimate development actor in localised, alternative health system development. If Sustainable Development Goal 3 on health is to be met in conflict-affected contexts, then context-specific ways to address critical health workforce shortages must be implemented that include these actors.

In addressing the third research objective, the chapter has identified some of the more general impacts of conflict-affected contexts on health system development. Chapter 5 will provide more context-specific detail about the research location to fulfil the research objective. The next chapter presents the conceptual framework for the research, based on the capabilities approach. This will be used to analyse crucial components of alternative health system development to meet the research aim of understanding how the approaches taken by an INGO support the capabilities of this health system.



## **Chapter 3: A capabilities framework for alternative health system development in conflict-affected contexts**

### **Introduction**

This chapter presents the conceptual framework for the research: **the capabilities framework for health system development in conflict-affected contexts** (hereafter the 'health capabilities framework'). The health capabilities framework will be used to better understand how the approaches taken by Partners Relief and Development (Partners), in partnership with the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), enable the development of alternative health system capabilities in Shan State, Myanmar.

First, the chapter introduces the integral concepts of Amartya Sen's (1999, 2005, 2009, 2013) capability approach and Martha Nussbaum's (2000, 2011) capabilities approach (both are referred to as the capabilities approach). The capabilities approach is understood to be a "broad normative framework for the evaluation and assessment of individual well-being and social arrangements" (Robeyns, 2005b, p. 94). Central to the capabilities approach is a focus on the expansion of freedoms (capabilities), and the realisation of those freedoms (functionings). The second section explains how the notion of health justice is grounded in the capabilities approach. This is central to the research which regards the development of an alternative health system as a social justice issue for conflict-affected communities. The chapter then addresses some of the critiques and limitations of the capabilities approach. Section 4 moves on from the more philosophical elements of the capabilities approach to demonstrate its operation in other research. Finally, key elements of the capabilities approach are assembled to be used as the analytical concepts in my health capabilities framework<sup>21</sup> for this research.

### **3.1 The emergence of the capabilities approach**

#### **3.1.1 Rights-based approaches to development: The roots of the capabilities approach**

The capabilities approach and its concern for quality of life and wellbeing arose from rights-based approaches to development. Rights-based approaches were informed by the seminal work of Sen and his concept of the human right to development (2000, 2001,

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<sup>21</sup> Creswell and Poth (2018, pp. 15-23) refer to this as the interpretive framework of the research, or the combination of the ontology, epistemology, axiology (values of the researcher), methodology, and the theoretical orientation of the research.

2002, 2004). He advanced the idea that rights could be progressively realised when “*equity and justice* [emphasis added] are primary determinants of development” (2001, p. 2535). Rights-based approaches gained prominence after World War II with the establishment of the United Nations (UN), and gradually became consolidated into UN frameworks, starting with the Universal Declaration of Human Rights (United Nations, 1948). In the 1970s, a radical push by a body of newly independent and developing countries to incorporate economic, social and cultural rights into development approaches culminated in the UN Declaration on the Right to Development in 1986 (Mohan, 2016; United Nations, 1986).

Rights were further integrated into the UN framework in the post-Cold War era through the Vienna Declaration and Programme of Action in 1993 (United Nations, 1993) that led to the creation of the United Nations Commission on Human Rights. By the 1990s, rights had also surfaced in development discourse as international non-governmental organisations (INGOs) incorporated them into their praxis (Cornwall & Nyamu-Musembi, 2004, 2005; Gready, 2008; Gready & Ensor, 2005; Kindornay, Ron, & Carpenter, 2012). INGOs integrated basic needs and service delivery approaches together with social justice issues through these rights discourses. The rights-based paradigm was further conceptualised into the capabilities approach, by its two most prominent theorists: Sen and Nussbaum. What follows is an elaboration of Sen’s and Nussbaum’s conceptualisations of the capabilities approach.

### **3.1.2 Sen’s capability approach: Development as freedom**

Sen’s capabilities approach has been selected as the basis of the conceptual framework for this research because of its orientation towards the assessment of quality of life, freedoms, rights and wellbeing (1999, 2005, 2009, 2013). This is of relevance to the research context of Shan State, Myanmar where injustices and a lack of health and wellbeing are prevalent due to ongoing conflict (this will be detailed in Chapter 5). Sen instigated his fundamental concept of ‘development as freedom’ as a critique of utilitarian economic frameworks that dominated notions of development progress. He stressed the link between human rights and capabilities stating that they “go well with each other, so long as we do not try to subsume either concept entirely within the territory of the other” (Sen, 2005, p. 151). One of the concrete outcomes of Sen’s initial work on the capabilities approach, in concert with the economist Mahbub Ul Haq, was the advancement of the United Nations’ Human

Development Index. Robeyns (2006) reiterates the capabilities approach’s move away from an economic paradigm, stating that the:

...core claim of the capability approach is that assessments of the well-being or quality of life of a person, and judgements about equality or justice, or the level of development of a community or country, should not primarily focus on resources, or on people’s mental states, but on the effective opportunities that people have to lead the lives they have reason to value. (Robeyns, 2006, p. 351)

### ***Functionings and capabilities***

The fundamental attributes of Sen’s capabilities approach that form the central elements of the conceptual framework for this research are functionings, capabilities, resources and conversion factors. The action of resources and conversion factors upon capabilities to convert them into achieved functionings is illustrated in Figure 3.1 below, and incorporated in my health capabilities framework in section 3.5.

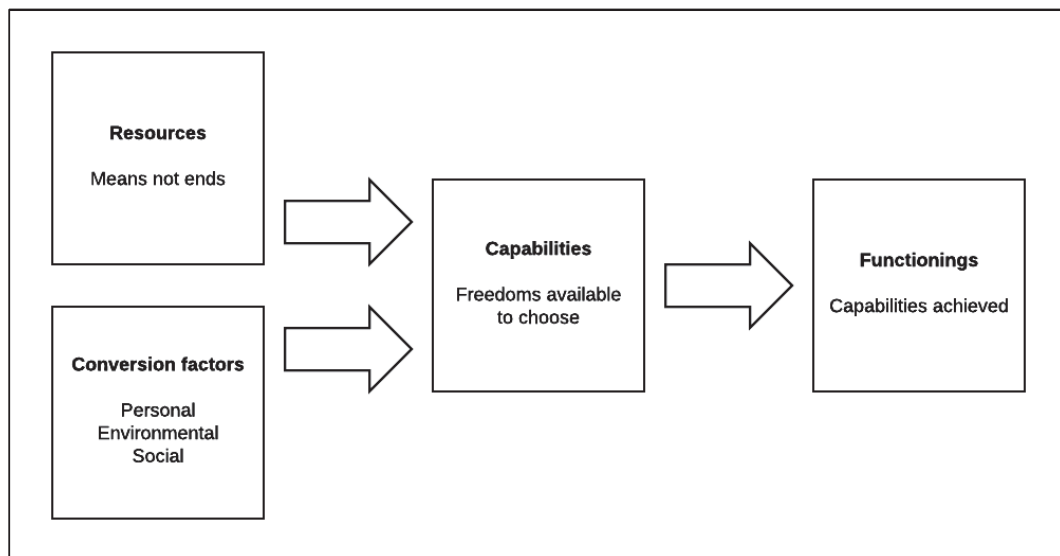


Figure 3.1: Outline of the core concepts of Sen’s capability approach (Source: adapted from Wells, 2017).

Capabilities are the opportunities or freedoms that an individual possesses, while in contrast, functionings are the actual achievements or realisation of those freedoms/capabilities (Crocker & Robeyns, 2010, p. 63; Hick, 2012, p. 292; Robeyns, 2005b, 2017, pp. 38–41). Sen defines functionings as the “things a person may value doing or being”

(Sen, 1999, p. 75). Robeyns labels these outcomes as “beings and doings” (Robeyns, 2003, p. 63).

Alternatively, capabilities are defined as the freedom and possibility to achieve these “beings and doing”. For Sen (2013), the focus is on freedoms being what a person values, stating that:

Human freedoms include the fulfilment of needs, but also the liberty to define and pursue our own goals, objectives and commitments, no matter how they link with our own particular needs. (Sen, 2013, p. 6)

The difference between functionings and capabilities can be summarised as “between achievements, on the one hand and freedoms or valuable options from which one can choose, on the other” (Crocker & Robeyns, 2010, p. 63). Therefore, an individual may possess capabilities that they choose not to or are not able to convert into achieved functionings. For example, a person may value and have the capability to be healthy, but lack the opportunity to achieve the outcome of being healthy. Sen (1999) established the idea that capabilities are valuable in and of themselves and not simply something that is only ‘utilised’, in an instrumentalist sense, to achieve various ‘goals’.

### ***Resources and conversion factors***

The other integral components of the capabilities approach that are incorporated into the health capabilities framework are the resources available to a person (Robeyns, 2017, pp. 145–147), and the conversion factors that act upon capabilities (Robeyns, 2017, pp. 45–47). Unlike economic frameworks, resources are not seen as only an end in themselves, but as a means to convert capabilities into functionings (Hick, 2012, pp. 304–306). This enables us to differentiate the resources that various individuals or groups require to achieve the capabilities that are valuable to them. Robeyns (2003) also highlights the fact that people have differing abilities to convert those resources into functionings, writing that:

Resource-based theories do not acknowledge that people differ in their abilities to convert these resources into capabilities, due to personal, social or environmental factors, such as physical and mental handicaps, talents, traditions, social norms and customs, legal rules, a country’s public infrastructure, public goods, climate, and so on. (Robeyns, 2003, p. 63)

Robeyns (2005b) further explains that it is not enough to evaluate available resources as an end themselves as this alone does not help us to understand what functionings someone can achieve.

Conversion factors provide more information on a diversity of circumstances. These factors enable or constrain the functionings of capabilities. Crocker and Robeyns (2010) categorise the conversion factors described in Sen's work into three groups as follows:

*Personal conversion factors* are internal to the person, such as metabolism, physical condition, sex, reading skills, or intelligence...*Social conversion factors* are factors from the society in which one lives, such as public policies, social norms, practices that unfairly discriminate, societal hierarchies, or power relations related to class, gender, race, or caste...*Environmental conversion factors* emerge from the physical or built environment in which a person lives. (Crocker & Robeyns, 2010, p. 68)

All three of these conversion factors are incorporated into the health capabilities framework to evaluate systemic aspects that help or hinder the achievement of medic capabilities in the research context.

### ***The flexibility of the capabilities approach***

The selection of specific capabilities to be used in this research is guided by Sen's broad conceptualisation of how the approach can be applied. Robeyns (2003) articulates that:

Applications of Sen's capability approach can be very diverse. They can be academic, activist, or policy-oriented. They can be abstract and philosophical, or applied and down-to-earth. They can be theoretical or empirical. They can concern social, political, economic, legal, psychological, or other dimensions of advantage, taken together or individually or in any combination. They can be specified for the global or the local context. And so forth. (Robeyns, 2003, p. 68)

Particularly germane to this research examining the role of the RCSS/SSA-S as a non-state actor, is Robeyns' contention that a pragmatic rather than idealistic view should be taken of what can be expected from governments and instead "focus on non-governmental agents of justice" (Robeyns, 2016, pp. 402-403).

Also supporting Sen's flexible view of the capabilities approach, Alkire (2005, 2007, 2008, 2010; Alkire & Santos, 2013) describes the concrete application of the capabilities approach as "more art than science" (2005, p. 129), due to its wide-ranging flexibility. She makes four observations about the capabilities approach's operationalisation (2005, pp. 127–128). First, functionings and capabilities will need to be selected for each specific piece of research, rather than being settled upon definitively. Second, operationalisation can happen in many contexts exploring many different problems. Third, it is a feasible approach that can be applied to concrete problems. Lastly, because the capabilities approach is flexible it contributes well to the methodology and methods chosen for this research, as will be detailed in Chapter 4.

Alkire (2007) also maintains that the process of selecting capabilities for evaluation research, such as this, must be explicit. She frames this view by asking "how should researchers decide 'what matters'?" (2007, p. 1). Five processes for making capabilities selections are outlined as follows:

- (i) utilizing existing data; (ii) making assumptions that are perhaps theory-based; (iii) taking advantage of existing lists generated through consensus; (iv) employing current deliberative participatory processes; and (v) proposing dimensions based on empirical studies of people's values and/or behaviours. (Alkire, 2007, p. 1)

This research initially employed the second process, starting with what Alkire (2007, p. 7) labels "informed guesses of the researcher", as to what capabilities should be incorporated into the conceptual framework for the analysis of the research findings. These, and the conversion factors, were further refined by an iterative process during data generation, as participants confirmed that these were components that they themselves valued (see section 3.3 for a discussion as to why a definitive list wasn't used). They will be incorporated into the final analytical framework in Chapter 8.

### **3.1.3 Nussbaum's capabilities approach: Social justice**

Nussbaum's (2000, 2011) capabilities approach builds on Sen's work and further establishes its relevance to this research as it is also:

...committed to the attainment, for all, of lives that are worthy of that equal dignity...is sensitive to distribution, focusing particularly on the struggles of traditionally excluded or marginalized groups. (Nussbaum, 2011b, p. 186)

Nussbaum's capabilities approach is distinguished from Sen's by providing a normative, general list of capabilities that she conceptualises as a "partial account of social justice, a set of basic entitlements without which no society can lay claim to justice" (Nussbaum, 2003, p. 36). Although the research does not utilise Nussbaum's list, because of its concern with health outcomes it supports items that Nussbaum has included on the list, such as health, living a normal life expectancy, and freedom of movement (Hugman, 2012, p. 25).<sup>22</sup>

Nussbaum (2011a, p. 29) holds that the capabilities approach grounds abstract concepts of human rights into local realities, preventing rights and justice from becoming an imposition of external ideas upon communities. Vizard, Fukuda-Parr and Elson (2011) also support the intertwining of rights and capabilities within the capabilities approach, maintaining that it is a:

...practical framework in which the substantive human rights position of individuals and groups can be evaluated and better understood. When applied as an analytical model, the capability framework captures the freedoms and opportunities that are within a 'person's reach' (a person's 'capability set') as well as the underlying variables that explain this set (entitlements, contextual variables, conversion factors, etc.). (Vizard et al., 2011, p. 4)

Sen's and Nussbaum's capabilities approaches, grounded in a concern with rights and justice, provides an appropriate framework to evaluate the diverse elements that contribute towards the functionings of health workforce capabilities in the research. My framework critically examines specific social and environmental systems that act as structural constraints upon the conversion of capabilities into functionings (Hugman, 2012, p. 35; Robeyns, 2005b, p. 108).

Having explained the basis of the capabilities approach, the chapter now turns to consider the relationship of the capabilities approach to the concept of health justice, which is central to this research.

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<sup>22</sup> Although this research doesn't use Nussbaum's list, Hugman posits that the list provides a set of goals for development policy and practice as it conceptualises a set of achievable capabilities that cross "national, ethnic, class and gender divisions" (Hugman, 2012, pp. 27–28).

## 3.2 Health justice and the capabilities approach

The research context of Shan State, Myanmar can be characterised as having an absence of health justice (see Chapter 5). Marginalised communities currently experience extremely poor health outcomes due to ongoing conflict and the lack of government health service provision (Davis & Jolliffe, 2016). As such, it is important to explore the small body of work that advances the capabilities approach's focus on health justice. Much of the capabilities approach literature highlights social justice issues, reflecting Sen and Nussbaum's explicit concern with justice.<sup>23</sup> Importantly, the capabilities approach provides scope to equally accommodate concerns for social justice issues and poverty reduction (Alkire, 2005, p. 117). Justice ensues when individuals possess a set of capabilities, and the ability and structural conditions to transform these capabilities into functionings (Begon, 2017, p. 157). Sen clearly distinguishes health as a human right and argues that there "are political, social, economic, scientific, and cultural actions that we can take for advancing the cause of good health for all" (Sen, 2008, p. 2010). Sen's 'health as a human right' ideal is reflected in Sustainable Development Goal 3 (SDG 3) to "ensure healthy lives and promote well-being for all at all ages" (United Nations General Assembly, 2015, pp. 16–17). Sen also maintains that the ability of people to fully achieve their functionings is influenced by their possession of good health (Sen, 1999, p. 5).

Currently, the most thorough account of health justice is found in the work of Venkatapuram (2011, 2013), who proposes that the capabilities approach is especially conducive to the concept of health justice. Rather than seeing health from the scientific understanding as an absence of disease, he views health as a meta-capability: "an overarching capability to achieve a cluster of basic capabilities to be and do..." (2011, p. 20). He notes that it is important to clearly conceptualise what health is, due to the increase in development programmes focused on healthcare (Venkatapuram, 2013, p. 271). Health must be seen as a function of justice as:

When health is properly understood as achieving vital goals, and the moral entitlements to the capabilities to achieve these vital goals are duly recognized as basic political principles grounded in freedom and equal

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<sup>23</sup> Sen and Nussbaum have both also written extensively about gender inequality and reinforced the need for gender justice, although a specific focus on gender justice is outside the scope of this research.

dignity, the health of citizens becomes the first priority of social justice, and one of the most basic values of society. (Venkatapuram, 2013, p. 279)

I contend that SDG 3 provides the necessary, widely agreed framework within which to conceptualise health (United Nations General Assembly, 2015, pp. 16–17). SDG 3 also provides a set of measurable targets and indicators for improved health outcomes, which will in turn demonstrate the presence of health justice in marginalised communities such as in Shan State, Myanmar.

While Nielsen (2015, p. 413; 2017) shares Venkatapuram’s perspective that “health is a valuable capability from the point of view of justice”, he considers that seeing health as a meta-capability overstates its importance in achieving capabilities. He takes a different approach by linking three distinct aspects of health to justice:

- (i) The functioning value of health: Health is intrinsically valuable because some level of health-functioning is important to people’s life, regardless of their own perception of the value of achieving this health-level.
- (ii) The agency value of health: Health is intrinsically valuable because it carries the freedom to choose valuable goals, regardless of whether people appreciate this freedom.
- (iii) The fertile-functioning value of health: Health is instrumentally valuable because some level of health is a prerequisite for effective access to other valuable capabilities. (Nielsen, 2015, p. 413)

Despite not seeing health as a meta-capability, Nielsen’s view is still congruent with Venkatapuram’s position that the capabilities approach fundamentally supports health justice.<sup>24</sup>

The connection between the capabilities approach and the concept of health justice has thus been established. This research contends that the development of an alternative health system in Shan State, Myanmar should lead to the provision of health justice, and the achievement of SDG 3. This is underpinned by the capabilities approach which enables

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<sup>24</sup> In contrast, Selgelid (2016) does not view health as a meta-capability, but rather a functioning that enables capabilities (2016, p. 31). He does not view the capabilities approach as necessary to addressing health inequities (2016, p. 33), and disputes the connection of justice entitlements to health.

an analysis of the functioning of health workforce capabilities to provide healthcare, and consequently, health justice to their communities.

The following section briefly addresses some of the critiques and limitations that have been identified in capabilities approaches, and that have been considered in the development of the conceptual framework for this research (seen in section 3.5).

### **3.3 Critiques and limitations of the capabilities approach**

#### ***To use a definitive list of capabilities?***

Before discussing how the capabilities approach can be operationalised in research, this section considers some of the limitations that have been identified with the approach. One of the questions raised is whether to have a definitive list of capabilities. Sen has not created a list of capabilities or functionings (Gasper, 2007, pp. 344–346).<sup>25</sup> Unlike Sen, Nussbaum proposes a definitive list of central human capabilities, arguing that Sen’s reluctance to produce a list limits possible applications of the approach (D. Clark, 2005, pp. 5–6; Nussbaum, 2003, 2011a; Robeyns, 2005a, pp. 195–198). However, Sen emphasises the importance of individual and collective agency in deciding which capabilities and functionings are important to them (Crocker & Robeyns, 2010). He maintains that a list restricts the evaluation of capabilities that are “suitable for different purposes and in different contexts” (Burchardt & Vizard, 2011, p. 95), and an already established list obviates public discussion to decide upon suitable capabilities (Sen, 2004, p. 77). He stresses that the process of selecting capabilities should be transparent and adaptable to each context (Sen, 2004, p. 78).

Others also regard having no definitive list as affording the researcher greater flexibility in different contexts (Alkire, 2005, p. 128; Fukuda-Parr, 2003, p. 302). Sen, himself, has used the flexibility of the approach from “...the conceptualization and measurement of development, to theories of justice and rights to issues about poverty, gender and social exclusion and disability...” (Qizilbash, 2012, p. 9). The approach offers the researcher choice to use capabilities and functionings as two, among many, possible components of their evaluation research (Qizilbash, 2012, pp. 15–17). Frediani (2006, p. 3) proposes that the capabilities approach’s adaptability contributes a “comprehensive and flexible theory of well-being that can capture the multiple, complex and dynamic aspects of poverty.”

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<sup>25</sup> Sen, instead, proposes a list of five complementary instrumental freedoms: political freedoms; economic facilities; social opportunities; transparency guarantees and protective security (Sen, 1999, p. 38) which Gasper argues can be seen as a list (2007, p. 344).

Likewise, Alkire (2005, p. 128) explains that Sen's insistence on flexibility shows an appreciation for the agency of the researcher.

Following Sen, this research has adopted a flexible approach and has incorporated specific capabilities that are valued by the participants as they emerged from findings, instead of adopting a definitive list of capabilities.

### ***The inclusion of collective agency, systems and structures***

As this research explores both individual and collective medic experiences of the Shan Healthcare Training Programme, as well as the relationships between different groups of actors, it is important to address the debate as to whether the capabilities approach is too focused on individual capabilities (Gasper, 2002; Stewart, 2005, 2013). Some also claim that the capabilities approach inadequately accounts for structures and their part in helping or hindering functionings (Gore, 1997; Ibrahim, 2006). Deneulin (2008, p. 111) notes the central importance of structures as these "can have a negative effect upon the good living of its members, such as structures of inequalities and oppression caused by an unequal distribution of power". Robeyns (2005b, p. 107) clusters these concerns about individualism and structure into three claims about the capabilities approach: that it fails to see individuals within their social environment; that it fails to account for group actions; and lastly, that it does not examine social structures. However, Robeyns (2005b, p. 108) disputes these claims and contends that Sen's work is not underpinned by "ontological individualism" but does recognise "the connections between people, their social relations, and their social embedment".

Likewise, in her work utilising the capabilities approach as the conceptual framework for the United Nation's Human Development Reports (<http://hdr.undp.org/>), Fukuda-Parr (2003) situates both individual and collective action, stating:

Human beings can be agents of change through both individual action and collective action. Individual action shapes development through activities such as the upbringing of children. Collective action is an important force that can pressure changes in policies and bring about political change. (Fukuda-Parr, 2003, p. 309)

Adopting a similar position concerning collective agency, Crocker and Robeyns (2010, p. 79) hold that people live both individually and collectively to achieve valued capabilities variously alone, helping others, and by exerting collective agency.

Similar to Stewart (2005, 2013), this research focuses on the role of Partners, an international non-governmental organisation, and reinforces the essential contribution of social institutions to the achievement of capabilities. Stewart (2013, p. 1) defines the capabilities of these institutions as their social competencies, or “what social institutions can do or be”. She posits that these institutions must have social competencies when engaged in activities that are best performed collectively, such as Partners’ provision of health workforce training. Social competencies emerged as a critical conversion factor in the achievement of medic capabilities during the research, and these will be analysed in Chapter 8, section 8.3.3.

Some of the critiques and limitations of the capabilities approach have been addressed, confirming its flexibility as a strength, rather than a weakness. This makes it appropriate for use in this research. Having outlined the choice to not use a definitive list of capabilities in this research, and established the capacity of the capabilities approach to integrate collective agency, the impact of structures, systems, and social competencies into its evaluative framework, the vexed issue of its practical application will now be addressed in the following section.

### **3.4 The capabilities approach in operation**

A prevailing critique of the capabilities approach is that it is difficult to operationalise in reality due to its fundamentally philosophical nature (Gasper, 2007, pp. 349–350; Qizilbash, 2012, p. 15). While Nussbaum states that “capabilities...can be viewed as one species of a human rights approach” (2011a, p. 23), and Sen considers that “human rights and human capabilities have something of a common motivation” (2005, p. 152), Birdsall (2014) strongly contests Sen and Nussbaum’s shared idea that human rights and capabilities reinforce one another. Conversely, he argues that the capabilities approach is a top-down philosophical approach disengaged from the political realities of human rights. He concludes that “...the capabilities approach lacks a foundation in the dynamics of local political struggles. It is a theory seeking to be put into practice” (Birdsall, 2014, p. 11) and therefore does not operationalise human rights in reality.

However, there is a growing body of literature that demonstrates the capabilities approach’s capacity to transcend its philosophical roots into more practical applications, such as a means for analysis in the evaluation of development programmes. This section presents a synthesis of some examples of these applications in diverse fields such as public health initiatives, international development programmes, and social sciences research.

These studies are clustered around seven general themes of shared commonalities as shown in Table 3.1 below, and explicated further in the following sections. They show that measurement and indicator tools can be developed to evaluate capabilities and functionings in specific contexts. However, to date there has been little research done using the capabilities approach to analyse the effectiveness of development programmes specifically in conflict-affected contexts.<sup>26</sup> This research seeks to address this gap by using the capabilities approach as a conceptual framework for research in conflict-affected contexts.

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<sup>26</sup> One possible exception is Andrews, Pritchett and Woolcock (2017; 2013) who utilise the terminology 'state capability' in their exploration of how to enhance organisational capacity at the state level for development. However, although they address the issue of 'fragile states', their use of 'capability' is a semantic replacement of the much-used development term 'capacity' rather than any claim for engagement with the capabilities approach.

Table 3.1: A selection of studies that have operationalised the capabilities approach

Area of research	Authors
Health justice; health economics; public health evaluation	Al-Janabi, Flynn, & Coast, 2012; Ferrer, Cruz, Burge, Bayles, & Castilla, 2014; Lorgelly & Lorimer, 2008; Lorgelly, Lorimer, Fenwick, Briggs, & Anand, 2015; Panzironi, 2012; Venkatapuram, 2011
Human Development Report; human/economic development; social & rights indicators; public policy	Conradie & Robeyns, 2013; Fukuda-Parr, 2003, 2011a; Vizard et al., 2011
Gender; quality of life measurement; multi-dimensional poverty measurement; public policy	Greco, Skordis-Worrall, Mkandawire, & Mills, 2015; Mehrotra, 2014
Development programme management; participatory monitoring and evaluation	Biggeri & Ferrannini, 2014; Muñiz Castillo, 2014; Schischka, 2012; Schischka, Dalziel, & Saunders, 2008
Welfare economics; social evaluation; capability indicators	Anand et al., 2009; Anand, Hunter, & Smith, 2005
Equality and human rights monitoring; inequality measurement; determinants of empowerment	Burchardt & Hick, 2017; Burchardt & Vizard, 2011; Trommlerová, Klasen, & Leßmann, 2015
Indigenous worldviews; wellbeing	Yap & Yu, 2016

(Source: Author)

### 3.4.1 Health research

Among the more pertinent studies to this research that use the capabilities approach, are a limited number with a health focus, particularly the evaluation of health programmes. One investigation that used the capabilities approach to assess specific health behaviours and adopt appropriate public health policies and interventions to enable the achievement of health capabilities in disadvantaged populations in the Global North is a study by Ferrer, Cruz, Burge, Bayles, and Castilla (2014). This study examined the personal and

environmental constraints that may act upon the opportunity to make good behaviour choices. They distinguish the agency to make those choices from having available opportunities to choose from. Available resources and conversion factors were also included in their analysis. They conclude that by assessing capabilities, more appropriate public health policies can be developed that can recognise and mitigate the constraints upon healthy choices (Ferrer et al., 2014, p. 54).

Similarly, the capabilities approach has also proven a useful instrument to evaluate public health interventions and “measure the effectiveness (and thus cost effectiveness) of public health interventions and programmes” (Lorgelly & Lorimer, 2008; Lorgelly et al., 2015, p. 79). It is particularly useful when assessing a wide range of possible outcomes beyond health improvements. Significantly, they encountered some difficulty in using the conceptual terms of the capabilities approach such as functioning, capability, opportunity and freedoms with participants (Lorgelly et al., 2015, p. 73). Accordingly, the terminology used in the interview guides for this research was modified to mitigate possible confusion (see Appendices 8-12). Another study used participatory methods to develop a capability wellbeing measure focusing on the freedom an individual has to function, and for use in evaluating the effectiveness of health interventions (Al-Janabi et al., 2012, pp. 173–174). Al-Janabi et al. (2012, p. 167) considered “health status as an influence over broader attributes of capability wellbeing”. This calls attention to the iterative nature of health and wellbeing both as an end itself, and as a means to achieve valuable capabilities.

Panzironi (2012) used the capabilities approach to develop a conceptual and policy framework, with a distinct connection to human rights, to evaluate a government Indigenous health policy to reduce health inequities. Her framework advances Indigenous conceptualisations of health and traditional medicine to advocate for an Indigenous right to health through the concept of ‘capability-rights’. ‘Capability-rights’ incorporate two critical aspects of Sen’s notion of freedom (2012, pp. 71–73). The ‘opportunity aspect’ of freedom highlights the ability of a person to achieve objectives that they value, while the ‘process aspect’ addresses the processes involved in the selection and achievement of those goals. The framework for this research incorporates a similar focus when it explores the conversion factors, including relationships and processes, that act upon the functionings of capabilities valued by an individual or group.

### 3.4.2 International development programmes

The United Nations (UN) Human Development Report is the most prominent example of the capabilities approach in operation in international development. In her work as a development economist with the UN, Fukuda-Parr (2003, 2011a, 2011b, 2012; Vizard et al., 2011) was especially influential in adopting the capabilities approach as a framework for the Human Development Report. The capabilities approach provides the rationale for the notable advancement of including gender sensitivity in its analysis, as:

...the philosophical foundation of equality of capabilities and freedoms, focusing on individuals as the objective of gender in development; the evaluative aspect of capability expansion; the agency aspect of capability expansion; measurement tools of the above. (Fukuda-Parr, 2003, pp. 313–314)

Fukuda-Parr (2011a) also adopts the position shared by Sen and Nussbaum that capabilities and human rights are interconnected approaches. She also emphasises the policy implications of the capabilities approach due to its emphasis on the “intrinsic value rather than instrumental value of development goals such important capabilities as education, health, employment, and participation” (Fukuda-Parr, 2011b, p. 124). Vizard, Fukuda-Parr and Elson’s (2011) work linking capabilities and human rights is of particular relevance to this research as it situates the human right to health as a concern for research utilising the capabilities approach.

Some scholars (Frediani, 2006, 2008, 2010; Frediani, Boni, & Gasper, 2014) stress how the capabilities approach complements both participatory research methods and development project planning, management and evaluation. Like Frediani (2008), this research seeks to explore the relationships between different actors in the Shan Healthcare Training Programme, asking similar questions to:

Are communities being empowered and being agents of change, or are they just being consulted, manipulated or co-opted to the implementation of pre-established objectives? Is power being shared with and within communities? Opportunity also relates here to the excluded and marginalised within communities, are they also being able to participate in the decision making process? (Frediani, 2008, p. 8)

Frediani (2010) argues that employing the capabilities approach enables existing power structures in these relationships at the local, national and international levels to be addressed, requiring:

(a) a focus on the conversion factors, transforming resources into achieved functionings; (b) the incorporation of power relations analysis in such processes; and (c) mechanisms to include participatory methods in the application of the Capability Approach. (Frediani, 2010, p. 178)

These three aspects have been incorporated into my health capabilities framework for this research, to be described in section 3.5.

Keeping with Frediani (2010, p. 176), this research focuses more on available opportunities, than being able to clearly evaluate the actual achievement of capabilities, because it was not possible to evaluate the actual achievements of the medics within their communities inside Shan State due to access issues (see Chapter 4, section 4.3.3 regarding research limitations). Frediani (2008, p. 1) contends that, without these appropriate opportunities, capacity building programmes will not enable the achievement of capabilities, such as opportunities provided by the Shan Healthcare Training Programme.

The value of using the capabilities approach in development programme evaluations is also highlighted by Muñiz Castillo (2014), who assessed their impact upon individual autonomy to achieve capabilities. Critical processes such as relationships, organisational practices, and their concomitant power relations, are essential to evaluate as:

...when project practices constrain the opportunities and felt competence of individuals to help themselves, the “development” or change promoted by those projects will not be sustained. If instead project planners and managers consciously select autonomy-supportive practices and adapt them to specific contexts, projects will have far greater chances of furthering sustainable human development. (Muñiz Castillo, 2014, p. 95)

Biggeri and Ferrannini (2014, p. 74) argue that the capabilities approach provides an innovative framework for development programme management to “sustain people-centred development, giving salience to the individual’s and communities’ experience, values, aspirations and participation (i.e. to processes)”. Their research focuses on identifying context-specific ‘opportunity gaps’ between an individual or groups’

capabilities and their achievement of valuable functionings which can then enable more appropriate interventions to overcome these constraints. As with Muñiz Castillo's study, Biggeri and Ferrannini (2014, p. 74) also based their research methodology on "on local stakeholders' knowledge of their community context, together with their values, desires and aspirations, thus nurturing also a process of local empowerment and communitarian brainstorming on policy actions".

The combination of the capabilities approach with participatory methodologies in programme management processes is further elucidated by studies which provided "the chance to find out the perspective of these people who are sometimes marginalized from mainstream society and often not given a voice in the decision making that affects their lives" (Schischka, 2012, p. 166; Schischka et al., 2008). These studies reinforce the capabilities approach's support of participatory methodologies, and the use of focus groups - a data generation method used in this research.

### **3.4.3 Social science research**

The applicability to this research of the studies on welfare economics, human rights monitoring, and indigenous worldviews is less direct but they are nonetheless included in Table 3.1 above to illustrate the operationalisation of the capabilities approach in a variety of epistemological contexts. Some authors propose that more work is needed to develop context-specific capabilities lists and indicators that can provide relevant statistical data to link economic development more clearly to wellbeing (Anand et al., 2009, 2005; Anand, Santos, & Smith, 2007). Others have developed a capabilities approach framework for measuring human rights in countries of the Global North (Burchardt & Vizard, 2011) and suggest that the capabilities approach should understand distributional inequality better (Burchardt & Hick, 2017). Yap and Yu (2016, p. 327) emphasise that using the capabilities approach enables Indigenous worldviews of wellbeing to be incorporated into research as it places "the person at the centre of development; through its evaluative space of capabilities, functionings and freedom, it enriches understanding of the pathways of development and the individual's agency in realising their capabilities". This supports the capabilities approach as offering possibilities for more context-specific approaches for the achievement of Indigenous wellbeing.

This research demonstrates a commitment to the capabilities approach principles of incorporating aspects that individuals have reason to value and participatory approaches. In the same way, Greco, Skordi-Worrall, Mkandawire and Mills (2015, p. 77) also

investigated the possibilities for a wellbeing measure “that can be used to assess and monitor quality of life, and to evaluate policies aimed at improving people's lives” where the capabilities for evaluation are elicited from the women themselves. Notably, they showed that meaningful research data can be generated that centres on capabilities and freedoms, that moves beyond a focus on “people's economic, material and health conditions” (2015, p. 77).

This section has briefly reviewed some studies that have operationalised the capabilities approach in different contexts and used for different purposes to determine its flexibility and utility. Taken together, these studies reinforce the position of the capabilities approach as a flexible, evaluative framework, that is people-centred, interlinked with human rights, and feasible for being operationalised through participatory methods. Capabilities and functionings are selected for evaluation in the specific research context. The capabilities approach provides a framework to examine power structures and relationships and focus on the opportunities that people possess “to transform resources into achieved functionings” (Frediani, 2010, p. 178).

The capabilities approaches’ interconnection to health justice, discussed in section 3.2, provides an opportunity to utilise it more widely as an approach in health focused research. This research positions itself at the intersection of evaluative research of international development programmes, and research that has a specific focus to explore health justice related issues. The next section presents my capabilities framework for health system development in conflict-affected contexts that was assembled for this research.

### **3.5 The capabilities framework developed for the research**

As the chapter has delineated, the capabilities approach provides a broad normative framework to examine and assess individual and group capabilities and functionings, as well as the social relationships and processes in which those functionings are embedded. There has been little qualitative research undertaken on the development of alternative health systems in conflict-affected contexts, particularly examining the factors that enable the capabilities of the health workforce. Thus, a **capabilities framework for alternative health system development in conflict-affected contexts** (health capabilities framework) was developed to provide an analytical approach to conceptualise the factors and relationships involved in this process and is shown in Figure 3.2 below. The components that are assembled into the health capabilities framework will provide a

means to better understand how the approaches that Partners takes in partnership with the RCSS/SSA-S support the development of an alternative health system, in Shan State, Myanmar, and these are now described.

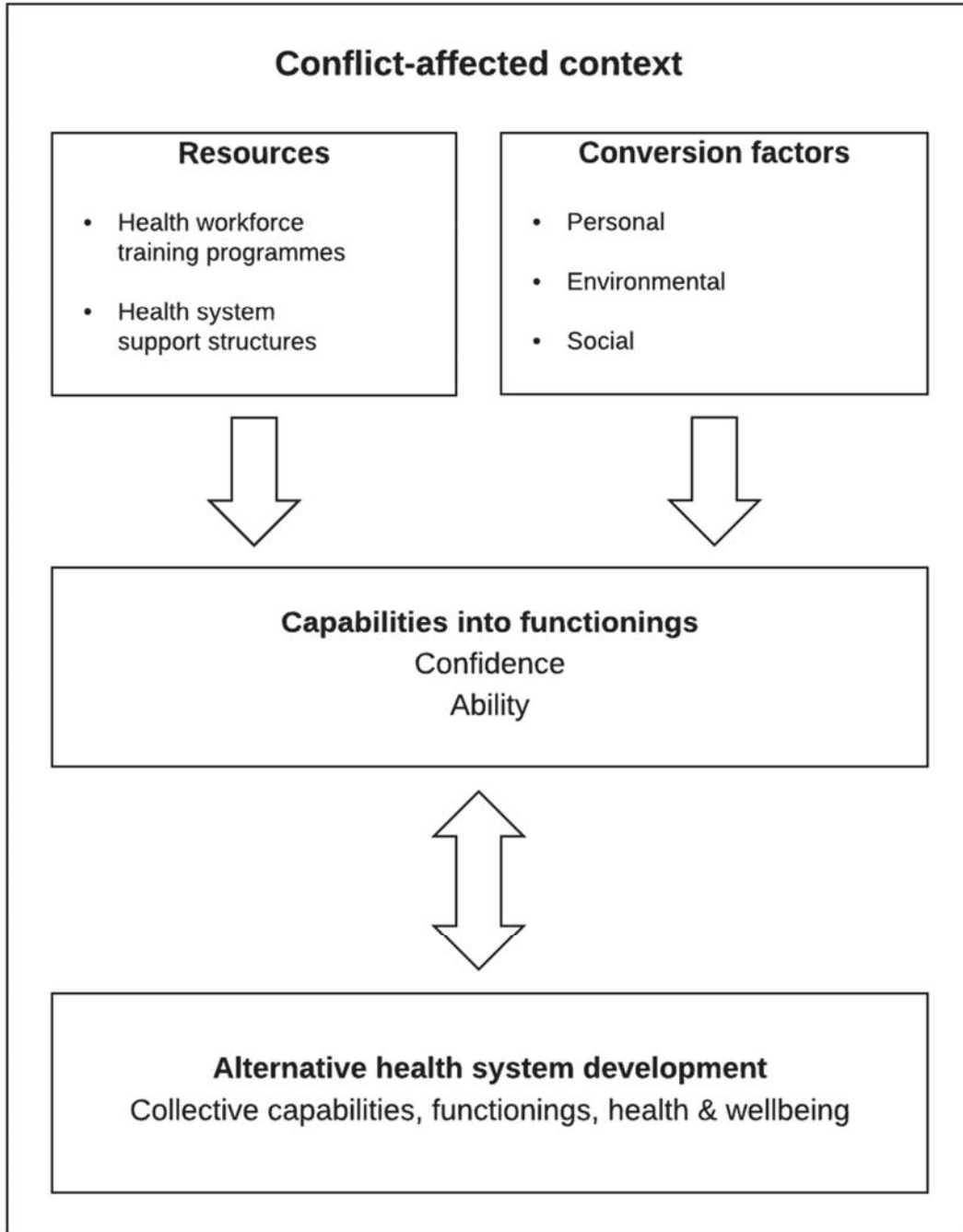


Figure 3.2: The capabilities framework for alternative health system development in conflict-affected contexts (Source: Author).

The third research objective seeks to identify the impact of the conflict-affected context on the capability of the alternative health system to deliver primary healthcare. As such, the health capabilities framework in Figure 3.2 views the process of converting capabilities into achieved functionings as impacted by the wider conflict-affected context. This complex context is considered to be an overarching socio-political and environmental factor that acts upon the achievement of capabilities (Crocker & Robeyns, 2010, p. 68; Robeyns, 2005b, p. 99). The research also uses a case study approach which also necessitates understanding the specific context. To this end, the framework is embedded in the conflict-affected and complex context of Shan State, Myanmar. Health system development in conflict-affected contexts was outlined in Chapter 2 to give further context to the research. The more specific contexts of Shan State, Myanmar and the Shan Healthcare Training Programmes are described in detail in Chapter 5 so their influence on processes and relationships can be better understood.

The second component examines the resources available or the means for achieving capabilities such as training programmes and support structures. The third component is the presence of personal, social and environmental conversion factors. Both the resources and conversion factors components were iterative elements, in that they were included based on their identification in the capabilities approach literature, and then the specifics of what they entailed emerged during the research process to become the basis of the analysis of the findings. The health capabilities framework is used in Chapter 8 to analyse the research findings. The key elements of capabilities and functionings are included in the health capabilities framework, as they are the central components for all capabilities approaches and will enable an evaluation of the effectiveness of Partners' approaches. The directional relationship of the diagram indicates the influence of both resources and conversion factors upon the existing medic capabilities to enable them to transition into functionings. It is important to note that the realisation of medic capabilities of confidence and ability is distinguished as a valuable end in itself. The analysis of these components contributes to meeting research objectives 1 and 2 regarding understanding the relationships involved in the SHTP, and evaluating the effectiveness of Partners' approaches.

Finally, the possibilities for the 'functioning capabilities' to act upon and lead to the collective functionings of a capable alternative health system is shown by the health capabilities framework. These functionings are crucial to the fulfilment of the collective

functioning and wellbeing of the alternative health system. There is an interdependent relationship between the health workforce contributing to the functioning of the alternative health system and, in turn, that system enabling the health workforce to perform well. The eventual goal of a functioning alternative health system is health justice, a meta-capability, which will be evidenced by improved health outcomes and the increased wellbeing of rural communities in Shan State.

## **Conclusion**

Drawing on the small body of literature that integrates the capabilities approach and the notion of health justice (Venkatapuram, 2011, 2013), this chapter has determined that the approach is an appropriate basis for the conceptual framework of this research. The research examines how Partners' approaches enable alternative health system capabilities in a context where health justice is absent. The philosophy, principles, and elements of the capabilities approach established by Sen and Nussbaum were outlined in the first part of the chapter. The connection between the capabilities approach and health justice was then highlighted. Some of the critiques and limitations of the capabilities approach were also addressed, showing that a definitive list of capabilities is not required to be able to utilise it. Evidence of the flexibility of the approach was provided in the fourth section, where the transition of the capabilities approach from a philosophical approach to one that is able to be operationalised in research was illustrated with various examples.

Finally, the capabilities framework for health system development in conflict-affected contexts has been presented. It details the integral components from the capabilities approach that have been assembled into the framework. These include examining the conflict-affected context that the research is embedded in, the available resources provided by Partners and the RCSS/SSA-S, and the possible conversion factors that may enable the functioning of health workforce capabilities. The framework is used in Chapter 8 to analyse the research findings and evaluate the effectiveness of the approaches of Partners and its relationships with the Tai organisations involved in the development of the alternative health system.

To follow, Chapter 4 describes the overall methodology and design that underpins the research. It also considers fieldwork processes and details the research methods I used.

## **Chapter 4: Research methodology and fieldwork**

### **Introduction**

The research methodology and fieldwork processes that were employed in this research are described in this chapter. As the research aim was to understand the approaches that Partners Relief and Development (Partners), an international non-governmental organisation (INGO), has taken in order to support the development of alternative health system capabilities a case study approach was most appropriate. In seeking to examine Partners' approaches, the research had three objectives: 1) to explore the relationships of the different actors in the delivery of the Shan Healthcare Training Programme (SHTP), particularly Partners relationship with the RCSS/SSA-S; 2) to examine the effectiveness of the approaches used by Partners in the SHTP, in order to evaluate whether they support the development of health workforce capabilities; and 3) to identify the impact of the conflict-affected context on the capability of the alternative health system to deliver primary healthcare. Objectives 1 and 2 are directly addressed through data generated by the fieldwork processes, explained in section 4.3. Objective 3 is elucidated by the discussions of conflict-affected contexts in Chapters 2 and 5.

The first section outlines the overall qualitative methodological approach that underpins the research, grounded in my health capabilities framework that was presented in Chapter 3, and explains the rationale for adopting a case study approach. The purpose of the second section is to detail the specific considerations of my research regarding the choice of research focus and location, ethics and the fieldwork itself. Finally, the third section recounts the qualitative research methods employed in the research. This includes the means of data generation and the process of thematic data analysis. The research limitations are also briefly addressed.

### **4.1 Research approach**

#### **4.1.1 Research design**

The overarching approach to this research draws particularly on Robeyns' (2016, pp. 403–409, 2017, p. 74) modular view of Sen's capabilities approach, as she advances its flexibility as a strength in research (as outlined in Chapter 3, section 3.1.2). Using the capabilities approach in this flexible way allows the researcher to assemble their choice of ontological and epistemological elements, research objectives, and methods to produce knowledge and construct meaning as appropriate to the research aim and objectives. The approach

reflects the idea that qualitative research is a bricolage (Denzin & Lincoln, 2011, p. 4), where various perspectives and methods are woven together for the research context (as discussed by Kincheloe, McLaren, & Steinberg, 2011, p. 168). In this way, researchers:

make do with a variety of data...in order to construct a meaningful, aesthetically pleasing, and useful research synthesis...[they] are flexible, creative, and make the most of the information available, whether that includes interviews, observations, documents, websites, or archival material. (Tracy, 2013, p. 26)

An ontological stance of critical realism is taken, which understands the nature of reality to be an objective world independent of human consciousness and socially constructed (Danermark, Ekström, Jakobsen, & Karlsson, 2001, p. 6). Critical realism is an appropriate approach for research such as this which examines mechanisms, processes, and “organisations and relationships” (Easton, 2010, p. 118) that are embedded in a reality that is both objective and constructed.

The research is also grounded in an epistemology of social constructionism, which argues that “all reality, as meaningful reality, is socially constructed. There is no exception” (Crotty, 1998, p. 54). Crotty also understands this as being congruent with the ontology of realism (1998, p. 63). Social constructionism sees individuals as embedded within groups and structures that construct and shape their reality together. Research that explores the “social practices engaged in by people, and their interactions with each other” (Burr, 2015, p. 11), and seeks to understand those processes as embedded in a specific context (Creswell & Poth, 2018, pp. 24–25) fits the social constructionist paradigm.

Importantly, for research that takes place in conflict-affected contexts, van der Haar, Heijmans and Hilhorst (2013) propose:

...explicit reflection on the co-construction of knowledge as it takes place in the interactive process. What happens in the research encounter is analysed as a social process of knowledge construction. (G. van der Haar et al., 2013, p. 25)

Specific reflections on the co-construction of knowledge are threaded through the passages on ethical and fieldwork considerations in section 4.2.

#### **4.1.2 A case study approach**

A qualitative case study was adopted as the most appropriate approach to examine the approaches that Partners took in implementing the SHTP, and in its relationships with other development actors such as the RCSS/SSA-S, as it is “an in-depth inquiry into a specific and complex phenomenon (the ‘case’), set within its real-world context” (Yin, 2013, p. 321), and involves the thorough “description and analysis” of that case (Z. O’Leary, 2010, p. 174). A case study aims to produce knowledge that can improve practice in the initiative that is being examined (Z. O’Leary, 2010, p. 140), as well provide findings that are more widely applicable in other locations or communities (2010, p. 39).

The strength of a case study inquiry into a bounded unit is that it allows for in-depth analysis (Creswell & Poth, 2018, p. 98) of the diversity contained within that one case (Saldaña, 2011, pp. 8–9). According to Flyvbjerg (2011, pp. 301, 314), it gives detailed insight about varied aspects, and an appreciation of the case study context. It allows the researcher to unravel and explicate relationships and other factors in organisations and relationships (Easton, 2010, pp. 118–119). A case study must be bounded by the specific case, and the context for that case (Easton, 2010, p. 123; Flyvbjerg, 2011, p. 301). In terms of this research, the single case study of Partners’ Shan Healthcare Training Programme was chosen partly because it fulfilled the pragmatic need, noted by O’Leary (2010, pp. 175–177), for the researcher to have access to both the organisation and the location. It was also selected because of my intrinsic interest in its location on the Myanmar-Thailand border.

Yin (2013), among others (Easton, 2010, pp. 126–127), maintains that the ability to make generalisations from individual case studies is determined by the “close-up, in-depth study of a specific case in its real-world context” (Yin, 2013, p. 327). Likewise, O’Leary (2010, p. 43) emphasises the need for “transferability” of findings to other populations or contexts. As such, the SHTP must be understood by its interactions within its specific socio-cultural context that forms part of the construction of reality for the health workforce and Partners expatriate volunteers. That context will be described in detail in Chapter 5.

A case study approach within an ontology of critical realism does not dictate the use of particular processes and methods (Easton, 2010, p. 123), but it uses multiple sources of data to describe the case and generate themes (Creswell & Poth, 2018, pp. 96–97). The following sections describe the choice of data sources, fieldwork processes, and then the qualitative research methods employed to generate and analyse data.

## **4.2 Research considerations: Location, ethics and fieldwork**

### **4.2.1 Choice of research focus and location**

#### ***Research focus***

My research focus originated in my previous career experience working as an international programmes officer with World Vision New Zealand (WVNZ) during the 1990s and early 2000s. As I describe in Chapter 1, in 1996, I visited a Community Health Worker (CHW) training programme supported by WVNZ in Mozambique, four years after the end of the civil war. I witnessed how it had enabled a group of internally displaced people to return to their community and use their capabilities to re-establish a life they deemed meaningful. This prompted my interest in the pivotal relationship between health and development in (post-) conflict-affected contexts that has continued in this research.

I particularly want to understand better issues where women and girls are disadvantaged, such as we see in health in conflict-affected contexts (Craig, 2012, pp. 17–19). Like Sen (2008), I contend that health is a human right, so the “acceptance of health as a right of all is a demand to take action to promote that goal” (Sen, 2008, p. 2010). This notion is grounded in the United Nations’ Sustainable Development Goal 3 to “ensure healthy lives and promote wellbeing for all at all ages” (United Nations General Assembly, 2015, p. 16).

My research focus therefore integrates my background as a development practitioner with my aim to examine the approaches of Partners in alternative health system development and, by extension, to promote health as a human right. INGOs are also positioned as:

...speaking out against injustice, enabling those most marginalized and excluded to find their voice, working alongside them with respect, giving them dignity, and tailoring support to the local realities in which they live.

(Wallace, 2013, p. 228)

#### ***Research location***

My choice of research location was Loi Tai Leng, a community on the border between Thailand and Shan State, Myanmar (see Chapter 5, section 5.2.3 for details). The selection was partially driven by a long-term interest in justice issues and the struggle for democracy in Myanmar led by Aung San Suu Kyi, and in the Southeast Asia region more generally. The choice was predominantly governed by my relational network with three New Zealand

volunteer staff members of Partners – Claire, Ruth and Stu.<sup>27</sup> This network, and my family's support of Partners' work on the border, had made me familiar with Partners as an organisation. My friendship with the New Zealand staff meant I already had an extensive knowledge of the specific community context and its actors. This stood me in good stead when negotiating ethics approval with my supervisors as I could trust the risk analyses provided to me by Partners. I and my family were also able to have confidence in my personal safety during my fieldwork. I relied on Claire, Ruth, and Stu, to assess whether my research would be useful and feasible for Partners, and to help mediate research permission with the relevant leadership of Partners, Shan State Development Foundation (SSDF) and the Shan Health Department. Claire also helped with the practicalities of my initial feasibility visit in November 2014, prior to her departure from Partners.

Previously, the assumption was that development research in conflict-affected or dangerous contexts was not possible, but it is now recognised that research in these environments is not only feasible, but crucial (Mazurana, Gale, & Jacobsen, 2013, p. 5; G. van der Haar et al., 2013, p. 20). To this end, the specific Myanmar-Thailand border location was not only ideal for my interest in health issues in conflict-affected contexts, but also a place currently underserved by academic research.

#### ***Four fieldwork visits***

The fieldwork consisted of four separate visits to Chiang Mai and Loi Tai Leng. I held discussions with Partners and SSDF staff during my two-week feasibility visit in November 2014, where they agreed that the research topic was acceptable and feasible. I proceeded to design and plan for a longer period of fieldwork during April to June 2015. This consisted of an initial week spent in Chiang Mai at Partners' annual retreat to further familiarise myself with the staff and organisation, and discuss with them the form my research would take while in Loi Tai Leng. I then spent five weeks in Loi Tai Leng at start of the SHTP for 2015 where I interviewed new medic trainees, Tai authorities, and Partners' expatriate volunteers. I observed and participated in the training, and accompanied the medics on their ward rounds. A further two weeks was spent in Chiang Mai, with more time spent with staff at Partners' offices. I also visited the SSDF offices to meet staff and interview the director, Sai Laeng. I spoke with Tai women who had completed the medic training but

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<sup>27</sup> At the start of my research these were: Claire, the SHTP programme manager; Ruth, Executive Director of Partners NZ, Stu, manager of Partners' programmes in Shan State, who had instigated the SHTP (see section 5.4).

moved on to other careers in Chiang Mai. I also unsuccessfully attempted to contact other Tai civil society organisations.

Murray and Overton (2014, p. 34) counsel researchers to retain flexibility in their research design as “no piece of research goes exactly as anticipated”.<sup>28</sup> This was the case for my fieldwork plans. Partners scheduled their first refresher training for practising medics in November 2015 following the completion of the SHTP for the year. However, the Myanmar government set the election date for 8 November 2015. Partners postponed the training to March 2016 due to safety concerns for the medics who would have had to travel through Shan State during electioneering, while the political climate was very uncertain. This meant I could not complete my data generation in November 2015 as originally planned. Instead, in November 2015 I spent three weeks in Myanmar, Chiang Mai and Loi Tai Leng. I witnessed the historic elections in Yangon, won by Aung San Suu Kyi’s National League for Democracy (NLD). I visited an incipient small-scale education and primary healthcare community development programme in a slum in Dagon Seikkan being partially supported by Partners. I then travelled to Loi Tai Leng for the closing ceremony of the SHTP for 2015. This gave me the opportunity to reflect with the medics on their experiences of the SHTP now that they had completed their training. I interviewed Tai and expatriate Partners’ volunteer staff in Chiang Mai and observed the basic community development training they were conducting with Tai staff from inside Shan State.

I returned to Chiang Mai and Loi Tai Leng in March 2016 for 25 days. Two weeks of this was spent in Loi Tai Leng observing the first refresher course, interviewing all of the refresher medics, and meeting some of the new 2016 intake of medics. In Chiang Mai, I interviewed Sai Laeng (SSDF) again. The process of conducting the fieldwork over four visits allowed me to refine my semi-structured interview questions, and more importantly, my repeat visits helped evidence my interest in the community and cultivated the community’s trust in me.

#### **4.2.2 Ethical considerations**

This section addresses the significant aspect of the ethical considerations and principles of conducting research with communities on the Myanmar-Thailand border. Rather than

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<sup>28</sup> Billo and Hiemstra (2013, pp. 317–318) argue that flexibility is a tool that can work in favour of the researcher, stating that “Dynamism and fluidity will mean different things to different researchers. The challenge is to embrace a notion of flexibility that allows you to approach fieldwork constantly ready and willing to assess, adjust, and be creative”.

viewing ethics as an external set of processes that are necessary to complete before conducting fieldwork, the overall ethics framework of this research is closely interwoven with my positionality as a researcher. The framework also incorporates issues of negotiating access with gatekeepers, informal research permissions, university ethics protocols, and issues of consent, privacy and confidentiality that are specific to my research context.

### ***The ethics of conducting research in Myanmar***

It is worth addressing some of the specific ethical considerations of conducting research in the context of the Myanmar-Thailand border before detailing the formal ethics procedures that I undertook. Communities in Myanmar bear the effects of a history of military rule and conflict (see Chapter 5), which must be acknowledged when conducting research. Researchers should therefore take account of their ethical positionality and consider whether their research contributes to conflict (Brooten & Metro, 2014, pp. 2, 7–8, 15–16). It is also appropriate to consider locally specific ethical requirements on a case by case basis, particularly in locations such as Myanmar (Brooten & Metro, 2014, p. 7; Décobert, 2014; Matelski, 2014).

At the time of this research, the specific case study location was not a site of conflict, however it has difficulties similar to those identified by Zwi et al. (2006), such as a:

...lack of formal ethical review structures in unstable settings, lack of required skills, limited political and institutional recognition of ethical issues, competing interests, and limitations in clinical and research practice. (Zwi et al., 2006, p. 264)

Therefore, I needed to place ethics at the very centre of my research practices to manage my ethical responsibilities beyond the guidelines provided by the university, while producing research with the potential to improve policy and practice (Zwi et al., 2006, p. 275).

I held the following six ethical guidelines in mind as part of my overall ethics approach. They are recommended for research in hazardous and (post-) conflict-affected environments, and align closely with “ethics from the bottom up”, advocated by Banks and Scheyvens (2014, pp. 161–162):

1. Respect the dignity of research subjects, their culture and their environment;
2. Safety first for researchers, research assistants and informants;
3. Respect and avoid doing harm to the position and reputation of research organisations;
4. Respect the principles of empirical research;
5. Act responsibly in the dissemination of research results;
6. Recognize the dynamics of being part of the research situation.

(Hilhorst, Hodgson, Jansen, & Mena, 2016, pp. 13-14)

These guidelines informed my conduct in my research relationships and the specific strategies I used for consent, privacy, confidentiality and research dissemination. The imperative to use participatory research methods (see section 4.3), and provide reciprocal benefits to participants also enables a progression beyond the minimal ethical requirement to “do no harm” when conducting research in difficult contexts (Hugman, Pittaway, & Bartolomei, 2011; Leaning, 2001; Mackenzie, McDowell, & Pittaway, 2007).

There are a particular set of challenges in conducting research on the Myanmar-Thailand border including issues of consent for vulnerable populations, clear identification of a community of research engagement among diverse groups, the complexity of researcher responsibilities at all stages of the research process, and the nature of research collaborations with organisations providing healthcare (addressed by Parker, 2012). I was cognisant of access issues that could impact useful collaboration, the interests of different stakeholders, such as Partners, and “geographical, physical, cultural, language, and political barriers” (Ditton & Lehane, 2009c, p. 46). Another important question related to access is whether the Myanmar government can legitimately oversee the research interests of border communities through research ethics committees (RECs) (Amon, Baral, Beyrer, & Kass, 2012), when they have no jurisdiction in areas that are controlled by non-state armed groups, such as the RCSS/SSA-S. There was no option for written research permission from the Myanmar government to conduct my research in the territory controlled by the RCSS/SSA-S, nor had the RCSS or Shan Health Department established its own REC, unlike other ethnic groups.<sup>29</sup>

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<sup>29</sup> One such REC was formed by members of the Burma Medical Association, “Myanmar physicians and nurses in exile, community health workers, community members, and faith-based leaders” (Amon et al., 2012, pp. 2-3), and it has overseen research in association with Johns Hopkins

I negotiated local research permissions by explaining my ethics processes to the Tai authorities involved in the SHTP, then obtaining their verbal approval based on the relationship of trust we were establishing (Ditton & Lehane, 2009a, p. 11; Matelski, 2014, pp. 75–76). In the beginning, I requested that Khu Tun Aye,<sup>30</sup> the head of the Community Health Worker (CHW) training programme, explain my research during one of the weekly meetings of Tai authorities he attended at the Supreme Offices of the RCSS/SSA-S so that the local authorities would be aware of the reasons for my presence in the community. He submitted my research information sheet and introduction letter, translated into Tai.

I also accompanied the new medic trainees to their introductory meeting at the start of their training in 2015, with General Botao Khur, third in command of the RCSS/SSA-S. I had a separate meeting with him to explain my research and request an interview with him, to which he agreed. However, before that could take place I was summonsed to meet General Jao Yawd Serk, leader of the RCSS/SSA-S, as he had decided he should be the one interviewed. However, I was too nervous to ask him to sign a consent form and it seemed highly inappropriate due to his senior leadership position. I assumed that his request to meet me had provided a form of tacit approval for my research (see G. Banks & Scheyvens, 2014; Stewart-Withers, 2016). This incident signified a number of key ethical considerations: the oftentimes informal nature of negotiating consent (G. Banks & Scheyvens, 2014, p. 168), the need for researcher flexibility, and the ongoing reflexivity required to mitigate ethical dilemmas that might arise (Campbell-Page & Shaw-Ridley, 2013, p. 489).

### ***Gatekeepers: A research memorandum of understanding***

At the outset of my research my aim was that it would be a collaboration with Partners where we co-produced knowledge that they could benefit from, even though I had determined the research focus. (see Aniekwe et al., 2012; Green, 2017; C. Mercer, 2006; Stevens, Hayman, & Mdee, 2013). I made an initial feasibility visit in November 2014<sup>31</sup> to ascertain whether the research would be acceptable and useful to Partners and the Shan

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University (Mullany et al., 2007; Teela et al., 2009). Another is the Tak Province Border Community Ethics Advisory Board (T-CAB) to foster community engagement in the ethical oversight of medical research on the Thailand-Myanmar border. This was formed in association with the Shoklo Malaria Research Unit (Cheah et al., 2010; Lwin et al., 2013).

<sup>30</sup> Not his real name. His role is explained in more detail in section 5.2.2.

<sup>31</sup> I was accompanied by Claire, who had been the previous manager of the Shan Healthcare Training Programme, to mediate my visit with Partners, the director of the SSDF, and Paw Shar Gay, all of whom she had worked closely with.

State Development Foundation (SSDF; see Chapter 5, section 5.2).<sup>32</sup> The chair of the international board<sup>33</sup> of Partners at the time also advocated for my research with Partners on the basis that, as Clark (2011, p. 492) describes, it would facilitate the identification of “...‘good practice’ that could then be used to facilitate change”. There was reluctance due to concerns that I would absorb some of their limited capacity but once they were made aware of my INGO experience, which positioned me as a “pracademic” (Stevens et al., 2013, pp. 1073–1074), they agreed. During this visit, I discussed the research with Paw Shar Gay, the head of the Shan Health Department. She gave oral permission and I attribute her trust in me to the relationship she has with Claire.

I then drew up a research memorandum of understanding (MOU; Appendix 1)<sup>34</sup> to formalise my relationship with Partners, clarify our expectations, and avoid “potential tensions in partnerships caused by asymmetries in power and philosophical differences in approach to outputs and ownership of research” (Aniekwe et al., 2012, p. 14). I explained the steps I was taking to ensure participant confidentiality, and emphasised participant ownership of any data generated. Ultimately, Partners exerted power as gatekeepers of my research (G. Banks & Scheyvens, 2014, pp. 172–174). As Clark (2011, p. 490) points out, it was not compulsory for them to engage with me, and they could withdraw their cooperation at any time. As a result I felt the constant tension of placating Partners to ensure my continued research access, while making sure that I represented the voices of the medic participants well, as advocated by Johnson and Duberley (2003, p. 1296). However, the SHTP programme managers went out of their way to facilitate my access to the community, provide information about the programme, and were always transparent and honest in their discussions with me. They were interested to see what research findings they could incorporate into the programme.

I concede that the MOU has proven a limited tool with which to genuinely engage Partners in the research process. However, despite “the obstacles to more productive collaboration” that I encountered (Green, 2017, p. 29), it was a worthwhile component of the ethics approach to the research.

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<sup>32</sup> SSDF is the development arm of the Restoration Council of Shan State, the non-state armed group.

<sup>33</sup> The chair, Rob, was conducting his own doctoral research into a different aspect of Partners’ work, so they were already accepting of, and familiar with, the contribution that academic research could potentially offer them.

<sup>34</sup> This was signed between Partners’ chief operating officer, the SHTP programme managers and myself.

### ***Massey University ethics protocols***

An important requirement in my research ethics process was to enter into the robust, “transparent, coherent, formalised internal process which all students (and staff) go through before even engaging with the university system” (Stewart-Withers, 2016, p. 32), that has been established by Massey University’s Institute of Development Studies. The Institute of Development Studies has moved towards a more principled approach to ethics requirements which understands ethics to be more than obtaining signed consent forms. I completed a screening questionnaire and then discussed ethical considerations and safety issues in depth with my three supervisors (see Stewart-Withers, 2016, pp. 32–33). The process centred the issues related to conducting fieldwork in a potentially conflict-affected and dangerous place. I provided a context and risk analysis of the location, and explained the risk mitigation procedures that Partners had in place with the RCSS/SSA-S in Loi Tai Leng (recommended by Hilhorst et al., 2016, pp. 18–19). My supervisors also knew I was familiar with working in these types of locations during my time working with WVNZ. Through this process we came to an agreement that my research was low risk.

To complete the mandatory ethics protocols, I applied for a low risk notification to the Massey University Human Ethics Committee, which was approved (Appendix 2). I provided this to Partners as part of our research MOU, so they understood the rigour of the ethics processes I undertook. I prepared a research information sheet (Appendix 3), and Dr Stewart-Withers<sup>35</sup> provided an introductory letter (Appendix 4). The information sheet was translated into Tai by my research assistant once I was in the fieldwork location (Appendix 5).

### ***Informed consent***

The principle of informed participant consent was foremost in my ethics approach (G. Banks & Scheyvens, 2014, pp. 164–168; Z. O’Leary, 2010, p. 41). The agency of participants must be kept paramount in the context of a community on the Myanmar-Thailand border, following their experiences of political repression and conflict (Brooten & Metro, 2014, pp. 11–13; Hugman, Bartolomei, & Pittaway, 2011, p. 656). I ensured that informed consent was provided by first explaining my research aim and the interview process to my research assistant. She, in turn, explained the research and consent process to participants as she recruited them on my behalf, meaning they could decline participation at that point (Ditton & Lehane, 2009a, pp. 11–12). I also had the opportunity to speak publicly about my

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<sup>35</sup> My primary supervisor.

research to each group of medics at the start of their training. I explained about the consent process, reiterated their ability to withdraw consent at any time during the interview process, and provided them with translated copies of my research information sheet. Oral explanations from myself and my research assistant mitigated any problems with literacy. The use of written consent was inappropriate for the medic participants due to the requirement for confidentiality and anonymity because of safety concerns for them once they returned to their communities, so I used oral consent instead (see G. Banks & Scheyvens, 2014, p. 167; Hugman, Bartolomei, et al., 2011, pp. 667–668; Matelski, 2014, pp. 74–75). Before starting the recording of interviews with participants, I explained the oral consent process again and asked if I had permission to record our discussion. I made a note of this in my fieldwork notes. All expatriate volunteers and Partners volunteer staff were happy to provide written consent (see the form in Appendix 6).

### ***Privacy and confidentiality***

The maintenance of privacy, anonymity and confidentiality is another critical facet of the ethics approach (G. Banks & Scheyvens, 2014, pp. 168–169). However, anonymity was not guaranteed within the community itself as all of the medics knew that they were taking turns to be interviewed. I used pseudonyms for all of the medic participants, and other participants where indicated (Zwi et al., 2006, p. 267). These were provided for me by a Tai public health researcher who was not involved in the research, was not familiar with the participants, and did not live in the community. Where I have used the real name of a participant I have their permission to do so. I also did not take note of the villages that they worked in inside Shan State so there was no risk of them being linked to health clinics operated by the RCSS/SSA-S.<sup>36</sup> Another essential component to safeguard the participants and their confidentiality was securing the interview recordings and photographs. I password protected and encrypted all research data on my laptop and external drives.<sup>37</sup> I kept participant's real names on an innocuously titled list separate from interview recordings and photographs. The confidentiality and data security measures were continued throughout the research process.

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<sup>36</sup> See section 5.2.2 for details about a Tai medic detained by the *Tatmadaw* for his medic role with the RCSS/SSA-S.

<sup>37</sup> I also recommended these precautions to Partners due to their frequent border crossings through military check points between Myanmar and Thailand, as well as their travel to Yangon and other places inside Myanmar.

### ***Decision to embargo the thesis***

I hold a deep commitment to open access to and public use of my research. However, I decided to embargo the thesis for a period in consultation with the programme managers in March 2017. Although the political circumstances in Myanmar had improved enough for Partners to hold the medic refresher training inside Shan State for the first time in 2017, the fluid nature of the ethnic conflict means that there is no certainty of these improvements lasting. The embargo follows Massey University's Grounds for Embargo Policy based on the disclosure of information that is personal or private, and is in conjunction with the rigorous measures undertaken during the research to ensure participant privacy and confidentiality. If the situation inside Shan State deteriorates the embargo provides an added layer of protection for the activities of the Shan Health Department and Partners' cross-border programmes. This is in line with the injunction to "act responsibly in the dissemination of research results" (Hilhorst et al., 2016, p. 13).

### **4.2.3 Fieldwork considerations**

Another key research principle is that of acknowledging my positionality (R. Scheyvens, Scheyvens, & Murray, 2014, p. 189; Stewart-Withers, Banks, McGregor, & Meo-Sewabu, 2014, pp. 61–62), and the influence of my life experiences, gender, ethnicity, and class on the production of knowledge (Billo & Hiemstra, 2013, p. 322; Burr, 2015, pp. 175–177; Chacko, 2004, p. 52). Braun and Clarke (2013, pp. 36–37) argue that personal reflexivity forms an essential part of the "quality control" of qualitative research. Similarly, Mosselson (2010, p. 493) maintains that reflexivity acts as an "ethical tool".

### ***Positionality: Being an outsider-researcher***

A great deal has been written exploring reflexivity as an insider- or outsider-researcher (Billo & Hiemstra, 2013; Cupples & Kinson, 2014; Johnson & Duberley, 2003; Minkler, 2004; Mosselson, 2010; Z. O'Leary, 2010; Stewart-Withers et al., 2014). Researcher identities are constructed and fluid, rather than fixed binaries, and can shift as they are negotiated by the researcher and their participants (Apentiik & Parpart, 2006, pp. 36–37; Giampapa, 2011, p. 142; Lamoureux, 2011, p. 208; Thomson & Gunter, 2011). Central to my positionality in this research is my identity as a 'pracademic': someone who has "shifted in the course of their careers between working within NGOs and academic institutions, or individuals who maintain an active role in both types of institutions" (Stevens et al., 2013, p. 1073).

Being a middle class, Pākeha/white New Zealand woman, and not a staff member of Partners, positioned me as an outsider-researcher to the Tai community and Partners staff

(Chacko, 2004, pp. 53–56; Giampapa & Lamoureux, 2011, pp. 128–129). I acknowledge the graciousness of the Tai community towards my clumsy efforts at appreciating and understanding their language and culture. My Pākeha outsidership was not always a negative as, despite missing some of the cultural nuances happening around me, I had the advantage of looking at things with ‘fresh eyes’. I also used the curiosity of my outsidership to negotiate access to Tai authorities. At times, I shifted to be an ‘insider’ with the programme managers because of my INGO experience, and our shared ethnicity, nationality, class, and faith. One benefit of my association with Partners was that my presence was easily accepted by the community. They were used to seeing expatriate medical volunteers come and go, as I did during the research process. Partners’ work had engendered a tremendous amount of community good-will which was extended to me by association.

My gender acted both for and against the research. Being a woman and a mother gave me ‘insider’ status with those who shared those attributes. Importantly, the women medics felt more at ease with me. On the other hand, some Partners staff and Tai authorities took me less seriously. Being a woman in a patriarchal socio-cultural context, structured along military hierarchy lines made it difficult for me to gain access to senior Tai military and political authorities. My research assistant, whom I discuss in more detail later in the chapter, was a young woman so was not able to easily broker this for me either. However, once General Jao Yawd Serk, head of the RCSS/SSA-S (see Chapter 5, section 5.2) granted me an audience, I understood that as him granting me permission to conduct my research in the location that he controlled.

Shifts in researcher identity also encompass the power and powerlessness of the researcher (Brydon, 2006, pp. 27–28; Z. O’Leary, 2010, pp. 27–28; Stewart-Withers et al., 2014, p. 62). For the most part I embodied a position of relative power in the socio-cultural context of the research location. As such, I was aware that there was a risk that the medic participants may tell me what they thought I wanted to hear because of our unequal power. However, rather than overstating the power that I held, I acknowledge that community members also controlled their involvement through “research resistance” (R. Scheyvens & McLennan, 2014, p. 9).<sup>38</sup>

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<sup>38</sup> A senior Tai political figure invited the programme managers and I to his house for dinner, but failed to pick us up as agreed. This is one indication of the ways in which community members wield agency. Other Tai organisations I contacted to participate simply failed to return my emails.

Rigorous research is also fostered by the awareness of and mitigation for any potential conflicts of interest (G. Banks & Scheyvens, 2014, pp. 169–171). I note here that at the beginning of the research I was a board trustee of Partners New Zealand until it resigned from its association with Partners in March 2016.<sup>39</sup> I discussed possible conflicts of interest of this role with my supervisors prior to becoming a trustee. However, Partners NZ was not directly involved with my research and had no involvement whatsoever with the management of the SHTP. I did not make Tai authorities and the SHTP medics aware of my board role as it was not relevant to the research and I did not want to create the erroneous impression that I had any influence upon programme management or funding. There was no issue with my board role until Partners NZ's resignation when I had to remind Partners' chief operating officer of my research aim and objectives as outlined in our MOU.

### ***Being a mother/wife-researcher***

My embodiment as a mother/wife-researcher also shaped my navigation of the fieldwork experience. Researchers have considered the impact of family and mothering during accompanied fieldwork, acknowledging that there are both advantages and disadvantages to this (Cupples & Kindon, 2003; H. Scheyvens, Scheyvens, & Nowak, 2014). In weighing the “practical, emotional, and ethical implications” (Lunn & Moscuza, 2014, p. 71), including financial and employment constraints, and safety considerations, we decided I would conduct the fieldwork unaccompanied. The advantages of not having to accommodate the physical and emotional needs of my children in a low resource fieldwork context outweighed the difficulties of being apart from them for so long (H. Scheyvens et al., 2014, pp. 136–139). During my time away from my family I existed in a liminal space: emotionally embodied as a mother/wife researcher while physically absent from and unaccompanied by my children/husband, an issue addressed by Farrelly, Stewart-Withers and Dombroski (2014). I was also aware that a married woman travelling alone went against cultural norms in the research context (Lunn & Moscuza, 2014, p. 72).

I particularly felt my emotional embodiment as a mother during two incidents. A child the same age as one of mine suffered a choking incident and was raced to the clinic where he was pronounced dead. His body was laid out close to the house where I lived. I also witnessed a traumatic birth where the baby eventually died (see Chapter 6, section 6.1.2). I felt the need to maintain the appearance of Western medical professionalism held by the

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<sup>39</sup> I have not gone into details about this event due to issues of confidentiality for both organisations.

programme managers who had delivered the baby, but deeply felt the absence of the close emotional support of my family following both of these deaths.

Despite these personal discomforts I recognised that my identity as a mother/wife facilitated “intimacy and a shared common repertoire” with my participants (Frost & Holt, 2014, p. 96), as it enabled them to openly share stories about separation from their families, the loss of a child, or a relationship breakdown. It was particularly relevant when I asked the medics if they thought they would be able to continue in their role once they were parents, as they were prompted to ask me to share how I juggled motherhood with work and study. This is consistent with Frost and Holt’s (2014, p. 99) argument that awareness of the intersections of maternal identity with that of researcher, woman and feminist in the research process can augment rather than damage the validity of the research.

### ***Working with a research assistant/interpreter***

Another challenge I encountered conducting the fieldwork was that of language, or rather my inability to speak and understand the local Tai language. This raised several related issues. First, I was very aware that community members who couldn’t speak English may be uncomfortable with hearing me hold conversations in English, as:

...those who have been badly treated by government authorities, people with notebooks recording details about their lives can appear threatening, especially if they are using translators and recording in a language the information does not understand. (Mazurana, Jacobsen, & Gale, 2013, p. 14)

Second, I was concerned that without the necessary aptitude in the local language, I would miss meaning and understanding in the generation of data with my participants (W. E. Murray & Overton, 2014, p. 20). While this is certainly the case, it is also important to recognise that even speaking the same language as participants does not always mitigate these misunderstandings and misinterpretations from occurring (Lamoureux, 2011, p. 209).

My inability to speak Tai meant I had to work with someone who could be a research assistant, interpreter, and “trusted intermediary” (Ditton & Lehane, 2009a, pp. 12–15). This did not avert all of the language issues as it was difficult to find someone in the community proficient in English (Z. O’Leary, 2010, pp. 201–202). Partners’ Tai cultural broker and

programme manager, Sai Seng Wan,<sup>40</sup> recommended Nang Mo Kham<sup>41</sup> to me. She is a young Tai woman who moved to Loi Tai Leng from inside Shan State and had already trained as a medic in the SHTP. She had undertaken the social justice education programme at The School for Shan State Nationalities Youth (<http://www.sssny.org/>), where English language was part of the curriculum. She was already experienced in interpreting for the expatriate medical volunteers in the SHTP, which she fitted in alongside her teaching in the CHW programme. Bujra (2006, pp. 177–178) has identified that “interpreters who speak the local language as their first tongue and have a first-hand knowledge of the area under study [are] more useful than those whose English is perfect”. As such, Nang Mo Kham was a ‘key informant’ whose intelligence, manner, local knowledge, and standing in the community allowed her to function as a “cultural mentor” (W. E. Murray & Overton, 2014, p. 33), and “cultural broker” for me (Leck, 2014, pp. 62–64). I relied on her absolutely and we developed a close rapport (see McLennan, Storey, & Leslie, 2014, pp. 154–155).

Edwards (1998, p. 205) argues that we ‘work with’, rather than ‘use’ interpreters, with a need to make their role explicit (Leck, 2014, p. 60). Accordingly, Nang Mo Kham was the first Tai participant that I interviewed as “part of the process of making the interpreter visible, and also accountable in the same way that researchers may seek to be explicit about their own social and political location” (R. Edwards, 1998, p. 203). As well as helping her to understand my research aim, objectives, and the interview questions, this allowed her to advise me on refining the questions. We also discussed participant responses after the interviews so I could adjust my interview guides and approach. This led me to use focus groups more than I had originally intended to. I interviewed her once more during my last fieldwork visit, so we could reflect on our fieldwork experience and the research findings together. An essential part of relying on Nang Mo Kham was having her sign a confidentiality agreement (Appendix 7), while understanding that this did not ensure participant anonymity as she was responsible for their recruitment (R. Edwards, 1998, p. 206; Zwi et al., 2006, p. 267).

One difficulty was arriving at a suitable rate of remuneration for Nang Mo Kham’s assistance (also described by McLennan et al., 2014, p. 155). She was prepared to perform the task unpaid as a form of service for her community, however I was ethically

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<sup>40</sup> Not his real name.

<sup>41</sup> Not her real name.

uncomfortable with her performing unpaid labour for me and I wanted to demonstrate how much I valued her. I consulted Sai Seng Wan, Khu Tun Aye (her manager in the CHW training programme), and the programme managers to settle on a wage that was fair and appropriate for the context. I also hope that her experience as my assistant will prove valuable to her personally (G. Banks & Scheyvens, 2014, pp. 174-175),<sup>42</sup> and will also serve as an investment, however insignificant, into wider research capacity building in Myanmar (Beran et al., 2017).

I explained to the participants that being monolingual was a disadvantage, so I could highlight the advantage of their being multilingual. As well as Tai, most could speak Burmese,<sup>43</sup> and many also spoke another ethnic language, Thai, or a small amount of English. One way I was able to engage in reciprocity was by giving the medics English language lessons (G. Banks & Scheyvens, 2014, p. 174). Spending this relaxed time together also removed some of the barriers caused by our uneven power relationship (Brydon, 2006, p. 27; Momsen, 2006, pp. 45-46; Z. O'Leary, 2010, pp. 27-28).

### ***Conducting research in a conflict-affected context***

In addition to the personal considerations there were considerations specific to the conflict-affected research context. I was confident in my ability to cope in a place that some might consider 'difficult' or 'dangerous': remote with difficult road access, poor communications, an unfamiliar culture and language, a low resource and potentially conflict-affected environment. I reflected extensively on this before conducting research in the community but knew I could depend on my previous experiences of travelling to areas of the Global South that shared these similarities. This was the case, although I still experienced the mixture of "anxiety and anticipation", described by Tracy (2013, p. 77).

It is important to not discount the integral role of emotion and empathy in the process of research reflexivity (B. Jones & Ficklin, 2012, p. 105). Likewise, emotional intelligence and empathy are considered desirable personal traits for fieldwork (McLennan et al., 2014, p. 151; H. Scheyvens et al., 2014, p. 128). I accommodated the "emotional mess" of fieldwork through a number of strategies (Humble, 2012, p. 84): my fieldwork journals (McLennan et al., 2014, pp. 148-149; Punch, 2012) and, when an internet connection was available,

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<sup>42</sup> In order to facilitate this, I made the small gesture of providing a written reference for her.

<sup>43</sup> Burmese is often the language medium of education, even in the ethnic states of Myanmar.

chatting through issues with my family and Claire. The broader value of empathy and emotions is that:

Engaging with the emotions of development research provides an opportunity to intersect with and challenge some of the emotional narratives of development, both within the experiences of the researcher and the researched. (Humble, 2012, p. 85)

Reciprocity and gratitude are another significant principle of the fieldwork process (G. Banks & Scheyvens, 2014, pp. 174-179; Brooten & Metro, 2014, pp. 14-15). I tried to help the programme managers wherever I could, even if this was limited to making coffee, doing dishes, laminating certificates, being a “patient” for workshops and exams, designing an evaluation for students to complete at the end of training, and sharing relevant articles or training materials. I verbally expressed my gratitude to medics and provided celebratory Tai BBQs<sup>44</sup> or morning teas.

The process of leaving the field and returning home to continue research processes can be fraught. I found this particularly difficult after my last fieldwork trip in March 2016 as I knew it was unlikely I would return due to personal funding constraints. I knew that “...participants will be left in that space, relating to all the other more powerful stakeholders, long after the foreign researcher has gone” (Ditton & Lehane, 2009b, p. 56). This left me with the ambiguity of holding a commitment to appropriately disseminating the research to my participants, without possessing the means to do so (Kindon & Cupples, 2014, p. 229). I was concerned that I had left the impression that my participants were only “sources of data rather than the traumatized yet resilient people they are” (Brooten & Metro, 2014, p. 17). I have maintained contact with many of my participants via Facebook™, even those who don’t speak English. I have been able to discuss the SHTP with Paw Shar Gay, and receive photos and updates about the work of medics inside Shan State.

### **4.3 Research methods**

This section presents the research methods for generating appropriate data to address the three research objectives, and the process of analysing that data. It also briefly summarises some of the limitations of the research. As described earlier in section 4.1, this research uses a case study approach to “allow for the building of holistic understandings through

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<sup>44</sup> This gesture was reciprocated to me when community members provided me with a Tai BBQ when my birthday fell during one visit.

prolonged engagement and the development of rapport and trust within a clearly defined and highly relevant context” (Z. O’Leary, 2010, p. 174). The use of qualitative data generation methods is most appropriate to foster a deeper understanding of participants’ experiences.

#### **4.3.1 Data generation**

I have used the term data generation to reflect my epistemological position of social constructionism, that the data is co-constructed/generated with my research participants, rather than collected by me.

##### ***Participant selection***

In qualitative research, there are various strategies available to select a fitting sample of participants to answer the research questions. In my single case study, I utilised the method of purposive sampling through which I aimed to generate more in-depth data on my topic (Braun & Clarke, 2013, p. 56; Stewart-Withers et al., 2014, p. 61). Saturation would be reached through this depth of data rather than sampling a wider selection of participants for breadth (Braun & Clarke, 2013, pp. 55–56; Z. O’Leary, 2010, p. 165). I used a narrow, non-random sample delineated “on the basis that [participants] will have certain characteristics or experience” (Braun & Clarke, 2013, p. 335). The specific criteria were: either participation in the SHTP; leadership in the Tai partner organisations; or involvement with Partners as a staff member or expatriate medical volunteer.

##### ***Semi-structured interviews: Individuals and focus groups***

The main methods for generating data in the research process were semi-structured interviews and focus groups (Braun & Clarke, 2013, pp. 78–80, 108–109; Lloyd-Evans, 2006; Stewart-Withers et al., 2014, p. 63; Willis, 2006). The advantages of using semi-structured interviews are that they enable a flexible conversation to take place that provides “rich and detailed data about individual experiences and perspectives” (Braun & Clarke, 2013, p. 80). Braun and Clarke (2013, p. 80) also suggest that they are ideal for generating data with smaller samples, and there is a greater likelihood of producing useful data when the researcher has some control of the process. I used interview guides (Appendices 8-12) to help address themes I had identified prior to fieldwork (see the health capabilities framework in Chapter 3, section 3.5), while also providing opportunity for the participants to share what they wanted to (Willis, 2006, p. 145). I audio-recorded all of the interviews, with participants’ permission, rather than taking notes as I found this to be a distraction from being fully present in the conversation. It also lessened any suspicions participants

may have had about me collecting written information about them and their clinic locations. There was also some initial awkwardness in the translated three-way conversation between the participants, my interpreter and myself that we overcome with more practice (Willis, 2006, p. 145). I also had to rely on the accuracy of my research assistant's translation (R. Edwards, 1998, p. 199).

I had planned to only use semi-structured individual interviews but soon realised that some medic participants were uncomfortable with this approach. After deliberation with my research assistant we agreed that some medics would prefer focus groups as they could feel more empowered by the group dynamics to share openly (see Lloyd-Evans, 2006, p. 155 for an outline of the strengths and limitations of using this method). To make sure that all participants in the group had the opportunity to be heard, I used the interview guide to facilitate turn taking (Z. O'Leary, 2010, pp. 195–196). Medics self-selected whether to participate in an individual interview or a focus group. The additional advantage of using focus groups was that I overcame the potential time limitation of individual interviews and included the majority of medics present during the time I had available during my visits.

The process of purposive recruitment of the medic participants for individual interviews and focus groups was facilitated by my research assistant (Braun & Clarke, 2013, pp. 59–60, 120–121). Table 4.1 below details a summary of the total number of 77 participants in both individual interviews and focus groups. I conducted 35 individual interviews in total: 22 with women medics and CHWs; six with men medics and CHWs; five with Tai authorities; and two with expatriate medical volunteers. I held 17 focus groups in total: nine with women medics and CHWs; four with men medics and CHWs; one with the SHTP programme managers; one with two Partners' staff; one with two expatriate medical volunteers; and one with a Tai authority and a Partners' programme staff member. A very small number of women medics I had interviewed individually also chose to participate in focus groups, but I have not differentiated these.

Table 4.1: Summary of number of participants by interview type

Type of participant	Number of participants
<b>Women medics and CHWs</b>	
Individual interview participants	22
Focus group participants	25
<b>Men medics and CHWs</b>	
Individual interview participants	6
Focus group participants	9
<b>Tai authorities</b>	
Individual interview participants	5
Focus group participants <sup>45</sup>	1
<b>Partners programme staff</b>	
Focus group participants	5
<b>Expatriate medical volunteers</b>	
Individual interview participants	2
Focus group participants	2
<b>Total number of participants</b>	<b>77</b>

(Source: Author)

Prior to fieldwork I developed separate interview guides for the medics, Tai authorities and Partners' expatriate medical volunteers (see Appendices 8-12). These were refined throughout the fieldwork process in discussion with my research assistant and as I included emergent themes. I observed that some of the interviews with Tai authorities and

<sup>45</sup> The Tai authority was interviewed alongside a Partners' programme staff member.

medical volunteers were more unstructured in nature, which I posit is due to their confidence to lead the conversation as they wanted to, something the medics may have felt unable to do.

### ***Observations***

The research makes no claim to be ethnographic in nature as I did not live in the community for a long period, I did not learn the language, and I did not make detailed observations (van Donge, 2006, pp. 180–181). However, the research benefited from informal observation – as Stewart-Withers et al. (2014, pp. 64–65) note, researchers do become involved in the lived experiences of participants, which is what naturally occurred due to my presence during the training. This took the form of more indirect, unstructured observations of day to day activities, lecture sessions, practical workshops and ward rounds, and on one occasion, my involvement in a medical event (see Chapter 6, section 6.1.2). I also participated in events such as the opening and closing ceremonies for the SHTP, meetings with Tai authorities, and community commemorations such as Shan Resistance Day (see Chapter 6, section 6.3.1).<sup>46</sup> I was always very clearly “noticed as an observer” in all of these situations (van Donge, 2006, p. 180). I consider that, although I took my role very seriously, I was a “play participant”:

...in which fieldworkers *play* at becoming active members engaging in a range of cultural activities, but their membership is improvisational and unbound by many formal norms of the scene - they can opt in and out in ways unavailable to a complete participant. (Tracy, 2013, pp. 109–111)

I was included in activities such as the practical training workshops of the SHTP as a “patient”, as shown in Photograph 4.1 below. My involvement helped break down barriers with participants. My observations of interactions between different actors allowed me to “get a sense of a reality and work through the complexities of social interactions” (Z. O’Leary, 2010, p. 209). Importantly, it meant that I could observe dynamics and situations that I was not being directly told about in interviews and focus groups. I recorded my observations through photographs and my fieldwork journals.

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<sup>46</sup> Shan Resistance Day is 21 May. It commemorates resistance to former Burmese regimes.



*Photograph 4.1: Dr Ken teaching a medic how to take a posterior tibial pulse on my leg (Source: Author, 2015).*

Although I didn't facilitate the use of participatory methods such as social mapping or ranking exercises for this research, I was able to observe and record the use of community mapping techniques during the refresher training in March 2016. The medics used this technique to help Tai authorities and the SHTP programme managers to understand the realities of the context that they practise in more deeply.<sup>47</sup>

### **Documents**

I supplemented my other research methods through the collection of secondary sources of textual data (Overton & Van Diermen, 2014, p. 44). This took the form of Partners' six-monthly progress reports for the SHTP from 2012 to 2016. I analysed these to assess the progression of the SHTP and how Partners represented the programme to an external audience. These reports were primarily produced for Partners' international funding partners to report back to their donors so contained very little detailed evaluative information about the SHTP. I also analysed reports produced by other researchers to

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<sup>47</sup> I have not replicated the images here as they detail specific clinic locations inside Shan State.

compare how other ethnic groups were involved in the development of ethnic systems for health and education in Myanmar (Davis & Jolliffe, 2016; Jolliffe, 2014; Jolliffe & Speers Mears, 2016; McCartan & Jolliffe, 2016). From this, I ascertained that there was a gap in specific data about health system development inside RCSS/SSA-S-controlled parts of Shan State (see Chapter 5, section 5.2.2).

Another important method was my maintenance of a fieldwork journal with notes of my observations. Punch (2012, p. 87) suggests that the process of researcher reflexivity is enhanced by “scrutinis[ing] their personal challenges and emotions in relation to the research process as well as the ways in which they may shape interpretations of the data generated”. My journals formed a part of both data generation and data analysis as I used them as a place of sense-making in the ongoing research process and to formulate my initial research findings (as described by McLennan et al., 2014, pp. 148–149).

In summary, this section has provided a description of the multiple methods used for generating research data to ensure the credibility and rigour of the research. The research aimed to do this through triangulation, which is:

...a way to get to the findings in the first place – by seeing or hearing multiple *instances* of it from different *sources* by using different *methods* and by squaring the findings with others it needs to be squared with.  
(Miles, Huberman, & Saldaña, 2014, p. 300)

This aim was built into the research design by using multiple sources of data, along with the use of the different data generation methods of interviews, focus groups, observations and document analysis. Tracy (2013, p. 237) takes the view that this approach fosters “crystallization” or the construction of “a multi-faceted, more complicated, and therefore more credible picture of the context”.

#### **4.3.2 Data analysis**

This section details the steps of qualitative data analysis that I undertook. I used thematic analysis to identify “themes and patterns of meaning...in relation to a research question” (Braun & Clarke, 2013, p. 175). It is suitable for the overall epistemology of social constructionism. Data analysis was primarily a reflexive and iterative process: moving between data generation, analysis, literature review and the health capabilities conceptual framework to produce understanding (Z. O’Leary, 2010, pp. 257, 261; Stewart-Withers et al., 2014, p. 75; Tracy, 2013, p. 184). As described in section 4.3.1, the process of data analysis

began with keeping a fieldwork journal, where emergent findings and themes were described. These incipient themes formed the beginnings of the thematic analysis framework using NVivo™ qualitative data analysis software.

### ***Transcription***

Transcribing all of the interviews and focus groups formed the first stage of preparing and analysing the data. Once back in Aotearoa/New Zealand I transcribed everything to familiarise myself with the data (see Bazeley & Jackson, 2013, p. 57). I used an orthographic, or verbatim, style of transcription but omitted non-verbal utterances (Braun & Clarke, 2013, pp. 161–162). I then formatted the text with headings and stored each interview in NVivo™. The transcripts were anonymised using an interview code for each participant which was changed to a pseudonym when writing quotes. I also didn't transcribe other names and specific locations mentioned. Although focus groups can be difficult to transcribe this was less so in my case because, although there were multiple voices engaged in conversation (Lloyd-Evans, 2006, p. 160), I only had to transcribe that of my interpreter. Once transcription was complete I read through all of the physical transcriptions and recognised themes that I had identified during fieldwork, and noted new themes that were emerging (Stewart-Withers et al., 2014, pp. 75–76).

### ***Use of NVivo™ data analysis software***

In the next stage, I used NVivo™ which made the management, coding, visualisation and analysis of the data more efficient (Creswell & Poth, 2018, pp. 208–209), but did not “supplant time-honoured ways of learning from data” (Bazeley & Jackson, 2013, p. 2). I used it to classify the participants by gender, ethnicity, approximate age, and their relationship to the SHTP. I then coded each transcription using broad themes that I had noted during fieldwork and the initial read through process, adding more during this process. During this primary coding process I arrived at an unwieldy number of codes so I then consolidated these into common themes for ease of analysis (Bazeley & Jackson, 2013, pp. 224–225). The use of NVivo™ reinforced the rigour of the research by “showing that the analysis has been carried out systematically and that the interpretation has been soundly argued” (Burr, 2015, p. 178).

### ***The process of thematic analysis***

I followed a systematic process of thematic analysis, similar to that outlined by Braun and Clarke (2013, pp. 202–203): transcription; reading and familiarisation with the data through journals and transcriptions; coding in NVivo™; searching for themes; reviewing themes;

defining and naming themes; writing as part of the final analysis. Immersion in the data avoided the risk of relying too heavily on NVivo™ to do the analysis for me. Searching for themes involved looking for patterns and interconnections (Z. O’Leary, 2010, p. 168), and then interpreting those to enable me to make generalisations about my case (Creswell & Poth, 2018, p. 206). I then mapped the themes back to the three research objectives to ensure I had met these. The major themes formed the basis of the findings chapters 6 and 7. O’Leary (2010, p. 271) maintains that the “power of qualitative data is in the actual words and images themselves”, so the findings chapters make use of participants’ quotes to elucidate on the dominant themes to avoid a reductive analysis.<sup>48</sup>

### ***Analysis through writing***

Writing formed a key part of data analysis by clarifying the emergent themes. Braun and Clarke (2013, p. 248) recognise that “qualitative analysis is writing”, so once I identified themes I began to write ‘around’ those ideas. Through this writing process the “analytic ideas [were] crystallised and refined” (2013, p. 297).

### **4.3.3 Research limitations**

Finally, there are some limitations to the research that need to be noted. First, when using a case study approach, some caution is warranted when generalising more broadly about the findings to other contexts. However, the critique that case study research findings have no wider value has been overstated. It is accepted that they can enable the development of theory and deepen our understanding of processes that take place in specific circumstances (Flyvbjerg, 2011, pp. 304–305; Maxwell, 2013, pp. 136–138). The case study for this research is bounded by researching one INGO programme in one conflict-affected context in Shan State, Myanmar. The possible lack of generalisability does not lessen the significance of the research findings as they are transferable to inform wider development policy and practice for development actors in similar contexts (Z. O’Leary, 2010, p. 43). As van der Haar et al. (2013) maintain:

...the validity of this type of research derives to an important extent from the researcher’s intimate knowledge of the setting and the trust that he/she has generated in long-duration fieldwork or recurring visits. (G. van der Haar et al., 2013, p. 23)

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<sup>48</sup> I have made the methodological choice to paraphrase participants words rather than quote word for word.

Second, the research explored the approaches taken by Partners in the SHTP, but due to safety concerns as an outsider-researcher, I had no access to rural communities inside Shan State where the medics practised. This meant I was only able to examine the effectiveness of the SHTP at a community level through the reports from medics. However, by using my health capabilities framework (see Chapters 3 and 8), the research was able to elucidate how the SHTP enhanced the capabilities of the medics. Linked to this, I was only able to visit the research location four times, for a few weeks at a time. Despite this potential time limitation, I interviewed the majority of medics participating in the 2015 SHTP as well as all of the key Tai authorities, and all of the medics participating in the March 2016 refresher training. I was also able to remain in contact with some of the research participants via Facebook™ if I needed to update or clarify any information.

Third, I was unable to connect directly with other Tai civil society organisations to obtain their reflections on Partners' approaches. I made numerous attempts to connect with Shan Women's Action Network (SWAN) but was unsuccessful. I have assumed that this was their way of expressing disinterest in participating in my research (G. Banks & Scheyvens, 2014, p. 168).

Fourth, one issue that the research did not examine is that of opium and methamphetamine addiction and production in communities in Shan State where the medics practise.<sup>49</sup> This is a major contextual issue that the medics reported has a negative impact upon communities and their work, but addressing it directly was outside of the scope of the research.

Finally, the research focused explicitly on the SHTP, the capabilities and lived experiences of the medics, and any possible improvements they may bring to health outcomes in their communities. It made no attempt to generate data that would enable an analysis of the impact of Partners and the SHTP upon the legitimacy of the RCSS/SSA-S and, accordingly, conflict and peace dynamics inside Shan State.

## **Conclusion**

To conclude, this chapter introduced the research methodology and fieldwork processes employed. This research uses a qualitative methodological approach, encompassing an ontology of critical realism and epistemology of social constructionism. The choice of a

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<sup>49</sup> Myanmar is the world's second largest producer of opium and has a growing problem with methamphetamine (United Nations Office on Drugs and Crime, 2016, pp. 27, 53).

case study approach, using Partners' SHTP located on the Myanmar-Thailand border as its case, was explained. The second section outlined the research focus and location, and addressed specific ethical and fieldwork considerations of this research. Finally, it detailed the research methods used to generate and analyse the data.

An essential element of case study research is the role that the context plays in shaping events, experiences and relationships. The chapter that follows provides an account of the wider socio-political and historical context of Myanmar, and conflict-affected Shan State. It describes Partners INGO, and details the history of the SHTP that is the case study for this research.



## **Chapter 5: The research context: Myanmar, Shan State, and Partners Relief and Development**

### **Introduction**

The case study approach for the research explained in the previous chapter, and the capabilities framework for alternative health system development in conflict-affected contexts, both necessitate an understanding of the specific research context. This chapter provides that important contextual information about Myanmar and the research location of Shan State, as well as the key actors involved in the Shan Healthcare Training Programme (SHTP). Much of Myanmar's ongoing conflict is rooted in the history of British colonial Burma and its transition to independence following World War II, so the chapter begins with this detail. It then gives an overview of the present socio-political climate in Myanmar following the signing of the Nationwide Ceasefire Agreement (NCA) in October 2015, and the victory of Aung San Suu Kyi's National League for Democracy (NLD) in the general elections in November 2015.

Having provided a literature review of health system development in conflict-affected contexts more generally in Chapter 2, the second section of this chapter gives specific detail about health system development and the prevailing poor health status of communities in Shan State. This also specifically addresses the third research objective, to identify the impact of the conflict-affected context on the capability of the alternative health system to delivery primary healthcare. The key Tai organisations involved in the alternative Tai health system are introduced: The Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), the Shan State Development Foundation (SSDF), and the Shan Health Department.

The third section chronicles Partners Relief and Development's (Partners) foundation as an international non-governmental organisation (INGO) in 1995, during the expansion of cross-border relief and development activities with refugee and internally displaced peoples (IDP) communities along the Myanmar-Thailand border. Partners' volunteerism model is explained as this is paramount to understanding the programmatic approaches described in the findings chapters. The chapter concludes with an overview of the SHTP, and the key expatriate medical volunteers involved.

## 5.1 Myanmar

### 5.1.1 Colonial Burma and Independence

Myanmar has faced decades of armed conflict between the state and various ethnic non-state armed groups (NSAGs). The characteristics of this conflict have led many in the international community to define Myanmar as a ‘fragile state’ (OECD, 2016; The Fund for Peace, 2016; World Bank, 2016). As was discussed in Chapter 2, the normative categorisation of countries in this way is highly contested and has been critiqued, and therefore, this thesis uses the term ‘conflict-affected context’ to describe the research location of Shan State, Myanmar. Despite various ceasefire agreements, and the relatively free and fair democratic elections in 2015, Myanmar remains a conflict-affected context. An understanding of the context is vital to appreciate the difficulties faced by communities, and other actors such as INGOs working in Myanmar. This section outlines the antecedents of the conflict in British colonial rule and the independence movement.

The seeds of the current conflict throughout Myanmar lie in its colonial history. Britain began the gradual colonisation of Burma through a series of wars from 1824, until its complete annexation in 1886, when it was made a part of British India. Britain’s control of Burma was primarily motivated by a desire to extract its many resources including jade, rubies, oil and teak wood (Gravers & Ytzen, 2014). Continued resource extraction is one of the primary drivers of the ongoing conflicts in resource rich regions of Myanmar today.<sup>50</sup> The British cultivated a middle class elite of the minority Burmese population through a British education and their employment in the colonial administration (Charney, 2009, pp. 28–30). Part of the colonisation process was the territorialising of ethnic differences by emphasising “cultural differences, boundaries and places on a map” (Gravers, 2007, p. 13). Myint-U (2006, p. 197) argues that “...a powerful ethnic nationalism...one that saw little need to accommodate minority peoples, took root. At the center of this nationalism would be a desire for a new martial spirit”. Current conflicts are therefore rooted in British attempts to control disparate peoples throughout the territory, leading to a profound depth of ethnic nationalism (see also Aung-Thwin & Aung-Thwin, 2013, pp. 197–199; Steinberg, 2010, pp. 28–29).

This form of ethnic nationalism, facilitated by the British ‘divide and rule’ policy, conversely strengthened a burgeoning push for independence throughout the 1920s and

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<sup>50</sup> Sadan’s (2016) edited volume gives details on the close links between conflict and resource extraction in Myanmar.

1930s. Aung San, considered the father of Burmese independence, rose through the student political movement during this time, to champion independence. Following the outbreak of World War II, his movement unsuccessfully pressed Britain for a promise of post-war independence. It then aligned itself with the Japanese in the hope that their victory in the region would trigger independence. However, the independence movement found Japanese imperial rule intolerable, as evidenced by the construction of the infamous ‘death railway’ from Thailand (Charney, 2009, pp. 51–52).<sup>51</sup> As a result, Aung San, by then a general, switched his allegiance to the Allied forces and aided them in defeating the Japanese in Burma.

Following Allied success in World War II, Bogyoke<sup>52</sup> Aung San petitioned Britain for independence. This was preceded by him signing the pivotal Panglong Agreement in 1947, with representatives of some of Burma’s ethnic minorities, including the Tai.<sup>53</sup> The agreement meant that signatory states were “...fully acknowledged, allowed enhanced representation in Rangoon, accorded devolved powers within their localities, and given the option of secession a minimum of 10 years later” (Holliday, 2011, p. 39). This has been described as an “event that came closest to embodying ethnic unity in Burma, and it remains a compelling image of the possibility of ethnic unity”, and which is invoked today in the name of national unity (Walton, 2008, p. 910). On 19 July 1947, Aung San and some of his cabinet ministers were assassinated by a group aligned to a political rival, the previous prime minister, U Saw. Six months later, on 4 January 1948, Burma gained independence from Britain and a new era of nation-building began.

### **5.1.2 The *Tatmadaw* and its juntas**

What soon became clear was that Aung San’s assassination and the retreat of the British had left a power vacuum that political factions, armed during the war, attempted to manipulate in the service of their specific ethnic agendas. As such, although for its first decade of independence Burma was governed under a form of parliamentary democracy, conflicts between the state’s armed forces, known as the *Tatmadaw*, and NSAGs were ongoing. These divisions contested the fragile unity of the country that the *Tatmadaw* saw as its duty to uphold (South, 2008, pp. 27–28). Crucially, various communist groups were

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<sup>51</sup> An account of the death railway was depicted in the Man Booker Prize 2014 novel, ‘The narrow road to the deep north’ (Flanagan, 2013).

<sup>52</sup> Bogyoke is an honorific for General Aung San, who is known as the Father of the Nation. For more, see Myint-U (2006) and Steinberg (2010).

<sup>53</sup> As explained in Chapter 1, ‘Shan’ is used where used officially in names and ‘Tai’ is used to describe the ethnic group and language.

involved in the wider context of the international Cold War and it was within this political arena that the *Tatmadaw* was able to position “itself as the critical institution in the state” against communism (Holliday, 2011, p. 45). It continued to strengthen its stance with financial and military help from the United States.

In 1962, General Ne Win seized power in a coup, giving the *Tatmadaw* control, ostensibly because of the “weakness, incompetence and corruption of the civilian government” (Egreteau, 2016, p. 22). Towards the end of the 1960s the *Tatmadaw* instigated its ‘four cuts’ policy against NSAGs, to deny them food, money, information and new members (Grundy-Warr, 2004, pp. 237–239), a practice which continues throughout Myanmar today. A military junta ruled from 1962 to 1988, during which time the country failed to develop economically through the *Burmese Way to Socialism* it employed (Steinberg, 2010, pp. 62–80). The lack of economic development meant the government was unable to provide services to its citizens and this impelled the United Nations to designate Burma as a ‘Least Developed Country’ in 1987, where it remains. This affront to the country’s dignity would lead to unrest the following year.

The climactic events on 8 August 1988, which became known as the ‘8888 uprising’, were triggered by student protests in Yangon (formerly Rangoon). Long term and widespread economic pressures caused by the failure of the military junta’s socialist development fed into the protests. Internationally this is often framed as the result of a strong grassroots desire for democracy. However, Aung-Thwin and Aung-Thwin (2013, p. 258) challenge this, arguing that the emergence of the pro-democracy movement is a consequence rather than a cause of the uprising. Regardless of the causes of the protests, these were brutally suppressed by the military and many involved fled, some overseas as diaspora, and some joining ethnic insurgencies in border areas of Myanmar. It was in these circumstances that Aung San Suu Kyi, Aung San’s daughter, emerged as the leader of the pro-democracy movement. The State Law and Order Restoration Council (SLORC) military junta was established strengthening the *Tatmadaw’s* power again, and in 1989, it changed Burma’s name to Myanmar.

The pro-democracy movement fomented by the 8888-uprising enabled Aung San Suu Kyi to form the National League for Democracy (NLD) which won the 1990 elections in a landslide. This was despite Suu Kyi being under house arrest. The junta refused to recognise the result and continued martial law. SLORC changed to the State Peace and Development Council (SPDC) in 1997 when Myanmar was granted membership of the

Association of Southeast Asian Nations (ASEAN), and following a purge of its members. The SPDC is considered by analysts as simply a new “phase of military rule since 1988” (Charney, 2009, p. 179). In 1997 the United States responded to these events in Myanmar with an isolationist strategy of imposing sanctions, but there is some debate as to whether international sanctions altered the behaviour of the junta (Holliday, 2011, pp. 114–122). Some scholars, such as Pedersen (2013a) have instead advocated for ‘principled engagement’ pressuring the junta to change behaviours as a “moral and practical approach, which puts human rights, humanitarianism and the welfare of ordinary people at the centre” (M. B. Pedersen, 2013b, pp. 199–200).

In 2007 another uprising against continued military rule occurred, labelled the ‘Saffron Revolution’ as it was started by saffron-robed monks. Aung-Thwin and Aung-Thwin (2013, p. 273) again stress the role played by “[s]ocio-economic factors, not ‘democratic ideology’” in the unrest. Yet again, protests were violently quashed, even as footage was smuggled out of Myanmar to the international community, as shown in the documentary *Burma VJ* (Østergaard, 2008). While these momentous events primarily occurred in the cities, conflict was ongoing between the state and NSAGs in peripheral ethnic areas. Change in Myanmar was further accelerated by catastrophic Cyclone Nargis which hit in 2008 and exposed the junta’s reluctance to open the country to international intervention, even in the face of a massive humanitarian disaster (Holliday, 2011, p. 75). Supposedly free and fair elections were held in 2010, which “installed a nominally civilian government, which, in practice, is mostly a “constitutionalized” façade for ongoing military rule” (Turnell, 2011, p. 148). Most notably, Aung San Suu Kyi was finally released from her long periods of house arrest. The next section moves on to establish the current socio-political context, particularly regarding events from 2011 onwards and what this means for ethnic minorities in the country, including those in Shan State, the subject of this research.

### **5.1.3 Towards peace and democracy post-2011**

Following the problematic elections of 2010, President Thein Sein began instigating political and economic reforms in 2011, that “have widened political spaces for opposition and civil society considerably” (Bünthe, 2016, p. 369). This included greater freedom for the press and the release of political prisoners who had been opponents of the military regimes. The international community welcomed these apparent changes with a sense of hopefulness that real change would eventuate. Indeed, significant changes occurred in 2012 following the further release of a large number of political prisoners involved in the

8888 uprising and the signing of a peace agreement with the Karen National Union. As a result, the international community began to lift sanctions which provided an opportunity for global corporations to enter Myanmar to commence business, although any benefits of economic growth from this, and specifically resource extraction, have remained in the hands of a few elites often with military ties.

These reforms did not translate into a reduction in conflicts with NSAGs, including those in Shan State (introduced in section 5.2). Tentative moves towards peace have been undermined by an outbreak of communal violence towards the Rohingya people in Rakhine State and continued discord in ethnic states which may prove to be “decisive setbacks” to ethnic reconciliation (Holliday, 2013, p. 100). In 2015, a crucial event was the signing of the Nationwide Ceasefire Agreement (NCA) between the government and eight NSAGs just prior to the elections. The Restoration Council of Shan State (RCSS), the political wing of the Shan State Army-South (SSA-S), was one of the signatories meaning it was then removed from the government’s list of illegal organisations. However, the NCA remains a highly contested peace accord as the government only negotiated with 15 of the many NSAGs, and only eight of these signed it (McCarthy, 2016). Conflict is still ongoing in many parts of Myanmar between the *Tatmadaw* and NSAGs, as well as inter-ethnic conflict as groups compete for legitimacy and resources.

The momentous democratic elections were held on 8 November 2015, resulting in a comprehensive victory for Aung San Suu Kyi’s NLD. Sixty-four women were elected to parliament, including Daw Kyi Par (shown in Photograph 5.1 below), one of the NLD women candidates. This doubled the number of women.



*Photograph 5.1: Daw Kyi Par, NLD candidate, with her proud supporters outside a polling station in Yangon, 8 November 2015 (Source: Author, 2015).*

While the elections were a critical step towards positive change, a key element of the 2008 Constitution that gives 25% of parliamentary seats to the *Tatmadaw* remains unchanged, so it is difficult to make meaningful reforms that threaten the power of the military and its cronies. Bunte (2016, p. 370) argues that Myanmar is undertaking a “protracted transition, in which oppositional forces, ethnic groups, and the military have started to renegotiate political power” with the *Tatmadaw* preserving much of its political and economic leverage. Aung San Suu Kyi continued the process of ethnic reconciliation through the ‘Panglong 21<sup>st</sup> Century Peace Conference’, harking back to the 1947 Panglong Agreement brokered by her father, Aung San. The outcome of this was symbolic rather than practical and, at the time of writing, remains uncertain as the *Tatmadaw* continues its offenses against NSAGs and the Rohingya.

Despite major political and economic developments, Myanmar remains at 148<sup>th</sup> on the Human Development Index (United Nations Development Programme, 2015), with any benefits of change remaining largely in the hands of elites. Myanmar has a population of 53 million people, of which 66% are rural and depend on a subsistence lifestyle (Thawngmung, 2016; World Bank, 2014b). Health and education infrastructure is still extremely poor throughout much of the country, especially in rural areas. Callahan (2007, p. 53) describes the resultant underdeveloped human resource capacity as “the greatest hindrance to the growth of the civil society sector”. Expenditure on health is only 1% of GDP (World Bank, 2014a), meaning health outcomes are still extremely poor, as indicated by an infant mortality rate of 40 per 1000 live births (Ministry of Health and Sports & ICF, 2017, p. 111). Women still have very low participation rates in the vital ongoing peace process, with advocacy groups recommending a quota of 30% participation up from approximately 7% currently (Alliance for Gender Inclusion in the Peace Process, 2015).

These negative factors, combined with continued conflict, have meant the international community continues to position Myanmar as a ‘fragile state’ (although this thesis defines it as a conflict-affected context). The Organisation for Economic Co-operation and Development (OECD), in its new States of Fragility Framework, defines this as “the accumulation and combination of risks combined with insufficient capacity by the state, system, and/or communities to manage it, absorb it, or mitigate its consequences” (OECD, 2016, p. 37). Myanmar sits within this typology as a state in ‘extreme fragility’ as measured by economic, environmental, political, security and societal dimensions and highlighted in Figure 2.1 (see page 15).

Although Myanmar has rid itself of the ‘pariah state’ epithet following the emergence of a nascent democracy from 2011, the development challenges Myanmar faces are multiple. The ‘fragile state’ classification, albeit a contested one, frames the current approach of governments, INGOs and businesses to working in Myanmar. Having provided a synopsis of pivotal events in Myanmar’s history, the next section moves on to give the historical context of conflict-affected Shan State, the focus of this research. It will consider the specific socio-economic impact of the ongoing conflict within Shan State, as well as discussing the different actors involved.

## 5.2 Shan State

### 5.2.1 Conflict and the Myanmar-Thailand border

#### *The formation of the Restoration Council of Shan State/Shan State Army-South*

Shan State, under the British colonial policy of pacifying and controlling ethnic minorities through mapping the country, was designated as a Frontier Area in the 19<sup>th</sup> century (Holliday, 2011, pp. 28–29). Despite British attempts to homogenise the country, Shan State has always been ethnically diverse and includes the Tai, Kokang, Palaung/Ta’ang, Pao and Wa groups. This diversity has meant that it has “never been effectively united” (Lintner, 1984, p. 415), which the British used to their advantage. The disunity continues today in the ongoing conflicts between different ethnic groups and is encouraged by the *Tatmadaw* in order to “undermine any broad-based national movement” (Thawngmung, 2011, p. 16). The 1947 Panglong Agreement was negotiated and signed in Shan State by the dominant Tai ethnic group, and provided for the eventual secession of Shan State from the Union of Burma. This provision to secede has formed the basis of current claims for political autonomy, and federalism, and “calls for a return to the “spirit of Panglong”” (Walton, 2008, p. 907).

One of the most salient aspects of this research is the relationship of Partners Relief and Development INGO with the RCSS/SSA-S non-state armed group. This group has its origin in the Shan State Army, formed during the 1950s as the *Tatmadaw* moved to control an incursion by the Chinese Kuomintang (South, 2008). The Kuomintang were never fully evicted from Shan State and became integral to ethnic insurgencies and the opium trade in this area. The SSA underwent various configurations during the 20<sup>th</sup> century, including as the Mong Tai Army (MTA) controlled by the infamous drug lord, Khun Sa.<sup>54</sup> They continued the insurgency against the *Tatmadaw* until 1996 when they negotiated a surrender. However:

Not all of the MTA soldiers accepted the surrender. Yawd Serk, a young officer, rejected the surrender, broke away, and set up an EAO [ethnic armed organisation] to oppose the government. He attracted several thousand soldiers and formed the Shan State Army–South, which later became known as the RCSS/SSA. (Buchanan, 2016, p. 17)

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<sup>54</sup> The history of the opium trade in Myanmar, and Khun Sa’s dominance of it from the 1970s to 1990s, has been detailed by Lintner (1999).

The Restoration Council of Shan State (RCSS) was established as the political arm for the SSA-S in 1999.

### ***Internally Displaced Peoples***

The endemic conflict in Myanmar's ethnic states has led to a crisis of refugees and internally displaced peoples (IDPs). Many refugees fled across the Karen State border into refugee camps in Thailand in the late 1980s following the 8888 uprising. This movement of refugees continued into the 1990s as the *Tatmadaw* suppressed NSAGs such as the RCSS/SSA-S through its 'four cuts' strategy. This led to the first of many large-scale movements of people to and across the Myanmar-Thailand border. An estimated 100,000 were displaced in 1996 alone (Marshall, 2002, pp. 167–173). INGOs have been engaged in extensive relief and development activities in refugee camps, informally since the 1980s, and on a more official basis since 1992 (South, 2008, pp. 89–100). There are no Tai refugee camps within Thailand, only five IDP camps set up along the border (The Border Consortium, 2016). INGOs operate cross-border into these camps from Thailand which is "...by definition illegal, as it challenges the sovereignty of the Burmese government..." (South, 2008, p. 97). Pedersen argues that this 'principled engagement' meant:

...the more 'quiet' activities of foreign aid agencies on the ground made substantial contributions to human rights and welfare. International humanitarian agencies delivering health information and consultations, medicine, water and sanitation, and other basic health-related services helped hundreds of thousands of Myanmar survive in good health rather than suffer unnecessary illness or death. (M. B. Pedersen, 2013a, p. 195)

There has been a considerable commitment of funding from INGOs to ethnic civil society organisations, including those associated with NSAGs. Principled engagement is enabled in Shan State by INGO partnerships with the RCSS/SSA-S, and local civil society actors such as the Shan State Development Foundation (SSDF) and the Shan Health Department (see section 5.2.2). International funding enabled these organisations to become well established and increase their legitimacy and operational capacity.

A nominal ceasefire was agreed between the *Tatmadaw* and RCSS/SSA-S in December 2011. Then in October 2015, the RCSS/SSA-S was one of eight non-state armed groups to sign

the Nationwide Ceasefire Agreement (NCA),<sup>55</sup> which lays a foundation for continued dialogue between the *Tatmadaw* and signatory NSAGs. It has also meant that the RCSS/SSA-S was removed from the Myanmar government's list of illegal organisations. However, even post-NCA Shan State best fits the description Callahan (2007, p. 49) gives to those parts of Myanmar that exist in a “not quite peace” state where:

...emerging political complexes that involve various government and nongovernment actors in ongoing contestation, negotiation, discord, cooperation, and/or complicity of the nature and composition of political authority [operate]. (Callahan, 2007, p. 49)

This continued to be the case following the NLD's success in the November 2015 elections. The RCSS/SSA-S ostensibly still controlled parts of Shan State but although it is officially no longer in conflict with the *Tatmadaw*, at the time of writing there were continued skirmishes between the two, and with non-signatory NSAGs such as the Ta'ang National Liberation Army (TNLA). The range of armed actors involved in contesting areas of Southern Shan State are shown in Figure 5.1 below.

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<sup>55</sup> The multilateral Nationwide Ceasefire Agreement (NCA) was signed on 15 October 2015 by eight non-state armed groups. Seven other groups with previous ceasefire agreements did not sign. Four other groups did not join the process and are involved in ongoing conflict with the *Tatmadaw*. (Buchanan, 2016, p. 21)

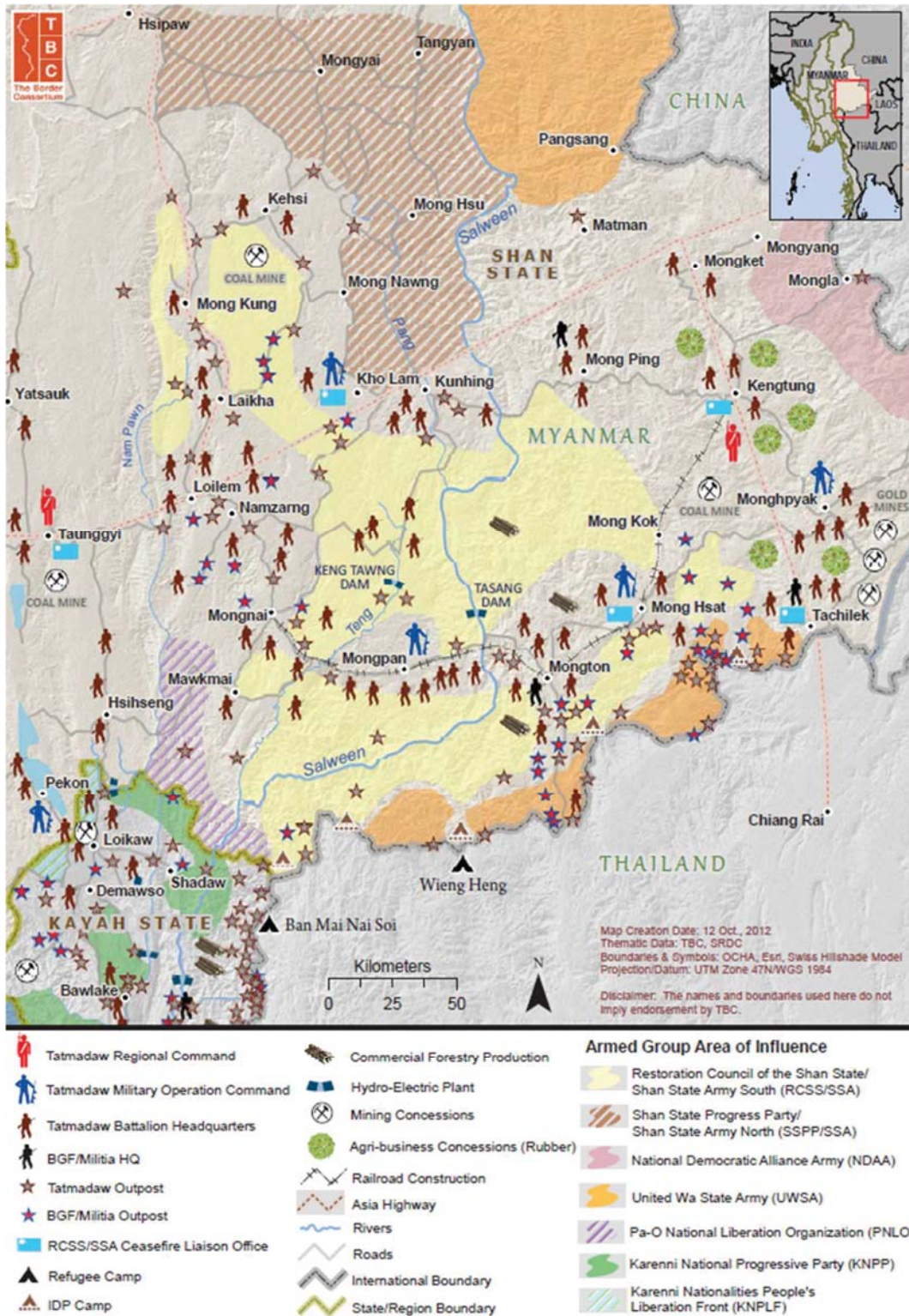


Figure 5.1: Contested areas of Southern Shan State (Source: The Border Consortium, 2012, p. 25).

### ***The reduction in international funding for cross-border programmes post-2011***

During the research, Tai authorities expressed unease about decreases in international donor funding, since 2011, for their cross-border work. This signified a transition in INGO priorities towards working with NGOs and civil society organisations (CSOs) inside Myanmar. Tai authorities noted that those programmes inside Myanmar were not broadening their reach to remote areas in Shan State, particularly those controlled by NSAGs such as the RCSS/SSA-S.<sup>56</sup> General Jao Yawd Serk (the Jao), head of the RCSS/SSA-S, summarised the problem:

Now more organisations are working inside Burma and they have a lot more funding. But not all areas are controlled by the Burmese government. So, I think that these INGOs cannot help the people very much if they can only go into areas controlled by the Burmese. (the Jao, May 2015)

As a result, the benefits of the burgeoning openness of Myanmar to INGOs are unevenly distributed, meaning ethnic populations are still disadvantaged by the lack of government service provision. Access to parts of Shan State was still limited due to ongoing conflict, as the Jao explained:

If INGOs want to go into the more remote villages in Shan State, the Burmese government won't allow this. If they are only able to work in the towns where the government allows then that is not helpful because there are already organisations and services there...For me, INGOs who work inside are not as helpful as those who work in places like here in Loi Tai Leng. After we finish the medic training, we can freely send the medics from here inside Shan State to where they're needed. (the Jao, May 2015)

Nang Mo Kham,<sup>57</sup> my research assistant and a medic, framed the issue in terms of ethnic desires to control their own affairs. She contended that international donor funding going to the Myanmar government is a way that the *Tatmadaw* can gain access to areas controlled by the RCSS/SSA-S. She commented:

The Burmese sometimes come into areas that we [the RCSS/SSA-S] control and there is trouble. Now we are in peace talks. But a lot of countries give

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<sup>56</sup> These areas included those contested by the RCSS/SSA-S and either the *Tatmadaw* or other non-state armed groups such as the Ta'ang National Liberation Army (TNLA).

<sup>57</sup> Not her real name.

their money to organisations in Yangon now. The Burmese say they will give us free healthcare and free education just so they can put their soldiers in our area to control Shan State. International organisations don't know this. They ask us 'Why do you have to do the training on the border or in Thailand? We will give you money if you do it inside Shan State'. INGOs and other countries give money to Yangon but they say they want to help here. I think if they give the money to us to do it ourselves, it will be better. If they let the Burmese come into our area then they will control us and there will be more problems. (Nang Mo Kham, April 2015)

Khu Tun Aye, the manager of the Community Health Worker training programme (see Figure 5.3 on page 114), also addressed suspicions held by Tai authorities about the role the *Tatmadaw* played in deciding which organisations operated where, regardless of agreements between these organisations and the government. He reiterated the importance of the Tai maintaining autonomy over their own development activities saying:

If Tai leaders meet with the government we should say 'It is good for our Tai people to choose what to do'. We can choose if we want a Tai organisation to help us. It should be up to the Tai people to decide this. We don't need the government to agree and give us permission. We don't need to tell them what we are doing with our own people. For now, maybe the government will allow us to do this as it is not a problem for them. The government might think that this is a good thing and say, 'You can do it for yourself if you want'. But the *Tatmadaw* won't agree. It is difficult. They will say 'You cannot do that'. They still use military power. So even if the government allowed us to undertake these activities the military will say 'We hold 25% of the power and this decision is under our control'. But we Tai don't know what will happen. The government and the military know each other. We don't. (Khu Tun Aye, May 2015)

His statement highlights that, at the time of the fieldwork, a high level of uncertainty existed about what a potential change in government would mean for the relationship between the RCSS/SSA-S and the *Tatmadaw* in Shan State, and the ability of Tai organisations to operate freely in areas they controlled.

The ongoing distrust between ethnic CSOs and the government was further illustrated by Sai Laeng, director of the Shan State Development Foundation (see Figure 5.3 on page 114):

The USAID are planning to do a nationwide health assessment survey. We [the SSDF] will participate in gathering data for households in Shan State. We will then be able to see the needs in those areas. But we have to participate anonymously. I had to tell them not to mention the RCSS because this project is working with the Ministry of Health. (Sai Laeng, May 2015)

The survey was conducted following the November 2015 election, from December 2015 to July 2016 (Ministry of Health and Sports and ICF International, 2016) and, despite the change in government, there is no mention of ethnic CSOs involved in the data collection.

It is worth briefly noting as part of the overall context for the research, that it is well established that Myanmar is the world's second largest producer of opium, the vast bulk of which is grown in Shan State (United Nations Office on Drugs and Crime, 2015, p. 30, 2016, p. 27) and this fuels inter-ethnic conflict (Meehan, 2011, 2015). There is also a growing problem with the production and consumption of methamphetamine or *yaba*. This research does not explicitly examine the issue of drug production and addiction. Nonetheless, this critical issue looms large where, in some communities, over 80% of the men are drug addicted. The RCSS/SSA-S has an anti-narcotics division and holds a low tolerance for drug use by its soldiers and in areas it controls.

A significant aspect of the ongoing conflict is its negative impact upon healthcare, which will be considered in the section that follows.

### **5.2.2 Conflict, healthcare and health system convergence**

#### ***Conflict and healthcare***

The extremely negative impacts on healthcare for populations in areas of protracted conflict have been well established (see Benton et al., 2014; R. J. Haar & Rubenstein, 2012; N. Howard, Sondorp, & ter Veen, 2012; PLoS Medicine Editors, 2011), and are discussed in Chapter 2. This includes factors of “high direct and indirect mortality, lack of governance, health system collapse and infrastructural breakdown [which leads] to increasingly poor health outcomes and life expectancy” (N. Howard, Hossain, et al., 2012, p. 32). These adverse consequences are present in Myanmar (Zaw & Pepper, 2016; Zaw, Htoo, Pham, &

Eggleston, 2015), including the Southeast regions (Davis & Jolliffe, 2016), where there are significant linkages between the presence of “militarization, human rights violations and poor health outcomes” (Davis et al., 2015, p. 5).

Accurate indicators of the health status of communities inside conflict-affected parts of Myanmar are difficult to obtain. Myanmar has a history of poorly conducted and contentious censuses including the recent one in 2014 (Spoorenberg, 2015; Than, 2015; Walton & Hayward, 2014). Communities have a deeply ingrained distrust of government officials and are hesitant to provide information, which has impinged upon the ability of INGOs to collect important data. INGOs also have difficulty accessing conflict-affected communities as they are required to gain government permission to visit areas that the *Tatmadaw* has designated ‘brown’ or ‘black’ zones where they may detain or fire freely upon civilians.<sup>58</sup> Much more is known about the healthcare situation in communities along the Myanmar-Thailand border, and particularly within refugee and IDP camps that INGOs are working in (Burma Medical Association, 2010; Davis & Jolliffe, 2016; Health Information System Working Group, 2015).

An important aspect of NSAG efforts to gain legitimacy has been the provision of social services such as health and education to their populations. The most well-known of these in the Myanmar context is the Mae Tao clinic (<http://maetaoclinic.org/>) set up by Dr Cynthia Maung in 1989 after she fled Myanmar following the 8888 uprising (Parmar et al., 2015; D. M. Pedersen, Pedersen, Santitamrongpan, & Barker, 2012; Win, 2016). The clinic is in Mae Sot, on the border with Karen State, and it initially supported Karen refugees with the assistance of the Karen National Union, an NSAG. It continues to provide much needed healthcare to underserved refugee and IDP populations in new premises. It also functions as a speciality training site for ethnic healthcare providers for health assistants, medics, midwives, pharmacists, and other specialties, including the Shan Health Department who send staff from Loi Tai Leng to participate. Mae Tao clinic maintains strong connections to the international community through Dr Maung’s reputation and research conducted in support of its work.

Healthcare provision is much less developed in Shan State. There are currently five IDP camps along the border in areas controlled and overseen by the RCSS/SSA-S. These camps

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<sup>58</sup> “According to Myanmar army designation, ‘white’ areas are those firmly controlled by the government, ‘brown’ areas actively contested with insurgents, and ‘black’ areas are those under [non-state armed group] control” (South & Jolliffe, 2015, p. 12).

and nearby communities share poor health outcomes due to the lack of government services and ongoing conflict which are detailed in *The Long Road to Recovery* (Health Information System Working Group, 2015, pp. 45–48). This report, and others (Davis & Jolliffe, 2016; Jolliffe, 2014; Jolliffe & Speers Mears, 2016) on ethnic health system development in Southeast Myanmar include data from Loi Tai Leng IDP camp, but not townships or villages further inside Shan State. These contested areas away from the border are less well served by any form of healthcare or education provision by either the Myanmar government, NSAGs or INGOs. Access remains limited for service providers and researchers so there is currently no accurate picture of health system provision in these communities. This research goes some way towards addressing the lack of information about the situation inside Shan State. The gap in information is shown in Figure 5.2 below, where I have added red arrows to indicate the provision of trained healthcare workers by the alternative Tai health system into Shan State.

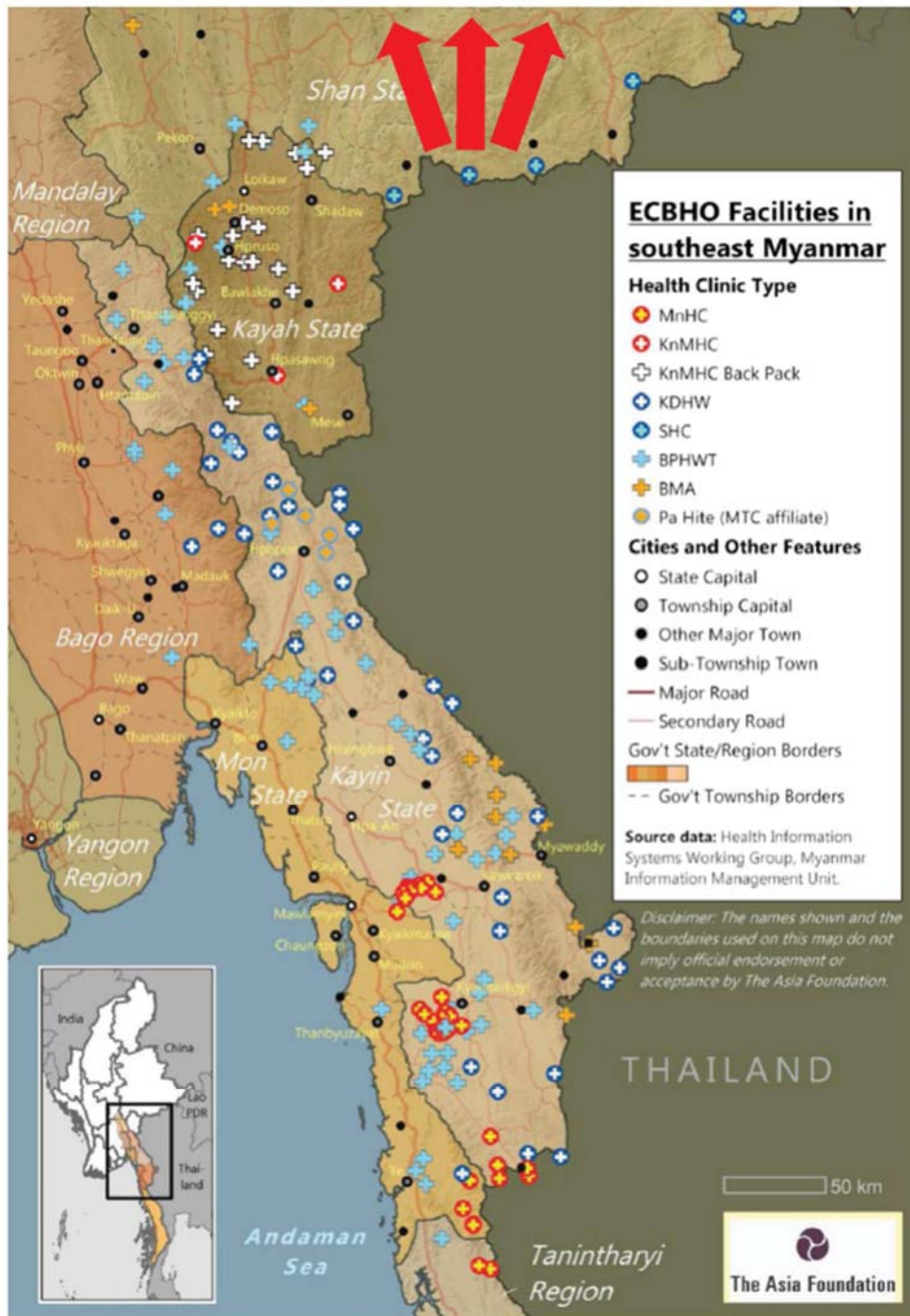


Figure 5.2: Ethnic and Community-Based Health Organisations facilities in Southeast Myanmar (Source: adapted from Davis & Jolliffe, 2016, p. iii).

### ***The Shan Health Department***

Hill, Pavignani, Michael, Murru and Beesley (2014, p. 7) argue that in a conflict-affected context, rather than a void existing where an unwilling or unable state has failed to provide services, “the bulk of health services is offered within this “void”: [and that] multiple, diverse substitutes have emerged where public services have been absent”. This is certainly the case in the contested areas of Shan State controlled by the RCSS/SSA-S, shown previously in Figure 5.2, where they initiated the provision of healthcare services under the auspices of the Shan Health Department. The health department originated in the Shan Health Committee, formed by two Tai medics in 1992, alongside the Shan Education Committee and the Shan Relief and Development Foundation. An organisational change in 2012 merged these three organisations into the Shan State Development Foundation (SSDF). Each organisation still retains a clear separation of mandates and functions and the health department operates in partnership with the SSDF. Paw Shar Gay, the functional head of the Shan Health Department, provided the diagram in Figure 5.3 below to explain the organisational structure and responsibilities within the health department and their relationship to the SSDF.

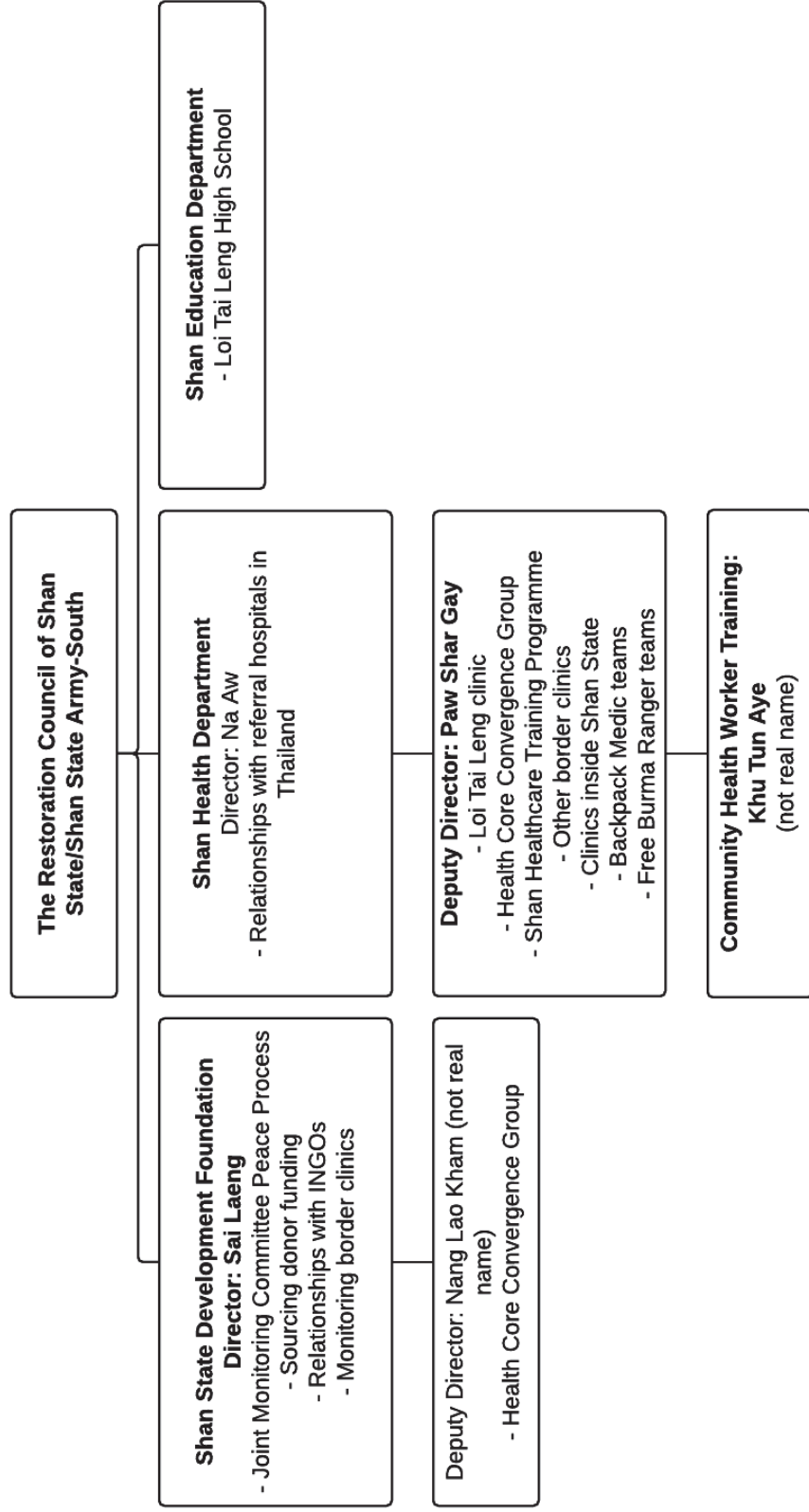


Figure 5-3: Organisational chart of the branches of the RCSS/SSA-S (Source: Author based on Paw Shar Gay's information, 2015).

The SSDF is predominantly responsible for accessing financial support from INGOs and other donors for development activities inside Shan State but it has no direct policy input into these activities (Sai Laeng, May 2015 & March 2016). It is headed by Sai Laeng who is also the RCSS representative on the NCA Joint Monitoring Committee to ensure that military signatories maintain the ceasefire.

The health department is currently headed by Na Aw, a military member of the RCSS/SSA-S, rather than a civilian health professional. He fosters the relationship between the health department and Thai hospitals to ensure that referred patients who cross the border illegally can receive treatment. The health department's mandate is to manage the five IDP clinics, the backpack medic teams, and the basic clinics staffed by medics inside Shan State. Paw Shar Gay, a Karenni medic, leads these activities as the second in charge of the health department. She was trained by the International Rescue Committee (<https://www.rescue.org/country/myanmar>)<sup>59</sup> and then practised in a refugee camp for five years before marrying a senior leader in the SSA-S and moving to Loi Tai Leng. It is highly unusual to have a woman in a senior leadership position within the RCSS/SSA-S, however she brings the vision and necessary medical experience to oversee these responsibilities. She also represents the health department in forums with other ethnic healthcare providers, such as the Health Convergence Core Group (see the following section). Khu Tun Aye heads the Community Health Worker (CHW) training programme for the health department. He received basic medic training as a member of a small Tai NSAG, that merged with the SSA-S in May 2005, rather than surrender to the *Tatmadaw*. He worked in informal village clinics and as a backpack medic with the NSAG. When he came to Loi Tai Leng in 2006 to join the SSA-S he was offered the opportunity to train as a health assistant at the Mae Tao clinic. After this, he returned to Loi Tai Leng in 2009 at the same time as Partners started the first CHW training.

### ***The convergence of the alternative Tai health system***

In 2012, the health department and seven other ethnic and community-based health organisations (ECBHOs) working in Southeast Myanmar, formed the Health

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<sup>59</sup> The International Rescue Committee is an international non-governmental organisation that has officially worked in Myanmar since 2008. It provides financial support and healthcare training, including training curricula, in nine clinics along the Myanmar-Thailand border.

Convergence Core Group (HCCG).<sup>60</sup> The primary function of the group is to explore the possibilities for the various ethnic health systems to converge with the Myanmar Ministry of Health and Sports (MoHS) system. The political environment following government reforms from 2011, the signing of ceasefires agreements, and the NLD election victory in 2015 are all seen as conducive to increasing cooperation. The overarching goal is to foster greater health equity in rural Southeast Myanmar. Central to convergence is the ethnic desire for federalism as encapsulated by the ‘spirit of Panglong’ mentioned in section 5.2.1. Any future convergence of ethnic health systems with the MoHS means that:

...overall decentralization of health system – decision-making authority, developing resources and public financing of health, and management of health programs and facilities – is required in order to address both the issue of accountability and the need for efficiency, and broader political reform is a necessity that must precede the efforts to decentralize the health system. (Health Convergence Core Group, 2015, p. 1)

The HCCG produced a diagram in 2014 to illustrate the possible progression towards the convergence of ethnic health systems with the Myanmar MoHS, occurring in parallel with the political process towards nationwide peace as shown in Figure 5.4. As the RCSS/SSA-S has signed the NCA, the phase that the Tai health system is at has been highlighted. There is a pivotal role for INGOs in this process, in maintaining their support of ethnic health system development alongside any cooperation that may be established with the MoHS (Health Convergence Core Group, 2016).<sup>61</sup> Indeed, Davis and Jolliffe (2016, p. 35) recommend that INGOs continue to “provide stable, long-term, systems-strengthening support for ECBHOs to stabilize and improve care for hard-to-reach and vulnerable populations in southeast Myanmar”.

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<sup>60</sup> These groups had already been cooperating since 2002 under the banner of the Health Information System Working Group. For more information see the website: [http://hiswg.org/?page\\_id=3473](http://hiswg.org/?page_id=3473)

<sup>61</sup> The HCCG made recommendations to the incoming NLD government in March 2016 in support of convergence alongside the current peace process (Health Convergence Core Group, 2016).



Figure 5.4: Primary Health Care Convergence Model Burma/Myanmar (Source: adapted from Health Convergence Core Group, 2014).

During the research, all Tai authorities were tentative in their support for the convergence of the Tai health system with the current Myanmar MoHS system (which contrasts with the unequivocal support of the SHTP programme managers discussed in Chapter 6, section 6.2.2). The Jao articulated that he thought the two systems should be kept separate, maintaining that “There is a chance to work together now that there is a peace process. But it is better for us to work alone” (the Jao, May 2015). However, in a later meeting with the programme managers he stated that as the Tai begin to cooperate with the Myanmar government under the terms of the NCA, it may open

possibilities for the Tai health workforce to be integrated into the government system (the Jao, meeting notes, November 2015). Sai Seng Wan, Partners' Tai cultural broker, later explained to me that the Jao was making a positive political statement about the NCA rather than supporting the likelihood of convergence (meeting notes, November 2015).

However, the reality of convergence is a long way off for rural communities inside Shan State. Despite the NLD election victory in 2015, the capacity and reach of government health services is limited in these areas. The RCSS/SSA-S fills the void by providing teams of medics to serve village tracts<sup>62</sup> in areas that they control. The medics continue to be at risk of arbitrary detention and violence from the *Tatmadaw* as it remains illegal for them to practise. In 2015 one newly qualified Shan Health Department medic was detained by the *Tatmadaw* after he was found with a photograph of himself with uniformed members of the RCSS/SSA-S at the SHTP closing ceremony. The International Committee of the Red Cross secured his release from prison in 2016. Another medic was detained by the Ta'ang National Liberation Army in 2016, during skirmishes with the RCSS/SSA-S, and is believed to be dead. A fundamental priority is the accreditation by the MoHS, of these medics practising within the alternative health system, which would provide some safety to practice. Medics still hold legitimate fears for their safety and utilise many different strategies to mitigate risk, described in Chapter 6, section 6.2.1. One common strategy is to undertake training as auxiliary midwives within the MoHS health system to receive official certification. Although this training is only for a short period and inferior to what they receive in Loi Tai Leng, it allows them to practice in contested areas, as well as those controlled by the RCSS/SSA-S.

Any discussion about convergence needs to account for the fact that the emergent Tai health system is inextricably linked with the RCSS/SSA-S and its military structures, which will be addressed in Chapter 6, section 6.3.2. Medics are overseen and supported logistically by local SSA-S commanders and these commanders may deploy medics to areas of their choosing rather than those with the greatest healthcare requirements. Those in military leadership do not necessarily possess the background knowledge to understand the healthcare priorities of their communities or the practical requirements of the medics. There is also some discrepancy between statements made by senior Tai

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<sup>62</sup> An administrative subdivision in rural Myanmar.

figures in public and private about the reality of convergence with the MoHS. Davis and Jolliffe (2016, p. 32) state that convergence “has different meanings to different actors” and the complexity of these relationships reflect this. The relationships between Partners, the RCSS/SSA-S, and the Tai health system, will be discussed in greater detail in Chapter 6.

### **5.2.3 Loi Tai Leng: A model health clinic for Shan State**

The fieldwork was conducted in Loi Tai Leng, located directly on the border between Thailand and Shan State, Myanmar. This area is described as the “fortress of mountains” (Marshall, 2002, p. 3), and is a site where Tai refugees relocated during the *Tatmadaw*’s ‘four cuts’ strategy of the 1990s. It was officially established as a Tai IDP camp in 1999/2000 and is one of five along the border. It is the main operational base for the RCSS/SSA-S and, although defined as an IDP camp, it could now more accurately be described as an established border township. The population of approximately 2,500 people comprises army soldiers and their families, IDPs, as well as people who have chosen to migrate to the border for economic opportunity (The Border Consortium, 2016).

Loi Tai Leng’s rugged and remote geography has made it a relatively safe location for IDPs. However, *Tatmadaw* and United Wa State Army (UWSA) positions are clearly visible from vantage points on hilltops. The RCSS/SSA-S and UWSA have clashed periodically in past years. Bolt holes are dug into hillsides throughout Loi Tai Leng, for villagers to retreat to if under attack, illustrating the reality of living in a conflict-affected context. However, there have not been any direct attacks on Loi Tai Leng itself since the UWSA mortared it in 2005. This stability, and its location so close to Thailand, attracts people who migrate there for economic opportunities provided by proximity to the porous Myanmar-Thailand border (Aung, 2014). Many of Chiang Mai’s illegal migrants are Tai who have crossed the border in search of the precarious work available in the Northern Thailand city.

The RCSS/SSA-S constructed a simple medical clinic in Loi Tai Leng in 2001, directly across the border in Thailand where Tai refugees had built homes. In 2010 the Thai army forced Tai refugees to relocate back across the border inside Shan State, so the clinic had to be reconstructed. Partners paid for a new clinic building to be built on the grounds of the National High School, where parents from inside Shan State send their children to board and be educated in safety. However, in 2011, the RCSS/SSA-S obtained

funding from a European government agency and rebuilt the clinic in its current location, which was a source of now resolved tension between the RCSS/SSA-S and Partners.

The clinic building is extremely basic and consists of women's and men's in- and out-patient wards, a pharmacy, a delivery room, a ward for maternal and child health patients and office space. Clinic supplies were previously funded by the INGOs Terres Des Hommes (<http://www.terredeshommes.org>) and International Rescue Committee. However, that funding has now ceased meaning crucial supplies are often unavailable. Separate buildings have recently been constructed for mental health patients to be confined in and for large community meetings. There are also various dormitory outbuildings for women and men medics. There is one open plan classroom that the bulk of the medic training takes place in. In 2011 Dr Bert, one of the expatriate medical volunteers, paid for a house to be constructed for the expatriate medical volunteers to reside in and some medic classes are held there as space allows.

The clinic is staffed by medics who have been trained in Loi Tai Leng, and some who received further training at the Mae Tao clinic. All of the trainee medics work inside the clinic during their training and conduct ward rounds with the expatriate medical doctors as an integral part of their training. If they see a patient that they feel they are unable to treat then they have the option to refer them to a small cottage hospital across the border in Pang Mapha, the nearest town in Thailand. This option is not freely available as the cost of transport and hospital payment are prohibitive for the health department. Paw Shar Gay is ultimately responsible for making these decisions and has often not referred patients, some of whom later died. The medics are trained to keep inpatient records for all of the five border clinics. These were regularly independently audited until recently when the funding was no longer available for the health department to do this. The overarching goal of the health department is for the Loi Tai Leng clinic to operate as a model for those inside Shan State, as it explores the option of convergence alongside the HCCG, and seeks to establish an alternative Tai health system.

While the reach of government ministries into conflict-affected areas continues to be poor, there is a need for ethnic civil society organisations to deliver these much-needed services. Ethnic CSOs consider the significant reduction in international donor funding to be premature, limiting their ability to continue to meet community needs. They still view the support of INGOs as an important factor in establishing alternative ethnic

healthcare and education services that support their desires for a measure of independence.

### **5.3 Partners Relief and Development**

#### **5.3.1 Relief and development on the Myanmar-Thailand border**

The origins of Partners' (<https://www.partners.ngo/>) work within the historical context of cross-border INGO work in Myanmar is established in this section. It locates Partners' activities within the service delivery and volunteerism development approaches that it employs (and that will be discussed further in Chapter 7). The aims and activities of the SHTP that Partners operates on the Myanmar-Thailand border are delineated, and the various actors involved in its implementation are introduced.

Partners is based in Chiang Mai, a hub for Christian missions and development organisations in Southeast Asia, because of its proximity to many other Southeast Asian locations. Partners also has a base in Mae Sot on the Thailand border with Kayin State (formerly Karen State) where its work began with refugees that had crossed the border from Myanmar into Thailand in the 1990s.<sup>63</sup> Partners has programmes in Kayin, Shan, Kachin and Rakhine States of Myanmar. It also has incipient small scale, emergency relief work in Syria and Iraq.

Like many INGOs that were propagated during the 1990s (N. Banks & Hulme, 2012; Fowler, 2011; Lewis, 2014, pp. 15-19; Lewis & Kanji, 2009, pp. 24-46), Partners arose in response to “unmet needs on the basis of [the] personal experiences and observations” (Carman & Nesbit, 2012, p. 612), in this case, of a charismatic and visionary expatriate couple based in Thailand. Steve and Oddny Gumaer, an American and Norwegian, worked with the Christian mission organisation, Youth With A Mission, in Bangkok. Oddny tells the story of how they started Partners when they were introduced to Kayin refugees in a camp on the Myanmar-Thailand border where they met a woman caring for orphans. She was unable to financially provide for the children herself so asked Steve and Oddny for assistance:

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<sup>63</sup> The Karen, now more correctly, Kayin, are one of Myanmar's 135 officially recognised ethnic minority groups. They number approximately 3-4 million (7% of total population) and live mainly in Kayin State. They have been engaged in conflict with the Myanmar military for over 60 years, leading to large numbers of internally displaced people and refugees along the Myanmar-Thailand border (Gravers, 2014, pp. 173-175).

“About a thousand baht a year”, Rose said. One thousand baht? That’s \$30. And that was all she needed to provide for the child! Well, now the answer was really easy. Of course we could help her. We pulled out the bank note with the spaghetti scribbles. It didn’t feel like much. It wasn’t much. But for that little girl, it was a lot. It was life itself. And it was then that a new kind of adventure started for us. Without really knowing that that’s what we were doing, we started our organization, Partners Relief & Development, that day. (Gumaer, 2011, p. 50)

In the decade following its establishment, Partners became predominantly involved in relief work in refugee and IDP camps along the border, establishing community based care homes for unaccompanied children. In 1998, it initiated its first development activity of an income generating weaving project with Kayin women. It opened an official office in Mae Sot in 2003, primarily engaged in healthcare training with the Kayin. In 2008, it started operating a sustainable agriculture training farm, practising the System of Rice Intensification (SRI) method.<sup>64</sup> The Shan Healthcare Training Programme commenced in 2009 and will be described in greater detail in section 5.4. Further work was instituted in Shan State with the Sustainable Schools Programme starting in 2011, working alongside rural communities to support their own education. In 2012 there was also an outbreak of violence against the Rohingya population in Rakhine State.<sup>65</sup> Since then Partners has been involved in relief activities inside the Rohingya IDP camps as the violence continues. They also instigated a Community Support Network inside IDP camps in Kachin State. In response to the large number of undocumented Tai migrants in Chiang Mai, Partners also provides vocational and educational training through its SEED Learning Center to mitigate against exploitation.

Since its beginnings, Partners has characterised itself as an INGO that has “...a willingness to go where nobody else has gone...” (Gumaer, 2011, p. 177). Unlike INGOs who maintained their neutrality but operated within Myanmar with the permission of

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<sup>64</sup> “The System of Rice Intensification, known as SRI...is a climate-smart, agroecological methodology for increasing the productivity of rice and more recently other crops by changing the management of plants, soil, water and nutrients” (SRI International Network and Resources Center, 2016).

<sup>65</sup> There are ongoing documented human rights abuses against the Rohingya, a population denied citizenship, that some characterise as genocide (Fortify Rights, 2015; International Crisis Group, 2016; McCarthy, 2016; South & Jolliffe, 2015). At the time of writing, the *Tatmadaw* had instigated further violence, leading to the mass exodus of over 500,000 Rohingya refugees across the border into Bangladesh (United Nations Office for the Coordination of Humanitarian Affairs, 2017).

the Myanmar government (see Ware, 2014b, pp. 256–258), Partners functioned ‘under the radar’. This said, there are other INGOs doing work in Myanmar similar to that catalogued above, such as International Rescue Committee and The Border Consortium (<http://www.theborderconsortium.org/>). Partners has previously partnered with Free Burma Rangers (<http://www.freeburmarangers.org/>), an INGO that operates covertly inside Myanmar alongside NSAGs. Partners has transitioned over the last twenty years from being based solely in Thailand, to having independent fundraising entities in USA, Canada, Norway, Australia, and UK,<sup>66</sup> which provide the majority of its volunteer staffing. In 2015, it started small scale relief work in Iraq and Syria following a similar shift by Free Burma Rangers into the conflict-affected territories of Sudan and Iraq. Partners believes it brings relevant experience of working in conflict-affected contexts to these situations saying that they “...know we are in the right place and that our way of working is a perfect fit for this complex conflict” (Partners Relief & Development, 2016), although this work is yet to be fully established due to the volatile nature of the fighting.

### **5.3.2 Volunteerism and advocacy**

Partners functions within a traditional service delivery model, as typified by their activities, common for INGOs (see N. Banks, Hulme, & Edwards, 2015; Desai, 2008; Lewis, 2014). According to Korten’s (1990, p. 15) ‘four generations of NGOs’ (see Table 2.2 on page 33), Partners predominantly engages in activities typical to second generation INGOs, that have a local level orientation. However, its involvement in health system development means it spans into some third generation strategies because of the regional focus of these activities. The need for INGOs to “fill the gaps” in education and health service left by the unwilling and/or unable state, particularly in conflict-affected contexts, was discussed prior in Chapter 2. Partners has worked in this space since its inception in 1995, alleviating clear service and skills gaps caused by the ongoing conflict in Myanmar. Chapter 2 also argued that partnering with ethnic CSOs, rather than the government, is an appropriate response for service delivery. At its outset, Partners established these types of partnerships, first with Kayin CSOs in refugee and IDP camps, and later with the RCSS/SSA-S in Shan State.

Partners undertakes its service delivery activities utilising a volunteerism model, that has come under some criticism in the development studies literature (see Chapter 2

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<sup>66</sup> Partners Relief and Development New Zealand also existed between 2008 and 2016, when it resigned from the international alliance.

and also Baillie Smith & Laurie, 2011; J. Howard & Burns, 2015; Lewis, 2003, p. 338; McLennan, 2017). Initially, Partners had to do so because it was operating on a very small budget. Deploying volunteers, who had sourced their own living costs, meant that the limited funds being raised by support countries could be directed to programme activities. It ameliorated prevailing donor concerns about INGO overhead costs, a paradigm that continues to hobble legitimacy and activities in the development sector (Fram, 2013; Taylor, Harold, & Berger, 2013). At the start, volunteers were primarily selected on the basis of their availability to participate in Partners' activities through sourcing their own support, rather than possessing a specific skill set. However, given the health focus, a cohort of expatriate volunteers who bring necessary medical experience and expertise was needed (see section 5.4.4.). The ongoing tension between volunteer availability and ability, and its impact on programmes will be discussed in Chapters 7 and 8.

Partners prides itself on being a small INGO that is agile and responsive, asserting that “we were able to respond quickly and provide aid before most organizations became involved” (Partners Relief & Development, 2015, p. 12). It recognised the potential limitation that acting in an advocacy space in Myanmar could jeopardise its development activities and crucial partnerships with NSAGs. Partners overcame this by spawning another INGO in 2013, Fortify Rights (<http://www.fortifyrights.org/>), who specifically research, monitor and report on human rights issues. Fortify Rights works in partnership with organisations such as the International Human Rights Clinic at Harvard Law School, “...independently documenting and exposing human rights violations while teaming with activists to advocate for change at local, national, and international levels...” (Fortify Rights, 2016). It is a completely independent entity, meaning it has the freedom to report on abuses that may be carried out by actors that Partners works with. Lewis (2014, p. 115) describes NGOs as able to catalyse and “influence policy in favour of marginalized groups” when they engage in advocacy work so, by proxy, Partners is enabled to do this through Fortify Rights. Having focused on the evolution and development of Partners' endeavours, the following section provides a description of the case study for the research, the Shan Healthcare Training Programme.

## 5.4 The Shan Healthcare Training Programme

### 5.4.1 The growth of a partnership and a programme

Partners has a formal partnership with the RCSS/SSA-S, mediated by a memorandum of understanding (MOU) signed with the SSDF. The informal relationship began in 2005 when Partners' staff made exploratory visits with another organisation, Free Burma Rangers, to the Loi Tai Leng IDP camp to assess how they could help. Initially, these activities were limited to relief delivery and a support role for Free Burma Rangers. Stu,<sup>67</sup> from Partners, was introduced to the Jao, the most senior leader of the RCSS/SSA-S, in 2008. They discussed how Partners could best support Tai communities. Paw Shar Gay had long recognised the need for health workforce training as she was already managing the basic border clinic. The Jao understood the benefits of an alternative Tai health system and requested Partners' help with starting a Community Health Worker (CHW) training programme.<sup>68</sup> During the research, the Jao shared his vision for the expansion of Tai capabilities through the SHTP. He acknowledged that the low levels of education inside Shan State contribute to their poor health system. He spoke positively about the partnership between the RCSS/SSA-S and Partners, and emphasised the need to focus on disease prevention, stating:

Our education levels are low, very low. We haven't had the chance to study, or have appropriate healthcare. Our people have had only traditional medicine to use to prevent disease and sickness. That why the RCSS and Partners have worked together to develop the CHW training to help prevent disease. (the Jao, May 2015).

The Jao believes that having an RCSS/SSA-S clinic in every village tract will facilitate greater community acceptance of the medics by demonstrating their abilities more widely.

Later in 2008, Partners adopted a CHW training curriculum on the advice of a group of border health experts. It had been developed by the International Rescue Committee specifically for healthcare workers on the border. Partners organised for it to be translated into Tai. The curriculum uses the recognised '*Burmese Border Guidelines*' (2007) which was translated into Tai by the SSDF, and updated in 2016. This was also

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<sup>67</sup> One of Partners' staff from Aotearoa/New Zealand, introduced in Chapter 4, section 4.2.1.

<sup>68</sup> For the purposes of this research, the term 'medic' is congruous to the definition of CHW established in Chapter 2, section 2.3.3, as Partners uses it to distinguish a CHW who has progressed to a second or third year of preservice training within their curriculum structure.

supplemented by the *'Where There Is No Doctor'* book (Werner, Thuman, & Maxwell, 2010). The relationship with the RCSS/SSA-S was formalised with a five-year MOU in 2009, and Partners sent Shaune, an expatriate medical volunteer, to Loi Tai Leng to train the first 59 CHWs to fill the gaps in healthcare provision, illustrated previously by the red arrows in Figure 5.2 (see page 112).

In 2010 the programme expanded to include a Train the Trainer component and the higher-level medic training programme was established with 18 trainee medics. The future of the programme, and indeed Partners' relationship with Tai authorities, was threatened in 2011 due to a lack of external donor funding for the training to continue. However, Dr Bert, an expatriate doctor that Stu knew, stepped in to provide the necessary financial support for Partners and became involved in the training. At this time, Shaune returned to the US and Claire, a New Zealand nurse, took over the management of the SHTP, and the organisation of medical volunteers.

Partners' continued mentoring of Tai CHW trainers enabled the full responsibility for the CHW training programme to transition to Tai leadership in 2012 (see Chapter 7, section 7.3.2). This was also the first year of the Advanced Medic training programme, meaning that three tiers of health workforce training are now running concurrently (CHW training, Medic Level 1, and Level 2). Partners expatriate medical staff continue to adapt and update the International Rescue Committee medic curriculum through their practice, with input from visiting volunteers. Importantly, in 2016 these medic training materials gradually began to be translated into Tai by a former medic who learned English in Aotearoa/New Zealand for a year. At the end of 2015 Partners signed a new five-year MOU with the SSDF to continue with the SHTP (Appendix 13; discussed further in Chapter 6). Partners only provides funding for the SHTP and CHW training, not for the Loi Tai Leng clinic's operating costs. Partners sources its funding year by year, meaning that the SHTP exists in a somewhat tenuous position, without the necessary committed funding available for the term of the five-year MOU. The agreed responsibilities between Partners and the SSDF are outlined in sections 1 and 2 of the 2015 MOU, shown in Figure 6.2 (see page 140). The relationship between Partners and Tai authorities, enacted through the MOU, will be explored in section 6.1.

Once CHWs and medics complete their training Partners has no influence over where they practice within the emergent Tai health system. Medics often remain in the Loi Tai Leng clinic for a period to hone their skills under the supervision of Paw Shar Gay and the programme managers. Most are deployed to rural communities inside Shan

State that are in areas controlled by the RCSS/SSA-S, as this mitigates safety concerns about interference from the *Tatmadaw*. New health clinics have been established in these communities in recent years, some in purpose built buildings, others in re-purposed homes, shown in Photograph 5.2. Other medics practise as backpack medics, either as civilians or mobilised with the SSA-S as it travels through conflict-affected areas of Shan State.



*Photograph 5.2: Shan Health Department clinic inside re-purposed home (Source: Paw Shar Gay, 2016).*

Partners is unable to formally monitor the medics and CHWs as this task falls under the responsibilities of the Shan Health Department. They receive some anecdotal reports as to their whereabouts and performance from Paw Shar Gay, who maintains this information informally at the Loi Tai Leng clinic. In March 2016, an inaugural medic refresher training was held in Loi Tai Leng which provided the programme managers with an opportunity to evaluate the success of the previous seven years of CHW and medic training. The programme managers drew up Table 5.1 to show the data gathered by Paw Shar Gay as to what previously trained medics are currently doing. It

indicates that between 2012 and 2015 the SHTP had a retention rate of 65% of medics still working within the Shan Health Department system.

*Table 5.1: What has happened to the students after graduation*

<b>Basic medic class</b>	<b>Left</b>	<b>Still training</b>	<b>Working for other as medic</b>	<b>Working in other professions</b>	<b>Medic in SHD clinics</b>
<b>2012</b>	5	2	2	0	<b>11</b>
<b>2013</b>	2	3	1	0	<b>15</b>
<b>2014</b>	3	4	1	3	<b>18</b>
<b>2015</b>	4	4	0	0	<b>20</b>
<b>Total</b>	14	13	4	3	<b>64</b>
<b>% Total</b>	<b>14%</b>	<b>13%</b>	<b>4%</b>	<b>3%</b>	<b>65%</b>

*(Source: McFarlane & McFarlane, 2016c, p. 10)*

#### **5.4.2 Regular medical volunteers**

Sourcing volunteers, with the appropriate medical skills and experience of working and teaching in low resource contexts, is of singular importance to the SHTP in order to foster these skills in the medics. Difficult living conditions, stresses due to the isolation of cross-cultural work, problems sustaining personal funding, and the transient nature of development work are all factors that require greater human resources management than Partners has had the capacity to provide. This has led to a high turnover of volunteers during the life of the programme. There were regular expatriate medical volunteers involved at the time of research, who were particularly influential on the programme and the clinic.

Dr Alison and Dr Ken are two semi-retired general practitioners from Aotearoa/New Zealand who manage the SHTP, and who have provided continuity of leadership since 2013. They became involved due to their relationship with Stu and their availability following their retirement from general practice work. In 2011, Stu invited them for a brief period of teaching in the Loi Tai Leng clinic, then based at the Loi Tai Leng National High School. At the time, the continuation of the programme was not assured

because of funding problems. However, once funding for the programme was stabilised and they had finished general practice work, Dr Alison and Dr Ken emigrated semi-permanently to Chiang Mai in 2012 to teach in Loi Tai Leng for longer durations. They were initially diverted to Rohingya IDP camps in Sittwe to conduct medical relief work with a team from Partners, following the outbreak of violence against the Rohingya. They have managed the programme since the end of 2014 when Claire left the organisation, and they spend much of the year between March and November based in Loi Tai Leng in this role.

Dr Bert is another expatriate doctor who has had a prominent role in both teaching and curriculum development for the SHTP since 2009. He also became associated through his relationship with Stu, when he was invited to undertake an assessment of the clinic at the high school. He was initially reluctant to become involved in Loi Tai Leng area as there were ongoing security concerns. As recently as 2005, Loi Tai Leng had come under mortar attack from the nearby rival ethnic army, the United Wa State Army (UWSA). However, Dr Bert was reassured that the SSA-S had taken sufficient measures to mitigate security concerns for visiting foreigners. In 2011, he provided funds so the training could continue, and began teaching in a more formal role to fill a gap in teaching capacity. He has since built a house in the community for expatriate medical volunteers to stay in while teaching, and provided basic dormitory accommodation for some of the students (see Photograph 5.3). He has been instrumental in reviewing and adapting the International Rescue Committee curriculum for use in the SHTP, based on his experience volunteering in Thailand, although he has had no specific medical training for low resource contexts.



*Photograph 5.3: One of the women's dormitories purchased by Dr Bert (Source: Author, 2016).*

Other expatriate medical volunteers, who have taught regularly for a number of years, maintain a more independent status within the SHTP. Dr Les' association also began with Stu, as a friend of his met the Jao with Stu when he requested Partners' help with medical training in 2008. Dr Pilou visited Loi Tai Leng with another organisation when the Jao asked him to assess the quality of the initial CHW training. He evaluated Partners positively, and was then invited by Partners to help with the teaching. Both Dr Les and Dr Pilou have taught since the inception of the SHTP in 2009, when there was very little formal curriculum. Dr Pilou primarily teaches Integrated Management of Childhood Illness (IMCI), while Dr Les instructs trauma and first aid. Dr Steve, whom I was unable to meet during the research, also works with the government of the Lao People's Democratic Republic so brings a depth of knowledge of working in the Southeast Asian context for the time he teaches, and he is a popular choice of the medics.

#### **5.4.3 Ad hoc volunteers**

Partners also uses other ad hoc expatriate volunteers to teach various modules of the programme. I was able to meet some of these, including a medical student and a

psychologist from Aotearoa/New Zealand; and volunteers from the US who taught English at the SEED Learning Center, who visited Loi Tai Leng for a short time. The programme has also used midwives, paramedics, laboratory technicians, pharmacists, dentists, and an orthopaedic surgeon. Despite a need for many of these specific skills, especially in maternal and child health, ad hoc volunteers appear to be selected by Partners on the basis of their availability for a period, rather than how best their particular skill set supports the needs of the medics and the training modules in the curriculum. The programme managers incorporate these proffered skills into the SHTP, so they can utilise the availability of these volunteers as best they can. However, there is some concern that volunteers may lack the skills for work in contexts such as Loi Tai Leng, and this “[o]verreaching or mismatching providers’ medical knowledge base and skill sets” is explored in Chapter 7, section 7.2 (Wilson et al., 2012, p. 614).

## **Conclusion**

The case study approach and the capabilities framework for health system development in conflict-affected contexts both call for an appreciation of the impact of the research context. The chapter provided a brief history of British colonial Burma, and the post-independence Panglong Agreement, which form the antecedents of current conflicts throughout Myanmar. It also delineated the current socio-political and economic context following the signing of the Nationwide Ceasefire Agreement by some non-state armed groups, and the success of Aung San Suu Kyi’s National League for Democracy at the 2015 elections. The history of the conflict in Shan State was outlined with attention paid to the effects of that conflict upon healthcare outcomes inside Shan State, despite the lack of data on this. Despite the burgeoning hope felt following the NLD’s victory in 2015, the situation in conflict-affected areas of Myanmar remains largely unchanged. During the research, it worsened in many areas, including in Shan State. The key organisations and individuals in the alternative Tai health system were introduced: the RCSS/SSA-S, the Shan State Development Foundation, and the Shan Health Department. The chapter then traced the emergence of Partners as a service delivery INGO on the Myanmar-Thailand border. It concluded by describing the evolution of the Shan Healthcare Training Programme and some of the key expatriate medical volunteers involved.

This chapter has gone some way to answering Objective 3, to identify the impact of the conflict-affected context on the capability of the alternative health system to deliver primary healthcare. The chapter that follows is the first of two chapters that will present

the findings from the research. It examines the relationships between the different actors involved in the SHTP, and recounts the views and experiences of the medics.

## **Chapter 6: The relationships in the Shan Healthcare Training Programme: Collaboration and complexity**

### **Introduction**

This is the first of two chapters that summarise the key findings of the research, drawing on fieldwork interviews and observations from four visits made in 2014, 2015 and 2016. The findings in this chapter primarily contribute to the first of the three research objectives: to explore the relationships of the different actors involved in the Shan Healthcare Training Programme (SHTP). Chapter 2 discussed the contributions of both international non-governmental organisations (INGOs) and non-state armed groups (NSAGs) to health system development in conflict-affected contexts, so these findings examine the intricacies of the partnership between Partners Relief and Development (Partners), the Shan Health Department and the Shan State Development Foundation (SSDF).

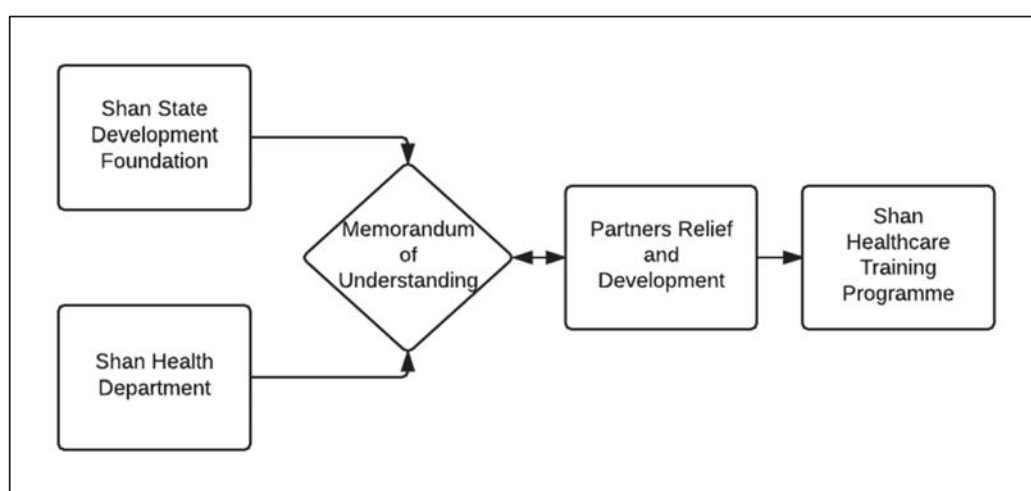
The chapter is comprised of three sections, the first of which explores the genesis of the partnership between Partners and the health department in a personal relationship, through to its outworking in the current memorandum of understanding (MOU; Appendix 13) with the SSDF. Some of the limitations of the MOU are considered. Second, the relationship of the Tai medics to the Myanmar Ministry of Health and Sports (MoHS) system is explored through the interrelated issues of official certification of the medics to ensure their safety, and Partners' support for the convergence of the Tai and Myanmar health systems. The findings also reveal some of the lived experience of medics in the conflict-affected context, which supports research objective 3, to identify the impact of the conflict-affected context on the capabilities of the alternative health system. The third section focuses on the indirect relationship between Partners and the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), and describes some of the limitations of having an emergent civilian health system embedded within its military structures. It also describes the relationship of the medics to that hybrid civilian-military system.

### **6.1 Partners Relief and Development and its Tai partners**

#### **6.1.1 The genesis of a positive relationship**

This research aimed to better understand the relationship between Partners, the Shan Health department, and the RCSS/SSA-S. The relationship was first informally established in 2005 when Partners staff visited Loi Tai Leng to conduct relief activities

(detailed in Chapter 5, section 5.4.1). Through this relief work personal trust was cultivated between Tai leadership and Partners staff, especially General Jao Yawd Serk (the Jao) and Stu, who headed Partners' work in Shan State at the time. The Jao requested Partners' help with specific healthcare training and this commitment was formalised with the first five-year MOU in 2009. The relationship between Partners and the RCSS/SSA-S is mediated by the Shan State Development Foundation (SSDF), the development arm of the non-state armed group, and the official signatory to the MOU (discussed in the following section). The diagram in Figure 6.1 illustrates the relationships between the SSDF, the health department and Partners (see also the RCSS/SSA-S organisational chart in Figure 5.3 on page 114).



*Figure 6.1: The relationship between the different actors in the Shan Healthcare Training Programme (Source: Author).*

The relationship has sometimes been difficult to navigate as Partners had to learn the different roles and responsibilities held by staff within the SSDF and the health department. The health department holds the mandate to set health system policy, training programme activities, and is responsible for overseeing the health workforce and clinics, as described in Chapter 5, section 5.2.2. Alternatively, the SSDF's primary function is to establish partnerships with INGOs, obtain international donor funding sources, and mediate those relationships. The differentiation in these roles initially caused tensions as Partners related to the SSDF, which had very little say in programme planning and activities for the SHTP that Partners was funding. Sai Laeng, the head of the SSDF, acknowledged these frustrations, saying:

The first two years were very confrontational...because of this misunderstanding. Stu thought that the SSDF had a mandate for everything. He would say 'Who has the power? You don't have any direction. You don't have the structure.' But it's hard to understand our structure. (Sai Laeng, May 2015)

Over time these tensions eased as the relationship became more fully established through the SHTP. Sai Laeng reflected that:

...on this road you [Claire, the previous programme manager], Dr Bert, Dr Alison and Dr Ken were very important to make the relationship continue...It required a lot of patience. We all needed to learn and develop together. (Sai Laeng, May 2015)

Sai Laeng partly ascribes the positive relationship to Partners' flexibility when the SSDF had not been able to provide the necessary health information to help with programme planning. The SSDF lacks capacity to undertake this task with communities inside Shan State. He shared that:

They [Partners] see the need for health information but they just do what they can with what they have. They are flexible or otherwise they would not be able to work. So, we did have conflict over this in the past - that the SSDF couldn't provide the information. But then later they understood our problem. (Sai Laeng, May 2015)

Partners' accommodation of the capacity difficulties of their partners has helped establish the positive tenor of the relationship.

The pace and significance of the changes within the community was evident in the observations of two expatriate medical volunteers, Dr Pilou and Dr Les, who have each visited once or twice a year since the SHTP was established in 2009. They expounded upon the rapid changes that have taken place, describing the extremely basic conditions they first encountered. The first clinic directly on the Myanmar-Thailand border lacked even the basic necessities such as water. Dr Pilou recounted that "it was very hard when we were in the small, old clinic directly on the border. And even after that in the clinic on the top by the high school. It was difficult without water for the students, for us, and for the patients" (November 2015). The teaching programme itself only had "...a whiteboard and a building with some palm fronds over top of it and

unreliable generator power for a projector for about two hours or so a day” (Dr Les, November 2015). Students lived in rudimentary bamboo dormitories that have now been replaced with sturdier wooden buildings. In terms of the curriculum, Dr Pilou reflected that:

The first year there was no programme, so I taught what I wanted. It’s better now as we have developed the curriculum. And for the last three to four years I’ve taught Integrated Management of Childhood Illness. It’s very difficult for the students but it’s necessary. (Dr Pilou, November 2015).

One of the most significant transitions that Dr Pilou and Dr Les have observed, aside from the physical developments, has been the transition in community attitudes from one of suspicion of outsiders to much greater trust in Partners and their activities. Dr Les shared:

The first year we came here there was so much suspicion that we weren’t allowed to bring cameras and everything was checked at the border checkpoint...There was a very low level of trust. But I believe that through the process that Partners has taken of servanthood, of coming alongside the people and serving them, that we have seen an improvement each year in the relationship. The first year we had to ask for special permission to get one group picture. And then two or three years in the tide seemed to change and there was a sense they could trust us. They’ve gotten over the suspicion of who you are and why you’re here. And now they think they can trust us. (Dr Les, November 2015)

Dr Les believed the ongoing programme improvements were aided by the positive relationship between Partners and Tai authorities, as Partners was very responsive to any needs that were communicated to them. He stated:

From the standpoint of the educational process, each year the programme has gone on it has improved. That’s in large part due to good collaboration between the Partners staff listening to what the Tai people say that they need, rather than trying to tell them what they need. You

build relationships through just doing what they're asking you to do.  
(Dr Les, November 2015)

Dr Pilou shared Sai Laeng's view that Partners was good at managing the complexity of the different relationships and expectations, observing that:

It's the problem of many NGOs. You must not come and say, 'I'm the expert and I want to do this'. You must first listen to what is needed...Sometimes it is difficult to find agreement between the Jao, policy, Paw Shar Gay, the clinic, Partners, and volunteers. We don't always have the same views. But you must listen to the people who are in this place. (Dr Pilou, November 2015)

Overall, the programme managers, Dr Alison and Dr Ken, also shared the predominantly positive view of their relationship, particularly with Paw Shar Gay, as the effective head of the Shan Health Department and manager of the Loi Tai Leng clinic (see Chapter 5, section 5.2.2). They felt that the rapport with both Paw Shar Gay and Khu Tun Aye (head of the CHW training programme) had improved due to their length of commitment to the programme and spending more time each year living in the community. Dr Ken commented that:

We're getting to know everybody. I wonder if us being here now for our third year, and being here more, has helped. We've had more to do with Paw Shar Gay this year than we have ever had. It has been totally, totally positive. We're developing a relationship. (Dr Ken, May 2015)

The relationship between Paw Shar Gay and Partners is a crucial one. Despite the difficulties alluded to by Dr Pilou above, Paw Shar Gay also commented that the relationship is an extremely positive one:

Partners are doing a lot. It's not short term. They've been here a long time. Maybe if there was no Partners we could not have started the Community Health Worker or Medic training. We love Partners. The relationship is good. The RCSS/SSA-S leader and the SSDF are in a good relationship with Partners. We trust Partners. It's not like they're our boss. We're like friends and can talk and discuss and have no secrets with each other. (Paw Shar Gay, May 2015)

As a cautionary note, the predominantly positive perspectives of Partners may be attributed to a reluctance to share negative views with an outsider, and one who may have seemed closely associated with Partners as the funding partner. However, as the discussions did generate a few unfavourable assessments independently of each participant, it is probable that the positive views expressed reflect the nature of the partnership. These views are backed up by observational data about the positive tone of the relationship. Without being fully cognisant of the funding environment earlier in the life of the programme, I understand that the SSDF could have chosen to focus more on its relationships with the other two INGOs who funded elements of the Loi Tai Leng clinic's work. The way in which the SSDF has continued their engagement with Partners demonstrates that they consider the partnership to be a constructive one, embodied in the MOU which will be discussed in the following section.

### **6.1.2 The memorandum of understanding 2015-2020**

#### ***Limitations of the memorandum of understanding***

The successful implementation of the SHTP during the term of the first MOU provided the basis for another MOU for five years which was signed by Sai Laeng, the SHTP programme managers, and Paw Shar Gay, in October 2015. The various roles and responsibilities of Partners and the SSDF are outlined in Figure 6.2 below. A strategic goal, held by both Tai authorities and Partners, is for the Loi Tai Leng clinic to function as a model clinic for the alternative health system, providing the medics with extensive practical clinical experience before they return to their rural communities. However, this goal can only be achieved with the proper levels of funding for the health department. Financing has proved difficult to secure in recent years as there has been a dramatic shift away from INGOs funding this type of cross-border work in Myanmar as detailed in Chapter 5, section 5.2.1.

## **Agreement**

This agreement outlines the roles and responsibilities of each party. It is not legally binding.

### Both parties agree that

#### **1 Partners Relief and Development will:**

- 1.1 Develop, supply and Continually improve appropriate curricula and supporting materials based on best clinical practice in low resource settings.
- 1.2 Where appropriate and over time develop curricula and supporting materials in Tai language.
- 1.3 Supply teachers to effectively teach the Medic level 1 and Medic level 2 curricula and other curricula that are developed.
- 1.4 Support the Shan teachers with teaching the Community Health Worker curriculum.
- 1.5 Supply teachers as clinical mentors for students and medics working in the Loi Tai Leng Clinic and at other teaching sites.
- 1.6 Develop new curricular areas, based on best practice in low resource settings, as agreed between the two parties. Funding for each new curricular area will be negotiated between the two parties. Two initial areas agreed for development are:
  - a. Continuing Healthcare Education
  - b. Health Administration
- 1.7 Fund Shan State Development Foundation for Student Support and Teaching Support, according to an annually agreed budget. The extent of this funding will be jointly reviewed in two years from the date of this agreement to assess the possibility of devolving some or all of the responsibility for funding Student Support to Shan State Development Foundation.
- 1.8 Provide clinical, policy and quality advice as requested by Shan State Development Foundation.

#### **2 Shan State Development Foundation will:**

- 2.1 Fund and operate the Loi Tai Leng Clinic to:
  - a. To function effectively as a model clinic of excellence.
  - b. Provide appropriate clinical exposure for the students.
- 2.2 Provide Student Support (clause 1.7) according to the annually agreed budget – including for:
  - a. Student allowance
  - b. Student meals
  - c. Fuel for generator use for training and clinic

- d. Firewood for cooking
  - e. Stationery for training purposes
  - f. Costs of Opening and Closing ceremony
- 2.3 Provide financial Support for the Teachers and Translators - according to the annually agreed budget - including for:
- a. Teacher salaries
  - b. Translator salaries
- 2.4 Provide monthly and end of year reports including financial accounts to Partners Relief and Development.
- 2.5 Share relevant healthcare and clinic audit data with Partners Relief and Development.
- 2.6 Provide translation Services for teaching and preparation of support materials.

*Figure 6.2: Sections 1 and 2 of the memorandum of understanding between SSDF and Partners (Source: Shan State Development Foundation & Partners Relief & Development, 2015).*

While in practice the MOU seems clear, there are a number of limitations inherent in it. First, linked to the volunteerism model that Partners employs, is that the MOU does not stipulate minimum requirements for the qualifications or experience of expatriate medical volunteers. The fundamental issues with this approach are specifically addressed in Chapter 7, section 7.2. Second, programme activities are reliant on an agreed commitment of programme funding from Partners that may not be available. Partners' operational model means it does not have funding allocated for the five-year period of the MOU, so in the case of any budgetary shortfalls Partners will be unable to meet its full programme commitments. This was evident in 2016 when the programme managers were observed having to reduce the SHTP annual budget by approximately 25% (Fieldwork notes, March 2016). In reality, this meant a cut in medic student numbers of 40% from the previous two years. There is some concern from the programme managers that Partners' committed programme funding for the SHTP could be further pressured as their focus shifts to relief work in the Middle East, away from their programmes in Myanmar. This difficulty is combined with the wider shift in INGO funding away from cross-border work already mentioned. It was not clear whether the reduction in Partners' funding and activities had strained their relationship with the SSDF and health department. The SSDF find themselves in a situation where they do not have an extensive choice of INGOs to partner with, so continuing to foster

their relationship with Partners would appear to be the most pragmatic course of action.

Third, the expatriate medical volunteers also perceive another impediment to the MOU, in that Partners involvement is limited to only the provision of appropriate curricula, training materials and teachers for the SHTP (see section 1 of MOU in Figure 6.2). In practice, this means that medical practitioners who are used to managing medical clinics in a Western context have very little influence over the day to day management of the Loi Tai Leng clinic, even if there are processes and practices they think require changing. Dr Bert noted that “...according to the MOU, our place is to teach. So, we have to be careful we don't overstep the mark and start pushing things in the clinic that we see need to be done” (April 2015). Similarly, Dr Ken said:

One negative is not being able to be particularly influential in how the clinic runs. It is a point of frustration. We know that there are things that could work way better or where we would structure it differently to make it more efficient. (Dr Ken, May 2015)

At times, this has strained the relationship with Paw Shar Gay, who is responsible for clinic management. One of the doctors expressed frustration, saying:

...one of the difficulties is that there is a person who thinks she knows what should be done and not done. She's a bit difficult, you know. Don't get me wrong, she's done a lot of good. (Dr Bert, April 2015)

They feel the tension of ensuring that the clinic is operating to the highest possible medical standards, despite it not being within their remit.

### ***The influence of personalities and power***

This section examines the influence of particular individuals upon the partnership between Partners and the Shan Health Department, central to the effectiveness of the SHTP and the MOU. When examining the relationships between expatriate medical volunteers, Tai authorities, and the community, it is necessary to explore aspects that Lewis (2014, p. 217) argues may “conceal elements of inequality and coercion between actors with different levels of power in the relationship”, as these may impact on the

SHTP more broadly.<sup>69</sup> One significant observation from the fieldwork was the level of influence that one of the long-term expatriate medical volunteers, Dr Bert, exerts within both the SHTP and the wider community. The MOU does not provide guidance as to how the programme managers should mediate potentially complicated relationships between volunteers, who are not officially Partners staff, and the community. The findings about Dr Bert's influence could be attributed to the extensive financial contributions he has made to the SHTP, and wider community, which appear to have engendered deference to his wishes in the community. In particular, Dr Bert has provided funds for the purchase or construction of various student dormitories. He paid for the teacher's accommodation used by the programme managers and controls who can use it in his absence. When one medic was asked to reflect on her medic training two years prior, she reported that:

We didn't have a lot of time to learn or practise. At the time, we had to build Dr Bert's house. The training was supposed to be for six months but we only spent about three months training. We didn't have time to work in the clinic. There was no time to study. We were tired in the classroom and at night we were too sleepy to study. (Nang Htar Gyi, November 2015)

An aspect of this influence is the entrenched view, held by the programme managers and Paw Shar Gay, that Dr Bert can always be relied on when there is a shortfall of funds for the programme or for specific purposes in the clinic. Dr Alison remarked that "I think another huge asset is having Dr Bert and his money behind us" (May 2015). This appears to give Dr Bert undue influence in decisions about the SHTP, clinic management, and programme roles for community members,<sup>70</sup> despite his volunteer status. His behaviour may reflect his long years of experience within the hierarchical Western medical system. These behaviours were also observed in the programme managers with their similar Western medical background. As Dr Alison once put it, "Our answer is the best answer too. If we want to teach to best practice then they have to know what we think" (May 2015). The situation is exacerbated by Partners' volunteerism model which attracts expatriate volunteers who share these attitudes

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<sup>69</sup> Contu and Girei (2014) also discuss the issue of power and politics in relationships between INGOs and national organisations in depth.

<sup>70</sup> Dr Bert financed one medic to live in Aotearoa/New Zealand in 2015 to learn English. When deciding upon her ongoing role within the SHTP and clinic operations, the young woman, the programme managers and Paw Shar Gay, all acquiesced to Dr Bert's opinion.

(discussed further in Chapter 7, section 7.3). However, it is understandable that in such a low resource context, and without any certainty of ongoing funding, Partners will utilise any available financial sources to maintain the programme.

Another example of the influence of personalities is the unexpected observation of the extent to which Paw Shar Gay found ways to exert her power in situations. Paw Shar Gay explained how she found herself effectively in charge of the Shan Health department (see Figure 5.3 on page 114), because “Na Aw is not a medical person. I’m medical. I control the training, the clinic, and the medics. His job is to connect with Thai hospitals. I stay close to the people here” (May 2015). She is also responsible for critical decisions about patient referrals to Thailand, and is often constrained by limited RCSS/SSA-S finances for transport and hospital costs. She is required to regularly report to the RCSS/SSA-S, making “a daily report including money, food, everything about the clinic” (May 2015). When asked how difficult it was to be a woman in leadership in the male-dominated RCSS, Paw Shar Gay reluctantly expressed her opinion saying:

This is a big question for me to answer! Maybe you can learn for yourself? The meetings are all men. Sometimes it’s difficult because they do not listen to women much. That is my feeling. So, it is difficult, but I do my job the best I can. (Paw Shar Gay, May 2015)

The programme managers explained Paw Shar Gay’s influence behind political things that often occurred within the community that they were either unaware of or did not understand. On one occasion observed during fieldwork, Paw Shar Gay decided to send a trained medic back inside Shan State to practise rather than have her join the advanced Medic class and provide translation help to the teachers. There are very few English speakers in the community, so it surprised the programme managers when she was sent inside despite them explaining to Paw Shar Gay that her skills were needed in the SHTP. Dr Alison was circumspect in her assessment of these types of events, reporting that:

As far as I know, we often get told lies or we get slid around. But you get used to that. I’m not angry about that. I’m not irritated by it. I’m mildly frustrated sometimes. You learn it. You can see when you’re being slid around. You know that you’re not being told the truth. (Dr Alison, May 2015)

It is likely that this is one way in which Paw Shar Gay exhibits her agency and maintains her authority within the programme, while subverting the level of influence of the programme managers and volunteers. It also reflects her deeper understanding of the needs of communities inside Shan State, that may take precedence over the immediate requirements of the SHTP.

While Paw Shar Gay has considerable agency and authority, the impact that the presence of Western outsiders has on events in the community and clinic cannot be overstated, as is illustrated by the following experience that I had during fieldwork.

I was woken up from my afternoon siesta to hear the doctors being summonsed to a difficult delivery. Surprise twins! The medics had delivered the first baby just fine. A healthy girl, 3.2 kg (pictured below in Photograph 6.1). One of the medics invited me to come and watch too. Births are not very private affairs here. The phone cameras are out videoing everything, not for posterity, but to show other medics for training purposes. Every person and their dog squeezes into the tiny delivery room – a stray dog was even shooed out. The second baby was stuck in a face first presentation with her arm already out. It was a long, complicated, scary, stressful, violent process. At one point, I had to race back to the house for the iPad with an obstetrics manual on it for Ken to see what he should be trying. Eventually Ken did an episiotomy, got a grip on the baby, shifted her position and delivered her. She had a barely detectable heartbeat and wasn't breathing so Ken started bagging her to resuscitate her. Instructions were being calmly given to the medics to find the specialised baby resuscitation equipment that the doctors knew was somewhere in the clinic. Eventually Khu Tun Aye found the oxygen bottle. Empty. Fetched another one. Another medic finally found the right sized mask to attach to it. All the while I'm wondering why this equipment isn't to hand near the delivery room! Somehow, I found myself in the middle of all of this helping to swaddle the baby to keep her warm, trying to attach the tubing to the oxygen bottle, rubbing her soft wee arm, praying, and encouraging her and Ken. While Ken continued his efforts Paw Shar Gay made the decision to

evacuate the baby and her family out to Pang Mapha.<sup>71</sup> After 45 minutes the truck was ready to take the baby while Ken continued resuscitation. It was going to be a horrendous two-hour drive for them on substandard roads. I stood there, stunned after what I'd just participated in, watching Sai Tun<sup>72</sup> sluice the delivery room. He had already swaddled the first baby, found the missing equipment, delivered the placenta and stitched up the mother's episiotomy. (He also runs the laboratory, manages the pharmacy, and keeps the diesel generator and solar equipment running.) The family reached Pang Mapha later that night. The baby was evacuated to a larger hospital in Mae Hong Son. The doctors there decided a week later that her prognosis was so poor that she was better to return to Loi Tai Leng. She passed away peacefully on her journey home. (Fieldwork notes, March 2016).



*Photograph 6.1: Healthy baby girl, Twin A (Source: Author, 2016).*

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<sup>71</sup> The Loi Tai Leng clinic evacuates complicated cases to Pang Mapha, a small town in Thailand with a hospital.

<sup>72</sup> Not his real name.

The correct medical protocol in this instance was to stop the resuscitation after ten minutes and allow the baby to pass away as there was already a high likelihood of an adverse outcome. Paw Shar Gay and the programme managers would have known this as the doctors had facilitated the Helping Babies Breathe<sup>73</sup> course in the SHTP and taught this protocol. Several factors may explain Paw Shar Gay's decision to evacuate. One is that the judgement of the experienced Western doctor to continue the resuscitation for 45 minutes may have given her some hope for the baby, even though this was unlikely even to a non-medical observer. The second factor is that the presence of the doctors and an outside researcher made her feel pressured to make a decision that she thought we would be happier with, as we avoided seeing the baby die. It raises the question of what she would have decided if we had not been there. Unfortunately, there was no opportunity to discuss this further with Paw Shar Gay as she had to leave the community before I could ask her about this.

This event highlights the complex interplay between the benefits of having skilled medical volunteers present to intervene and provide training in these difficult cases, and the negative influence that their presence may have on the critical decisions made by the Tai health workforce, who make these life and death determinations in their absence by necessity. The reality is that the mother may have also died if Dr Ken had not been there with his experience.

In summary, this section has described the development of a largely positive relationship between Partners and the Tai authorities, and the MOU that outlines each party's responsibilities. It has illustrated some of the limitations of the MOU and described some of the personalities involved in the SHTP and the ways in which they wield their influence. The following section now moves to provide an overview of the relationship of the alternative Tai health system to the Myanmar Ministry of Health and Sports health system.

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<sup>73</sup> Helping Babies Breathe is part of a wider programme developed by the American Academy of Pediatrics to help reduce neonatal mortality in low resource contexts. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/helping-babies-survive/Pages/Helping-Babies-Breathe.aspx>

## 6.2 The alternative Tai health system and the Myanmar health system

### 6.2.1 Myanmar health system certification for the medics

One crucial consideration that emerged during fieldwork was the relationship between the alternative Tai health system, its health workforce, and the Myanmar Ministry of Health and Sports (MoHS) system. This was exemplified in the problem of finding a way for the RCSS/SSA-S medics to practise legally inside Shan State. The convergence model, which aims to bring together the various ethnic health systems with the Myanmar MoHS system in order to foster greater health equity in rural Southeast Myanmar, through collaboration, may lead to the eventual certification of ethnic health training programmes (see discussion in Chapter 5, section 5.2.2). However, at the time of fieldwork, the medics remained at risk of being detained by the *Tatmadaw* or arrested by local Myanmar authorities if they were found to be practising as “fake” medics, without legal certification from the MoHS. Medics reported being fearful of Myanmar authorities, pointing out that “If I don't have the certificate from Burmese training the Burmese soldiers will catch me” (Nang Khay, April 2015). It was hoped the threat of this happening would reduce following the signing of the Nationwide Ceasefire Agreement in October 2015, and the elections in November 2015.

It seems possible that the NCA has led to changes in the situation between the medics and MoHS. One discovery from listening to discussions and interviews conducted during the refresher training is that low level collaboration between some medics and MoHS officials is now possible in some areas. During the medic report backs at the start of the refresher training some told of being able to talk to local MoHS officials to arrange for a government midwife to occasionally travel to their area. The medics utilised many different strategies to mitigate any risk of being arrested without certification. One of these was to complete an auxiliary midwife training course that provided certification from the Myanmar MoHS. The three-month course is run by a Tai organisation called Nam Khone in Taunggyi and satellite locations,<sup>74</sup> and is partially funded by the International Rescue Committee (see Chapter 5, section 5.2). The medics have assessed that this training is inferior in quality to the SHTP, describing it as “lower than here” (Nang Mo Kham, November 2015). However, it is currently the only method of certification. Some medics have this training paid for by the SSA-S commander of the area they practise in, while others must pay for it themselves. The health

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<sup>74</sup> Nam Sang, Kun Hing, Mawk Mai.

department has no organised strategy to ensure that all of the medics who require certification will go through the course. Those who spoke Burmese found the training more useful as it was conducted in Burmese so “if we learn in Burmese it is easier for us. Plus, the medicine inside Burma is different to Loi Tai Leng so we can learn about those medicines” (Nang Voe Seng, November 2015).

The fact that the training is inferior to the SHTP is offset by its certification and the secondary benefits such as easier access to pharmaceutical supplies and immunisation programmes. If the medics have official certification they can also access government vaccination and malaria control programmes since they are considered legitimate healthcare professionals. Certification has also enabled them to refer difficult cases to higher level healthcare and obtain cheaper medications through local hospitals rather than having to buy from local pharmacies, or wait for the Loi Tai Leng clinic to send supplies. However, the programme managers continue to be very concerned about the safety of the medics and want to have the SHTP officially recognised so it could provide this necessary certification. They had unsuccessfully explored various possibilities of developing cooperative relationships with universities in Myanmar or Thailand to fall under their accreditation processes.

The most interesting aspect of the auxiliary midwife training is that, as well as being a safety strategy deployed by the medics, the SSDF uses it as one way to engage in an indirect relationship with the Myanmar MoHS. Having some relational engagement with the MoHS is important as the SSDF receives some funding from the United States Agency for International Development with the proviso that the SSDF makes efforts to connect with the Myanmar government. Indirect engagement is a useful way to address this proviso while the SSDF is unable to fully engage. As Sai Laeng explained:

We are not ready to engage directly yet. That’s why we take the medics to that training. It is partly offered by the government but organised by Nam Khone, a Tai NGO. They are a buffer between us and the government. The government acknowledges that some of the funding comes from us. It is low profile cooperation. In Burma, they have a saying that in some areas the government officers close their eyes and ears. They understand the needs of the community and recognise that we are acting to meet these. They cannot officially recognise our health system though. So, it’s not direct, but rather indirect engagement. Then

when the medics get the certificate they able to work inside Shan State, move freely, but under our system. (Sai Laeng, March 2016)

The programme managers and the SSDF have divergent views about the likelihood of the SHTP becoming accredited to the MoHS to provide certification. The programme managers believed that accreditation could happen in the short term, and with the cooperation of a university. Dr Alison commented that “The medics would do it properly with university academic supervision. That seems to be the way it happens in other parts of Myanmar now” (May 2015). Dr Ken reflected that “It should come from the Burmese side. It needs to be accepting of the fact that there are systems that have evolved and are functional, and that provide big capacity” (May 2015). Alternatively, when Sai Laeng was asked about the prospect of the SHTP being officially accepted, he said, “To get certified will be a long way to go. It depends on how the political dialogue continues. I don’t think the Myanmar government will recognise the SHTP” (March 2016). The programme managers have made some approaches to universities and other organisations about potential certification pathways. However, they did this without cooperating with the health department, responsible for the overall health system, or with the SSDF, who has the mandate to connect with outside organisations. Partners’ unilateral approach does not recognise the knowledge that these Tai organisations possess about the current political climate in Myanmar and the state of the RCSS’ relationship with the Myanmar government. A stronger partnership between Partners, the health department, and the SSDF may be better fostered by cooperating on the certification problem.

Those who have not obtained certification deploy a variety of alternative strategies to maintain their safety inside Shan State including not divulging that they received their training in Loi Tai Leng, widely known as the SSA-S base. Any public association with the SSA-S holds the potential to cause personal harm to the medics, as has happened in the past. One medic explained that:

If we want to go into town to buy medicine or go shopping we have to get permission from the SSA-S. They have information about whether it is dangerous for us or not, and where the *Tatmadaw* is patrolling. We sometimes have a radio that we contact the SSA-S with and they say,

‘Don’t go this way, it’s not safe’. If we are in the SSA-S it is dangerous for us to travel in our uniform.<sup>75</sup> (Nang Mo Kham, May 2015)

They ensured that “if we are going into a village we make sure we dress like we are from that village” (Nang Zarm Inn, May 2015) to not stand out. In some locations, the medics cannot start a public clinic so they operate covertly out of “a home and keep the medicine and equipment hidden there. It is dangerous for the medic and for the villagers too” (Nang Mo Kham, May 2015).

The Shan Health Department has fostered relationships with some villages so that villagers provide situation reports to the department. Paw Shar Gay reiterated the dangers medics face saying, “sometimes the medics receive information that the *Tatmadaw* is coming to their village so they will leave and hide and sleep in the forest” (May 2015). She added “but before we send our medics back, we contact their village for information. They know the situation. They know how to be, how to protect the villagers. So those medics are safe”. When asked how the communities feel about having a medic associated with the SSA-S there, she thought that most were very positive but “some villages are a bit negative. They’re afraid if the medic doesn’t have a certificate. They’re afraid the *Tatmadaw* or government will come. So, if they hear information about the government coming they’ll go to the clinic and say ‘Hide your medicine, hide your equipment. Go away for a while!’”. The need to monitor their personal safety conflicts with the medics’ desire to be fully available to meet community needs, as explained by Sai Nguen who said:

We go where people need us. Sometimes if the SSA-S needs us, we go with them. Sometimes the villagers say ‘We need a medic. We want you to stay. It’s safe for us if you do and we need you here’. So, we make a small clinic and stay. If we can’t stay in the village it’s safe with the SSA-S. (Sai Nguen, May 2015)

Unsurprisingly, women medics utilise additional strategies to ensure their personal safety. The majority shared similar sentiments to Nang Beun Tai, who explained that “if we are female medics and if we have to travel, we are afraid. We need a motorbike or we don’t travel far” (April 2015). Another remarked that “It’s a big problem being a female medic as we have to travel from one village to another. It’s dangerous for females

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<sup>75</sup> Medics choose whether it is appropriate to wear their RCSS/SSA-S uniform in their communities.

when we meet Burmese soldiers” (Nang Khay, April 2015). They choose to not travel alone or at night, as Nang Hleng Khong reported “when we go to see patients at night we cannot go by ourselves for our safety. We are scared and also tired because of the travel distances that we have to walk when we cannot go by motorbike or car. Not like men. Men can go” (March 2016).

It is therefore predominantly men who travel as backpack medics with the SSA-S as the health department considers it unsafe for women in conflict-affected areas. These medics do not require certification as the SSA-S provides their protection. However, one man expressed that “sometimes it is safer to not be with the SSA-S” (Sai Pan Sar, November 2015). One man also shared that the volatile situation inside Shan State could change so “even if I had a certificate I don’t feel safe enough. It’s hard. I cannot work openly” (Sai Parn, March 2016).

Although primarily negative views were expressed by medics about their personal safety there were some positive stories about cooperation with Myanmar authorities at the local level. One medic reported that the village headman had already negotiated with local Myanmar authorities to gain permission for a clinic. He had organised for five community members to travel to Loi Tai Leng for the SHTP, and planned for them all to do the auxiliary midwife training immediately afterwards. He had explained to authorities that the training had nothing to do with the SSA-S. What is also noteworthy is that he had also arranged for the medics to use the local Buddhist temple. Nang Ying Hom explained:

They have said that after they finish medic training here they will call them back to that village and send them to Burma to train for the certificate.<sup>76</sup> And then they will open a clinic in the temple to treat old people, as they go there every day. (Nang Ying Hom, May 2015)

This use of the temple as a clinic was an encouraging finding as the temple is a big part of life in many communities. Further research is needed to understand the role of temples and other local civil society organisations, and possibilities for collaboration with these in the development of health systems in Myanmar.

Having explained the issue of RCSS/SSA-S medics relating to the Myanmar MoHS system, and the problem of medic safety due to a lack of official certification, the

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<sup>76</sup> Myanmar Ministry of Health and Sports certification as an auxiliary midwife.

following section presents views held by different actors about the possible convergence of the alternative Tai health system with the Myanmar health system to overcome this difficulty.

### **6.2.2 Partners' support for the convergence of the Tai and Myanmar health systems**

The convergence between the Tai and Myanmar health systems was a key concern identified by both the programme managers and Tai authorities during fieldwork. The programme managers mainly raised it in discussions related to the need for medic certification, as discussed in the previous section. In contrast, Tai authorities associated the notion more strongly with greater aspirations for their political autonomy. The programme managers were positive about the possibility of convergence, certain that progress in this area would be rapid following the NLD's election win in November 2015. When asked about the likelihood of convergence, Dr Ken commented that "there are some positives and challenges with what happens next as these two parallel systems start to mesh more" (May 2015), despite no evidence at the time of writing that the two systems had started to converge. Dr Alison explicitly referred to certification, saying "it's inevitable and in fact it's probably the quickest way to a solution. These guys are getting put in prison because they don't have the certificates" (May 2015).

However, Tai authorities were less positive, and expressed the view that they did not wish to seek greater cooperation with the Myanmar MoHS. Unlike the programme managers, none declared any confidence in the idea of convergence in the short term. Commenting on whether there was a chance for the Tai health system to integrate with the Myanmar system, the Jao preferred to remain independent, saying:

I think they need to be separate. There is a chance to work together now that there is a peace process. But it is better for us to work alone. If we are autonomous, then we have the right to do as we wish. We have the freedom to do everything that we consider to be important. (the Jao, May 2015)

Sai Laeng unequivocally linked the idea of an alternative ethnic health system to Tai desires for federalism (described in Chapter 5, section 5.2.1), stating:

Like the RCSS, [the SSDF's] aim is independence. If not independence, then at least a federal union based on the Panglong Agreement. So, if we have a federal union then it should be a decentralised health

system...so when it comes time for the decentralisation of the health system then our Tai system needs to be in place. Otherwise the Burmese government would say, as they are saying now, that ethnic groups are not ready for federalism. We do not have the systems in place yet. (Sai Laeng, May 2015)

Paw Shar Gay also agreed that the Tai health system needed to develop greater capacity before any convergence took place, saying “It is not possible [to converge] right now. It will take time. The health systems need to be the same” (May 2015). The programme managers also understood that the process of building the necessary capacity would take a long time, with Dr Ken articulating that:

This is the place which is Tai territory and not Burmese. So, who knows what that brings? But even if everything worked and developed and Loi Tai Leng clinic grew, it's going to be a low resource setting for a very long time. It's not going to happen even if peace suddenly breaks out and a truckload of money descends on Loi Tai Leng with more health training. The whole Burmese health system is so broken. And education is so broken. They need enormous amounts of money to get anywhere near where they need to be. I mean everything is broken. Their telecommunications are broken, their processes are broken, and their administration is broken. Just their processes, not necessarily the people. (Dr Ken, May 2015)

Later in another interview, Khu Tun Aye agreed, noting that:

We don't know about convergence for now. Maybe it's still difficult and too early to talk about that. It would be good if we could trust the Burmese to work together so we can use their system to help people. It depends on what the Tai medics can do. We cannot treat everything so we have to refer to hospitals in town sometimes. The government should allow us to use our medics in the rural areas as well. (Khu Tun Aye, May 2015)

One of the Tai medics summed up the prevailing opinion:

We cannot trust the Burmese yet. Maybe not for a long, long time. I hope we can one day. We don't need Tai to control the whole country.

If the Burmese control the country and bring peace, but give us our rights to have an education and healthcare then it is not a problem for us...We should build our Tai health system from the bottom up. We cannot wait for them to help us. (Nang Mo Kham, April 2015)

All of these participants shared the sentiment that a strengthened Tai health system was a priority, as it would put them on a more equal footing with the MoHS, regardless if convergence was ever to occur.

The difficulties in progressing convergence were illustrated by problems that the SSDF had in cooperating with government officials at different levels, despite some incipient grassroots collaboration experienced by the medics. Sai Laeng, commenting further about how collaboration with the MoHS may be outworked, said:

We have to negotiate for our very existence with the government. Demarcation between government and RCSS territory is hard. Last month,<sup>77</sup> the NLD held a meeting about convergence so we hope they will recognise what we are doing. The Ministry of Health may be alright. But not the Ministry of Home Affairs, the military. We have never discussed collaboration with the Ministry of Health. I think it's still a long way off. (Sai Laeng, March 2016)

Even though the RCSS/SSA-S have signed the NCA and are engaged in the government's peace process, any agreements made at this higher level may not be replicated in cooperation at a local level. The Joint Monitoring Committee, which oversees the NCA, has a military code of conduct for all signatories and Sai Laeng added the stipulation that:

Military personnel are not able to interfere with health personnel, no matter which side. This means that even if medics don't have the certificate recognised by the government, they should be allowed to practise freely. But this is only in the military Code of Conduct, not for local government officials. So, Ministry of Health officials can still

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<sup>77</sup> This was in February 2016, one month prior to the NLD officially taking up government in March 2016.

accuse Tai medics of being illegal and 'fake'. Their actions are not covered under the Code of Conduct. (Sai Laeng, March 2016)

This section has delineated the disparate views of the programme managers and Tai authorities regarding the possibility of the convergence of the two health systems. It has also highlighted the complex reality of the current political situation in Myanmar that the Tai health system and the SHTP are embedded in. The programme managers' concern to find solutions to the problem of certification for the SHTP is not a priority for the SSDF and the health department, who regard the development of an independent Tai health system as their focus.

Having addressed the relationships between medics, the alternative Tai health system and the MoHS system, the next section provides an account of the less explicit partnership between Partners and the RCSS/SSA-S, and the experiences of the medics' relationship with the RCSS/SSA-S.

### **6.3 The RCSS/SSA-S' relationships with Partners, its medics, and communities**

#### **6.3.1 The indirect partnership between the army and Partners**

The nature of the relationship between Partners and the RCSS/SSA-S is effectively a partnership by proxy. That is, the formal aspect of the relationship between the two parties is mediated by the SSDF, as the non-military development arm of the RCSS/SSA-S. This is done through the MOU between the SSDF, the Shan Health Department, and Partners. However, it is important to explore Partners' informal connection to the non-state armed group, particularly as the SHTP is located in Loi Tai Leng, which serves as the RCSS/SSA-S' main military base. The relationships are illustrated in Figure 6.3 below.

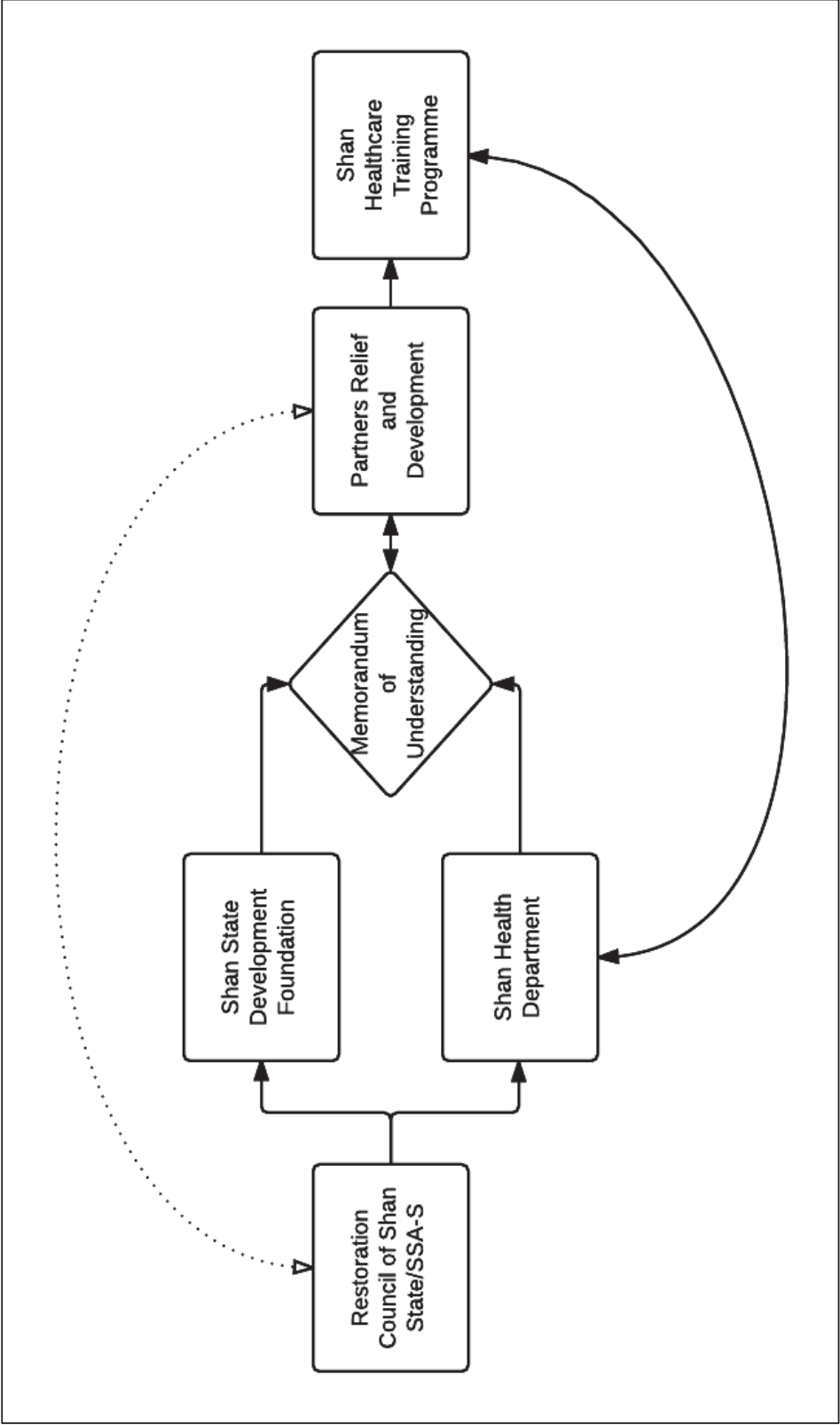


Figure 6.3: The partnership by proxy between the RCSS/SSA-S and Partners Relief and Development (Source: Author).

The relationship between Partners and the RCSS/SSA-S is generally perceived as positive by the RCSS/SSA-S. When asked to reflect on the value of the partnership with Partners, the Jao maintained that “it is good that our youth can study here and we can send them back inside Shan State. More than 70 medics have gone back inside after training to be medics. Partners Relief and Development have come here to help poor people who don’t have healthcare” (May 2015). As the Jao had been the one to request help with healthcare training from Partners, the number of medics provided him with evidence of the positive outcomes of the SHTP.

The health of the relationship is also quantified by the ways in which the Tai authorities enact their support of the SHTP. Sai Seng Wan, from Partners, confirmed that their participation in events such as the SHTP opening and closing ceremonies was significant, stating that “I don't know whether you realise it or not, but if the leaders don't like what is happening with the programme then they will not come to the ceremonies” (November 2015). The programme managers also reported that the increased attendance of Tai authorities had been an encouraging development in recent years following very little involvement in earlier years. The Jao and his senior leadership attended both closing ceremonies I observed in November 2014 and 2015, and the senior leadership also opened the refresher training in March 2016. Botao Khur, the third in command of the RCSS/SSA-S, made a point of receiving the new medic students at his compound at the start of training each year to offer his encouragement. These actions demonstrate the direct support of the RCSS/SSA-S for the SHTP, and Partners’ continued involvement in Loi Tai Leng.

Strikingly, despite the direct support of the RCSS/SSA-S leadership, the programme managers framed their relationship with the RCSS/SSA-S in less direct terms. Dr Ken alluded to the fact that they have to cross the border illegally to conduct the SHTP, and rationalised this by saying “I think of the SSA-S as being the government of Shan State. We're here with their permission and we cross the borders with their permission” (May 2015). They don’t specifically ask the medic students if they are involved in the RCSS/SSA-S at the start of training, although it is often obvious when these students wear a uniform and conduct drills with the other students. Dr Alison did not view the RCSS/SSA-S as a non-state armed group, articulating that “we haven’t had experience of the Shan Army as an army either. They’re just a bunch of guys in uniforms and they carry a few guns” (May 2015). They indicated some discomfort with the notion that working in partnership with the RCSS/SSA-S could be construed as a political act, as

they consider medicine to be an apolitical discipline. They explained that “we have to turn a blind eye to the fact that this is an army base” (Dr Ken, May 2015). Days after Dr Ken making this comment, we attended Shan Resistance Day on the main parade ground for the RCSS/SSA-S where a large number of battalions gathered to commemorate the formation of the antecedent of the RCSS/SSA-S on 21 May 1958 (shown in Photograph 6.2). This event was a stark reminder that the programme managers are involved in a military area even though they don’t want to recognise the explicit partnership between Partners and the RCSS/SSA-S.



*Photograph 6.2: SSA-S troops, Shan Resistance Day 2015 (Source, McFarlane, K., 2015).*

One reason the programme managers may want to disassociate themselves from the RCSS/SSA-S is their concern about the army's treatment of prisoners in Loi Tai Leng.

The SSA-S operates its own judicial and penal systems in areas that it controls inside Shan State and these do not appear cognisant of human rights considerations.<sup>78</sup> The programme managers' concerns are based on seeing prisoners who attend the clinic, as they have not been allowed to visit the prison despite requesting permission. Dr Alison commented:

We look at the prisoners and they're in shackles and they're escorted by men with guns. They tell us about the beatings but we've never seen evidence of that. We've seen evidence of frightened prisoners and frightened soldiers. And people tell us they're in fear of beatings. (Dr Alison, May 2015)

During my fieldwork, I also observed shackled prisoners being escorted or carried to the clinic by armed SSA-S guards (as shown in Photograph 6.3 below). The doctors have chosen to not address their concerns to Paw Shar Gay or the Tai authorities, presumably because they feel it is outside the scope of their partnership to do so without jeopardising the SHTP. They were also initially worried as to whether, in such a punitive environment, some of the medics were participating in the SHTP under duress from their communities or the RCSS/SSA-S (see Chapter 7, section 7.1.1 about medic agency to participate). It is possible that this was the situation in earlier years but no evidence of this was uncovered in discussion with the medics, and they all reported having freely chosen to participate in the SHTP (see Chapter 7, section 7.2.1).

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<sup>78</sup> The RCSS/SSA-S runs drug rehabilitation centres inside Shan State that have a reputation for the punitive treatment of addicts, including shackling and hard labour, rather than a health-based detoxification programme.



*Photograph 6.3: A shackled prisoner who was a patient at the clinic (Source: Author, 2016).*

It seems clear that the programme managers' compartmentalisation of their own relationship with the RCSS/SSA-S has meant that they may not have considered some of the ramifications for medics of the embeddedness of the Tai health system in the military structures of the SSA-S. This is despite the fact that many of the medics they train now work as backpack medics in the SSA-S, or fall under the command of the local SSA-S leadership once back in their communities. The programme managers remained focused on their responsibilities to the SHTP in Loi Tai Leng. They have little capacity within the terms of the current MOU to consider these wider issues for practising medics. The next section moves on to consider what the hybrid civilian-military health system looks like in practise for medics inside Shan State.

### **6.3.2 A hybrid civilian-military health system and its limitations**

#### ***Embeddedness of the civilian health system within the SSA-S***

One of the most striking findings of the later part of the fieldwork was the extent to which the emergent health system is embedded within the military systems of the SSA-S inside Shan State, despite the Partners programme manager's compartmentalisation.

It appears that the capacity of the health department is such that it is reliant on existing military structures to manage the medics and provide supply lines. I describe this composite of the two systems as a hybrid civilian-military health system. This system influences the medics' experiences of the relationship and these are addressed in this section.

The Jao has fostered this embeddedness by proposing a management structure for the medics that follows distinct military lines, where 100 medics are divided into groups of ten with one leader. This raises questions about the appropriateness of managing a health workforce within military structures. The current RCSS/SSA-S leadership has been involved in many years of military conflict with the *Tatmadaw* and other non-state armed groups so maintains a military outlook on development issues. The programme managers did not appear to have a strong enough relationship with the Tai authorities to strongly advise them to transition to a civilian model of health system management. Sai Seng Wan confirmed this saying, "I feel like Dr Ken and Dr Alison are a little bit *kreng jai* [shy] to say anything. They don't want to put other people out. Also, they are very quiet. And sometimes when things aren't clear in a relationship, things can be misunderstood and things go wrong..." (November 2015). Regardless, the positive view of the SHTP held by Tai authorities, and demonstrated by their attendance at important events (shown in Photograph 6.4 below), means there is a strong mandate for Partners to continue the SHTP to support the vision of the Jao.



*Photograph 6.4: (L-R) Sao Sai Ye, Gen. Jao Yawd Serk, Botao Khur, at the SHTP closing ceremony, November 2015 (Source: Olson, 2015).*

This hybridity and embedding of the health system into the military system was evident in the recruitment of the medics into the SSA-S during their time in the SHTP, as they were exposed to RCSS/SSA-S activities in Loi Tai Leng, its main base. A result of this was that one third of the medics interviewed were members of the SSA-S. Many of the medics had heard about the SHTP through information provided by the SSA-S in their communities (as described in the following Chapter 7, section 7.2.1). Some participants reported that they had had no experience of the SSA-S at all until they moved to Loi Tai Leng.

One ramification of the hybrid system is that membership of the SSA-S confers some advantages on those medics, not the least of which is a higher monthly salary once they return to their communities. The SSDF accesses some international donor funding to pay operational costs for clinics but this does not include the medics' salaries. The RCSS/SSA-S is responsible for paying these from their own funds. However, this appears to be discriminatory in practice. Medics who are SSA-S members receive a monthly salary of approximately NZ\$20, while civilian medics only receive NZ\$16. There are also differences between areas inside Shan State. One medic said "Some people have a salary, some do not. It depends on the different SSA-S officers in each area. Some

officers have more money and some officers have none” (Sai Yawd Hkur, March 2016). A number of medics who returned for the refresher course in March 2016 were particularly critical about the lack of a functional salary system. Medics commonly reported things like “We have enough instruments in the clinic but not enough money for medicine or patient transportation costs if we have to refer them. It is still difficult for us” (Sai Kawn, March 2016). Another medic commented “Sometimes the salary just doesn’t arrive. We need to pay for fuel for our motorbike with our own money” (Nang Khay, April 2015), which was an issue for women as they felt safer on this mode of transport.

A number of participants spoke of having to continue farming or other jobs alongside their medic practice to make money for themselves, and to buy food and blankets for patients. If the patients are SSA-S soldiers the medics are expected to meet all the costs, whereas if it is a villager they can request a small payment from them. They considered this a positive aspect as “sometimes it’s better to ask the villager for money as if they get treated for free they might think that our medicine is not good” (Sai Yawd Hkur, March 2016).

In order to address the salary issues, during the refresher training Paw Shar Gay suggested the medics write a proposal requesting regular salaries for her to present to the Jao, an opportunity they welcomed. Garnering the wider support of the medics to make requests of the RCSS/SSA-S leadership appears to be another way in which she enacts her agency. At the time of writing it was not known what the outcome of the proposal was, however the fact that Paw Shar Gay suggested this proposal is an indication of the seriousness of the concern held by the medics.

Although the pay is more stable for RCSS/SSA-S medics, one of the notable downsides is that the medics are bonded to the army for at least five years, limiting options to undertake other work alongside their medic practice in order to raise extra funds. There was also a risk that “the army will tell me to do another job instead of being a medic” (Sai Aw, March 2016) which would squander the medic training.

The hybridity/embeddedness was also evident in a meeting with the programme managers and Paw Shar Gay in November 2015, where the Jao rearticulated his vision for the ongoing development of the healthcare system based on a hierarchical militarised structure. This included having a clinic with a SHTP trained medic in it at every village tract level in RCSS controlled areas. He also advocated for a restructure of

the health department to manage the process of new clinics, but it was unclear when the restructure was planned for. He was eager to see Partners monitor these clinics in the future. This was tempered by the view of Sai Seng Wan that it was still too difficult for foreigners to travel in these areas. The Jao's priority was to have suitably trained medics so that villagers would see their skills demonstrated and come to accept them, rather than focusing on clinic infrastructure. He commented that "once this project has been implemented there will be a lot of donors willing to support it. We have to show what we can do. We must help each other to find the funds" (November 2015). The Jao's allusion to the need for international donor funding showed that he was well aware of funding difficulties.

There are advantages to having the health system linked so closely to the RCSS/SSA-S, including the protection provided for medics by SSA-S commanders. As discussed earlier, commanders also provided financial assistance and maintained supply lines for medical equipment in some locations. The army already has military structures in place to reach remote communities. This means that even if there is not an RCSS/SSA-S supported clinic in particular conflict-affected areas, these communities can still access healthcare provided by the backpack medics that accompany the troops. However, there is evidence that this is not favoured by the medics, with one medic expressing a preference to practise as a clinic medic rather than a backpack medic saying "I don't want to go with the SSA-S. I want to stay in a clinic. But my area doesn't have a clinic yet so I have no choice but to go with the SSA-S" (Sai Pan Sar, November 2015). New RCSS/SSA-S clinics were being opened in 2016 and 2017 so the priority was to provide suitable medics to staff these rather than backpack medics for the army.

This research also sought to determine how Partners supports the development of community healthcare capabilities, something which is particularly affected by the links to the SSA-S. The notion of 'community' must speak to all groups, including women and children. One unexpected observation from the fieldwork is that the Loi Tai Leng clinic appears to treat a disproportionate number of men, many of them SSA-S soldiers. There is a maternal and child health unit in the clinic, and women and children were observed in the outpatient's department during the fieldwork. However, visits to the inpatient wards often found the men's ward completely full and no one in the women's ward. This observation raises the concerning possibility that there are gender inequities in the delivery of healthcare in the clinic. It also supports the finding of a strong association between the military and the health system and suggests that

the clinic may be seen as primarily for the military. Another possible explanation may be that community access to the clinic became limited when it relocated from the National High School, which is more central to the community, to its current site. The programme managers had noted this issue to me, as they observe it while conducting their ward rounds, but they had not mentioned it to Paw Shar Gay. As regular clinic audits are no longer conducted by the SSDF, Partners could establish processes to evaluate this issue, in partnership with the health department, to ensure that the SHTP does not contribute to inequities in accessing clinic healthcare. Gender based inequities in healthcare delivery is clearly an important issue here, but one that was not addressed in the scope of this research and further investigation is warranted.

### ***Cultivating community cooperation***

Another notable finding was that Paw Shar Gay cultivates strong relationships with communities, in her pivotal role in selecting the locations for new clinics inside Shan State. The decision-making process involves discussions with the community leadership in potential locations to assess their level of support, as well as incorporating the situation assessments of the local SSA-S to ascertain if the area is safe to deploy medics to. Khu Tun Aye explained that:

We have to ask the SSA-S and the local leader of the village. They know where will be safe. If it is not under SSA-S control then it's difficult to do the job. Even if our health workers are doing a good job, the right job, they're still afraid of the *Tatmadaw*. They will say 'You do not have a government certificate'. It is sometimes better to be in a black zone. The ceasefire is good but we still don't trust the *Tatmadaw*. (Khu Tun Aye, May 2015)

In relation to their deployment, the majority of medics reported that Paw Shar Gay has the final say as to where they go. This caused tension when the medics held a different opinion about where they should be based. One remarked that:

After we finish the training many students want to go back to their home town. But the leader [Paw Shar Gay] sends us where she wants to send us. We come here because we want to work as a medic back home. But the leaders think if we go back home we will not do our job. So, they make us go with the army and the army controls us. (Nang Khay, April 2015)

In contrast, another medic said

Paw Shar Gay has said that if the people from my village want me to go back, and the SSA-S is around them, then it is good. She will send me back to that village. It depends on the situation in that area. (Nang Ying Hom, May 2015)

Nang Mo Kham explained that:

If the village that we come from wants medics then Paw Shar Gay will decide we can go back and help the village. If another village wants medics but we cannot build a clinic yet, if she thinks we can go there then she will send us to that area. She has to decide the safest place. Some medics have already discussed this with their head villager. People in that village also give them money to support them to come here to study. So, they make plans for them to go back and build a clinic. Some of us have come here because we're interested in being medics but some people in our village don't even know we've come. (Nang Mo Kham, May 2015)

Another medic reported that it is often a request from the local SSA-S commander that influences deployment decisions:

The local commander asks the head villager if they agree to have a clinic, mostly in areas that are safe. The commander announces that there is training in Loi Tai Leng and asks who wants to join. They then bring people from that area to train here, those who want to come and who are interested. Some officers give money to help with transportation. Some people use their own money to travel here because they are interested to join. A lot of villages in those areas are far from the town and they need medical care. Before it was difficult to travel to training but now it is a bit better. (Nang Voe Phoung, March 2016)

It is clear from these findings that Paw Shar Gay relies on the level of community support, as well as SSA-S knowledge of the conflict, to decide where medics should be based. Photograph 6.5 below shows Paw Shay Gay meeting with villagers to garner support for a potential clinic inside Shan State. She also decides which medics have the

opportunity to undertake advanced specialist training at Mae Tao Clinic. Nang Mo Kham reported that:

Paw Shar Gay asked me if I wanted to go to Mae Tao to do the Emergency Obstetric Care course. I can then train other medics. I can learn other things. If I go inside to a clinic, and if I can't deliver babies, then I'm not so confident in obstetrics. (Nang Mo Kham, March 2016)



*Photograph 6.5: Paw Shar Gay hosting a community meeting to discuss a new clinic (Source: Paw Shar Gay, 2016).*

Paw Shar Gay possesses a level of responsibility and decision making within the Tai health system that belies the opinion of the programme managers that she does not possess the capability to manage the medics (see section 6.1.2). Their underestimation of her may be explained by the fact that Paw Shar Gay functions predominantly within a Tai/Karenni cultural framework and a military system that they are unfamiliar with, rather than within their Western medical framework.

Some communities held divergent views about the safety issues involved with the medics being linked to the SSA-S. Anxiety about safety is a result of the many years of conflict inside Shan State. Nang Wo Hlaing pointed out that “...if the SSA does good things for the village they are happy, but they don't want their daughter or son to come to Loi Tai Leng to be in the SSA-S” (May 2015). Some of the men mitigate security concerns by travelling as backpack medics with the SSA-S, still able to help their

community but not risking danger by being based in a village. When asked what his community thought of him training as a medic, one responded:

They think it is good. The people from my community hope I will come and help them. But I think it's not possible at the moment because it is not safe for me being in the SSA-S. But the SSA also helps around that village. But if I have to go to that area with the SSA-S I might try to go often to my village and see the villagers. (Sai Hark Khur, May 2015)

Sometimes communities prefer the medics to simply remain working in their villages rather than doing the SHTP, as one medic recounted, “Some people think it is good to be a medic. But some people say it is not good. If we can get work there, it is better to do our job than come here and be a medic” (Nang Seng Jin, May 2015). What is evident is that the high levels of motivation from the medics and the gradual increase in community support for them reinforces Partners’ mandate for the SHTP as it is training medics to meet community healthcare needs.

This section has described the level of decision making and personal oversight that Paw Shar Gay has of the emergent health system, especially cultivating the necessary cooperation from communities for medic deployment in their areas. Despite this there are limitations to the alternative health system that the following section will address.

### ***Limitations of a hybrid civilian-military health system***

Despite the protective factors the hybrid civilian-military system conferred upon the medics, their practical relationship with it was more complex. Key concerns are the reporting system and evaluation. The medics commonly reported difficulties with communications in rural areas where they were based. Many had no cell phone or internet reception, so medics had to either travel to a town where these were available or provide their regular monthly clinic reports to SSA-S commanders, sometimes using their army satellite phones to communicate with the Loi Tai Leng clinic. Unfortunately, a lot of these reports were not forwarded on to Paw Shar Gay and the clinic by the commanders. Some medics commented that they did no reporting at all, and some did not even have access to a computer. This meant that Paw Shar Gay was unable to easily monitor the situation of some medics inside Shan State. Any reporting that is done is based on quantitative information about the number of patients seen, types of medical

diagnoses and treatments, and the numbers referred to a higher-level medical centre. Khu Tun Aye explained the reporting problem:

NGOs want information from the medics. How effective they are, how they're doing a good job, how they're developing. They want to know. The medics work hard but they still don't understand how to give the report and how to collect the data. We need training. (Khu Tun Aye, May 2015)

This sentiment was echoed by Sai Laeng who said:

We have trained them on reporting. We have trained them on writing proposals. So, the medics or [Shan Education Department] teachers understand what we are doing and why we need reports. But we still do not get proper reports. So normally what we do is, when we're going to write the report for the donors, we go to clinic for monitoring. We talk to the medics to get the information for the report. But the SSDF now only has five staff. We cannot travel to the border [and inside Shan State] to get the reports. (Sai Laeng, March 2016)

The programme managers had hoped to include training on health administration that would incorporate reporting requirements but the reduction in Partners' budget in 2016 meant this did not happen in the course of the research.

When the Jao was asked how the RCSS/SSA-S itself evaluates the outcomes of the SHTP inside Shan State he explained that there was no formal process in place. Any evaluation was performed informally by RCSS/SSA-S commanders, saying "We have our soldiers and our media inside to check" (May 2015). He considered that it was incumbent upon Partners to conduct their own monitoring and evaluation of the medics, stating, "They should get the information and the data about what their students are doing, and whether they are doing a good job or not. They should get this feedback". Partners' responsibility for this would need to be negotiated with the SSDF and included in an updated MOU. The Jao also suggested that the medics could use technology for monitoring purposes:

If the medics work, then they should give feedback. When the students go back inside Shan State, Partners should give them a camera to take

videos to send back to Loi Tai Leng. The technology is now developed and they can teach this to the students. (The Jao, May 2015)

This suggestion coheres with the programme managers' idea to connect the medics to the Loi Tai Leng clinic through the use of mobile technology, and "hear what the problems are inside to know that we're teaching the right things. We'd use Facebook to communicate with the medics and give them ongoing education every month" (Dr Ken, November 2015). More detailed information about what the medics are experiencing inside Shan State would enable the programme managers to be more reflexive in their programme design. Although it could be argued that this is a solution to the lack of supervision of the medics in remote locations, the programme managers fail to recognise the current reality of extremely limited mobile and internet coverage in these areas.

Another limitation of the hybrid system is with the military hierarchy. Some medics expressed a desire to have more power in decision-making about their practice, saying "sometimes if the villager calls for help, if we don't have permission from the officer, then we can't go to help the patient" (Sai Yawd Hkur, March 2016). My research assistant, Nang Mo Kham, explained that SSA-S commanders provided a form of necessary managerial oversight, but this was complicated by the attitudes of commanders in some areas:

They don't understand about healthcare and still believe in traditional healers. They give medicine and some money to the medics because the Jao tells them to. But they don't think it's important. That's why in some areas medics get a salary and money for food but in some areas, they don't. The commander would even choose to see a traditional healer over the medic. (Nang Mo Kham, March 2016)

She argued that:

I want the Tai health system to be like the Mae Tao clinic with Dr Cynthia Maung. Even if sometimes we have a really sick patient and we need medicine, we have to ask [the SSA-S commanders] for money. Sometimes we have no medicine. If the health system is controlled by someone who understands about healthcare, and the need for medicine and instruments, or the need to refer patients, then it is better. If we

report to a leader who understands about health it might be better.

(Nang Mo Kham, March 2016)

These findings demonstrate that the hybrid civilian-military system has limitations that need to be accommodated to better enable the medics to do their job in their communities.

As noted at the beginning of this section Partners' has a partnership by proxy with the RCSS/SSA-S. Despite this the programme managers display some discomfort with their association with the army, particularly due some of the conduct of the SSA-S. However, the civilian health system is clearly deeply embedded within the military structures of the SSA-S and these structures remain critical to its success. Also critical to successful practice is the role of Paw Shar Gay, who has fostered a high level of community cooperation in support of the health department clinics and medics inside Shan State. The section concluded by exploring some of the limitations of this relationship between the medics and the hybrid civil-military health system.

## **Conclusion**

The findings in this chapter provide important insights about how the relationships of the different actors in the SHTP might enable the capabilities of the health workforce, and consequently, the alternative health system. Partners, the SSDF, and the health department all hold largely positive views about their mutual relationship, which has been successfully outworked in a series of MOUs. These positive determinations about the relationship underpin a mandate for Partners' continued involvement. However, there are some limitations to the MOU which impact upon Partners ability to provide an effective programme. As Partners has made no provision to allocate committed funding over the five-year period of the MOU, this may jeopardise the future of the SHTP. The SDDF have little option but to remain in partnership with Partners, one of the few INGOs still funding cross-border work with ethnic civil society organisations. The influence of some of the personalities involved also impacts negatively upon the equality of these relationships. Difficulties and contradictions in Partners use of a volunteerism model will be addressed in Chapter 7.

The chapter also examined the relationship between the emergent alternative Tai health system and the Myanmar Ministry of Health and Sports system. There has been some opportunity for low level collaboration between the two systems at the community level. However, the problem of obtaining official MoHS certification for the

Shan Health Department medics had not been overcome, and acted as a safety constraint on their ability to practise. Partners supports the eventual convergence of the Tai health system with the Myanmar MoHS system, which may be unrealistic in the short term and is also in contrast to the desires of Tai authorities to remain independent. The ambiguities in Partners' indirect relationship with the RCSS/SSA-S were explored as these hinder the programme managers' ability to accommodate medic experiences of the hybrid civilian-military system in the programme. Limitations of the emergent civilian health system being embedded within military structures were also outlined, even as these are outside the direct influence of Partners.

Chapter 7 moves on to consider research findings about the approaches taken by Partners in the SHTP. It provides the views and experiences of the different actors in the SHTP. Importantly, the medics recount their experience as healthcare providers in their communities.



## **Chapter 7: Enabling medic capabilities with a programme approach based on volunteerism: Inherent contradictions**

### **Introduction**

The second of the two findings chapters explores the approaches that Partners Relief and Development (Partners) uses in the Shan Healthcare Training Programme (SHTP). It addresses Objective 2, to examine the effectiveness of these approaches in order to evaluate whether they support the development of health workforce capabilities. The chapter is in three sections. In keeping with the research focus on enabling medic capabilities, the first section presents the experiences and views of the medics of Partners' approaches. It helps to understand whether these enable medics capabilities and functionings. It incorporates some of the more intangible outcomes such as agency, opportunities, confidence and ability that are incorporated into the health capabilities framework for the research and used to analyse the research findings in Chapter 8 (see Figure 8.1). It also describes medic experiences of their healthcare practice inside Shan State. This enables an evaluation of Partners' ability to engender effective health outcomes in these communities. The specific programmatic approaches used by Partners in the SHTP are recounted in the second section, with attention given to the effects of Partners' volunteerism model. Limitations such as the technical SHTP curriculum, and the difficulties caused by the volunteers and medics not sharing a language, are also examined. The third section highlights some of the positive developments in Partners' approaches which may go some way towards mitigating these difficulties.

### **7.1 The experiences and views of the medics**

#### **7.1.1 Participation in the training programme: Medic agency and motivation**

Education levels remain low inside Shan State and there are limited options for young people to engage in training or higher education (see Chapter 5). The SHTP provides a chance for medics to realise their capabilities that they would not have experienced otherwise. The programme managers argue that, even if the student does not remain practising as a medic, the educational investment has not been wasted. Dr Ken expressed this:

...one of the things with the whole course is that it opens a door...here's an educational opportunity...they learn that they can learn...so suddenly

that opens up the door to you know to a career and or being a doctor...[former student] has a big goal ahead of her [to become a doctor], for instance. And that's because of one step in terms of doing the medic thing...that's not a failure. That's positive. It would be a negative if they'd dropped out and were only back farming. (Dr Ken, May 2015)

This view was supported by informal discussions I had with two women who were early graduates of the SHTP. They were no longer medics but had accessed employment opportunities in the field of media and management with Tai civil society organisations based in Chiang Mai, that they would not have had without this training (Fieldwork notes, May 2015).

Dr Ken further emphasised the overarching benefit that any educational opportunity offers, particularly to those with minimal or no formal education, noting that this was particularly important to young men, explaining that “...especially the young men. I mean they've got no education at all. And they're bright kids. You can't do what we're doing without a fairly good degree of intelligence. You really can't” (May 2015). This was reflected in the responses from one young man during the refresher course when I asked if he would recommend being a medic to others. He proudly explained that, like many young men, he had only received a couple of years of temple schooling so:

When I first came, the first time I couldn't read or write. But I think that even if the students don't have an education, if they want to study that is up to them. And they have to try like I did. Before I came I didn't know the ABC but now I can understand diseases, their names and the names of medicines to use. (Sai Hsar Lu, March 2016)

This is a cogent reflection on the fact that despite having minimal education, the medics possess abilities and skills that can be unlocked by the training.

Perhaps because of these benefits, it became apparent during the research that the medics fully exercised their agency when choosing to participate in the training. This was an unexpected finding as I had assumed that a level of coercion from village headmen,<sup>79</sup> families or the SSA-S might exist. Dr Alison and Dr Ken had also indicated

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<sup>79</sup> Tai culture is patriarchal, especially in rural areas. I did not hear mention of any village headwomen during my research.

they held earlier concerns that some medics may have been under duress to do the training as they were aware of students in “that first class where...people ran away” (Dr Alison, May 2015). Whether this was due to duress or fear of the unknown is unclear. Without exception, all of the medics interviewed for this research affirmed that they were interested and had personally chosen to participate in the SHTP once they heard about it. This was the case even for members of the SSA-S, who could feasibly have been ordered to join to serve as army medics.

The medics recounted the various ways they had initially heard of the opportunity to join the SHTP. One prevalent method is for the SSA-S to hold meetings with village headmen and villagers as they travel through SSA-S controlled areas inside Shan State. One medic related that the “SSA told my head villager and the head villager asked who wanted to do it, who was interested to study” (Nang Hom Kham, May 2015). Some medics are members of the SSA-S themselves, or have family members who are, so they learned about it through these channels. My research assistant began her training after her uncle in the SSA-S told her that “if you want to study [Loi Tai Leng] has training and they give everything for free...you just have to go and have that” (Nang Mo Kham, April 2015). This was the first report that the SSA-S is strongly linked to the SHTP, even at the level of programme promotion. At other times village headmen or family members have travelled to Loi Tai Leng to participate in SSA-S training themselves or for large scale ethnic events such as Shan National Day<sup>80</sup> and Shan Resistance Day.<sup>81</sup> Paw Shar Gay and SSA-S leaders take this opportunity to encourage villagers visiting from inside Shan State to promote the programme when they return home, and encourage young people to show interest. This has been a successful approach in recruiting trainees.

Another key element that surfaced in interviews was that the motivations held by the medics to participate in the SHTP were strongly connected to the needs in their communities. This concern revolved around the lack of healthcare access and workers in their villagers. Nang Seng Jin explicitly referred to this, reporting that:

There is no Tai medic in my village. We have one clinic with a Burmese health worker. Around my village we also have a small village of the Ta'ang ethnic group. They live in the remote mountains and it is difficult

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<sup>80</sup> Shan National Day is 7 February. It signifies the unification of Shan State in 1947.

<sup>81</sup> Shan Resistance Day is 21 May. It commemorates Tai resistance to former Burmese regimes.

for the medic to go to them. Also, if they are sick, they cannot come to our village. It is difficult. There are no roads to go to where they are. There are some health workers there but they just use injections [poor medical practice] so people don't get better. I would like to learn the right way to help. (Nang Seng Jin, May 2015)

One medic stated, along similar lines, that:

I want to be a medic because I want to help the people in our state, in our country who are suffering from diseases who really need help. It is difficult for them to get access to health. I want to help them. (Sai Kawn, March 2016)

Nang Mon Si Oung also alluded to the poor medical practice of the current healthcare workers in her community, commenting that “in our community there are no medics and they just use Chinese medicine. That is why I'm interested to train, to improve this” (Nang May 2015). A concern about access to healthcare was echoed by Sai Parn:

My village is a long way from a hospital. Sometimes if our people are suffering from diseases it is really difficult to go to the hospital. So, I decided to be a medic to help them. (Sai Parn, March 2016)

Some of the medics reported being motivated by self-improvement and the education that the healthcare training would provide them (also discussed in section 7.2.1). However, this motivation was closely associated with a desire to help their community or meet family expectations. For example, Nang Ying Hom said “I'm interested in becoming a medic. My family also want to see me become a medic. If I become a medic then I can help my village and community” (April 2015). As another medic put it:

Paw Shar Gay came to tell us about the training so I was interested in coming. I called my family and asked them if they thought it was good to do or not. My family said that if I wanted to do it then I should. I want to be a medic because in my community there is only a Burmese trained medic. That medic told me ‘If you would like to study, then you should study because I am getting older and older. And eventually we will need a new medic’. (Nang Mo Hsai, May 2015)

Another medic, Nang Hleng Khong, shared this sentiment saying, “I want to come. No one learns about healthcare and not many people have an education inside Shan State. So, I want to come here to study” (March 2016). Nang Shwe also commented that she wanted “knowledge for myself. And also, when I go back to my village I can help the villagers” (May 2015).

A small number of medics gave personal accounts of family events and circumstances that motivated them to become a medic. One shared:

Our cousin died when he was eight years old but we don't know what happened. We have to pay a lot of money for healthcare. Our family, our mother, sister, cousins, extended family, they have to pay lots of money to get healthcare. I think that I can help our family and our people in our community. (Nang Beun Tai, April 2015)

What stood out in the research was the sacrifice that students make to participate in the training, and their level of achievement despite their difficulties and lack of education. Dr Les, an expatriate medical volunteer, shared:

...I am overwhelmingly impressed with the performance of the students. We're talking kids with essentially high school education and they're taking care of sick and dying people. And it's no small task...they are working so hard...think of how hard their life really is. Just to survive is a lot of work for them. (Dr Les, November 2015)

Dr Pilou, another expatriate medical volunteer, agreed:

The first positive of teaching here is that every year new young students come who want help people. First, believe me it's very important, they come from far away, from inside Shan State. One, two, three days travelling to come here, then staying eight months, nine months. Wow. (Dr Pilou, November 2015)

As the expatriate medical volunteers have recognised, the sacrifices and struggles of the medics explains their strong motivation to take advantage of the opportunities the training provides to them.

### 7.1.2 Opportunities provided by the training

What follows is an account of the opportunities that the March 2016 refresher training medics felt the SHTP had personally provided them. Unlike the student medics, they had already had experience practising as a medic inside Shan State. The concept of opportunity was also a dominant theme in the speeches given by senior RCSS/SSA-S leadership at the opening ceremony. Sao<sup>82</sup> Ong Moug exhorted the medics to study hard, stating:

Today we have all the opportunities we need and we are getting help from outside. It is not easy for us to get this kind of opportunity so please concentrate and study hard during the training to be able to provide healthcare to our people inside Shan State. (Sao Ong Moug, March 2016)

Sao Sai Liek reiterated this saying:

It is extremely hard to get this opportunity. You spent a lot of time and effort coming here. You have to study, you have to understand about the difficult situation inside Shan State. So, study hard so you can feel more confident and skilled. (Sao Sai Like, March 2016)

These speeches highlighted the expectations that the RCSS/SSA-S leadership had of the medics to take advantage of the opportunity of the SHTP to serve their communities.

Most of the medics felt that participating in the SHTP had given them the opportunity to help others. As one medic put it “I can help others and it makes me feel happy” (Sai Aw, March 2016). Another said “I can help people and I can prevent diseases. Some diseases have decreased in my community” (Nang Mo Hom, March 2016). Again, another shared that “I can help people in my village be healthier” (Nang Phoung Sim, March 2016). Nang Mo Kham was pleased for the opportunity to “save more lives” (March 2016). Nang Zarm Tai summed this view up saying “I feel that I can help our Tai people by using this knowledge. If I can help people it makes me happy and the other people might also be happy” (March 2016). A number of the medics also reported that they had gained personal opportunities simply by being able to “learn more” (Nang Lao

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<sup>82</sup> Sao/Jao is an honorific for leaders.

Lao, March 2016). This observation is particularly pertinent because many of the medics had low levels of education, as explained earlier in the chapter (section 7.1.1).

Some medics were greatly encouraged by the high regard that communities held them in, saying “the villagers respect me more” (Nang Kham Hsai, March 2016). Sai Kawn stated “Many people respect us and we have good dignity. We are important to the people” (March 2016). Sai Seng Kaeo reported he could now “decide things for myself. People trust me” (March 2016). Sai Parn welcomed the opportunity to “become a leader and have the ability to be in charge, get involved in management in some way” (March 2016).

Nang Than Nu also suggested that, as well as increasing her personal confidence, she had been able to overcome differences in her community, saying “As a medic I am equal to everyone. Sometimes I treat rich people. Sometimes I treat poor people. I treat people from every ethnic group” (March 2016). The medic’s decision to not discriminate based on ethnicity or class is important in the Shan State context. Myanmar government services have discriminated on this basis, and health inequities continue to be reinforced by a lack of financial access to services.

For some medics, their reflections were strongly linked with their Buddhist faith and the requirement to perform good deeds. This meant that being a medic gave them the opportunity to exemplify one of the key tenets of their faith. One medic said, “If we do good things in this life, we will get good things in the next life also” (Sai Seng Kaeo, March 2016). This view was encapsulated by Nang Hleng Khong:

Being a medic helps me know about diseases. Also, when I get old the people I have looked after will then look after me. We also believe that if we do good things for people then we will also get good things. We believe that after we die then we have another life. Even in the next life we will get good things. (Nang Hleng Khong, March 2016)

All of the refresher training medics agreed that they would recommend being a medic as a profession to the new students who were then arriving in Loi Tai Leng for the SHTP. All participants in the refresher training expressed their intention to continue practising as medics for as long as possible (although as noted in section 7.1.1 some medics have gone on to other careers). One medic remarked that “There is no limit to how long I will be a medic. If the place that I live has no health worker then I will help.

I will stay doing this forever” (Sai Hsar Lu, March 2016). When asked how this would work if they had children one woman reported that:

I think the medic job is better than any other job. If I can't do this job with children then I won't be able to do another harder job. This isn't manual labour. (Nang Mo Kham, March 2016)

Some expressed reservations saying, “I think it will be difficult but we won't know until then” (Nang Seng Sim, March 2016). Similarly, one man thought “It might be difficult but I am going to try” (Sai Yawd Hkur, March 2016). These accounts all evidence the opportunities that the medics felt the SHTP had provided to them, alongside the expectations that Tai authorities had of them to take advantage of these opportunities.

### **7.1.3 An indicator of effectiveness: Confidence and preparedness**

A useful indicator of the effectiveness of Partners approaches to the development health system capabilities (a key research aim), was to ask how confident and prepared the medics felt when returning to their communities following the training. One important thing to note is that SHTP programme managers had not been able to travel to communities inside Shan State themselves to undertake extensive, formal monitoring or evaluation of the impacts of the programme because of the security situation. This meant they did not have the opportunity to adapt the programme based on this information. Up to date health information for communities in conflict-affected areas is difficult to come by, as noted in Chapter 5, section 5.2.2. Rather than attempting to measure health outcomes based on baseline medical indicators that weren't available, interview questions for the medics at the 2016 refresher training were framed around the issues of confidence and preparedness for the role; the good and bad aspects of being a medic; what opportunities being a medic had provided for them; and what levels of support they received from their communities. These aspects shed some light on the effectiveness of the approaches that Partners had used to train these medics. During the refresher training, the medics were also asked to share positive and negative stories of treating patients with one another (as pictured in Photograph 7.1 below). The programme managers took this opportunity to hear about the prevalent health problems the medics were treating to tailor the refresher course to their needs.



*Photograph 7.1: Women medics sharing positive and negative stories (Source: Author, 2016).*

First, the medics were asked how confident they felt in their role within communities, and how well the SHTP had prepared them. Interestingly, they presented their confidence levels in the form of a percentage. The results ranged from not very confident or only 50% confident, to 100% confident. What was notable was that for all of them, their confidence had increased following the training. One medic who was preparing to return inside Shan State following her training in 2015 shared that:

Working here in the clinic is good because if there is a patient that we don't know what to do with, we can ask the doctors for help. But when we return inside Shan State we have no one. We have to look in the textbook and ask ourselves. (Nang Ying Kon Kham, November 2016)

However, she went on to reflect that however, “it might be good though because we can decide by ourselves with our experience and so improve”. Another medic also felt that he could refer to the training materials and textbook if he felt out of his depth, saying, “I feel like I can help. If I don't know a treatment I can open the book and look it up” (Sai Pan Sar, November 2015). Others understood the limitations of their

knowledge and experience and could refer difficult cases on to a larger clinic in a nearby town, reporting “I have confidence. I treat the diseases that I know. Some diseases I cannot treat, but I can refer them” (Sai Yawd Hkur, March 2016). Unfortunately, referral was not an option for those medics practising in extremely remote areas far away from more advanced healthcare providers.

Some medics attributed their confidence to working with a team, rather than by themselves, remarking that “My confidence is 100% because I work with other medics inside [Shan State]” (Nang Zarm Tai, March 2016). Nang Kham Hsai reiterated this, saying “If I go with other medics then I feel confident” (March 2016). This feedback suggests that the Shan Health Department should ensure that medics are based in a team as much as is feasibly possible. CHWs working in a team alongside medics felt that they were able to learn from the medics, even though they hadn’t had the opportunity to advance their own training in Loi Tai Leng. One CHW had welcomed the opportunity to increase his confidence and experience when the medic he was teamed with had to go to hospital himself with appendicitis. The CHW reported:

When the medic and I work together, I just treat common colds or small things. But when the medic had to go to hospital [elsewhere] I saw patients with severe problems like seizures. I helped those people and they became better. I feel thankful and really proud. One patient had cut his thigh open and was bleeding heavily and in shock. I helped him and he became better. (Sai Hsar Lu, March 2016)

When the medics were asked what they did not feel confident about most of the responses centred on specific illnesses or medical problems. For example, one medic shared that he did not feel confident treating “malaria, haemorrhages or mental illness” (Sai Seng Kaeo, March 2016). Mental illness had not featured prominently in the SHTP at that point. A few disclosed they worried about treating patients with tuberculosis (TB) or human immunodeficiency virus (HIV), so they referred them onto larger healthcare providers, where possible. Nang Hleng Khong said:

Sometimes I tell the patient to go into the town to be tested for TB. If they cannot go then I’ll take their sputum to be checked and take their medicine to them every month. Sometimes I refer the patient and go with them into the town. (Nang Hleng Khong, March 2016)

Many of the medics expressed concerns about their ability to deal with difficult obstetrics cases, which was not unexpected for the programme managers. One reported that:

It's a dangerous sign when they bleed heavily before they give birth. It is not a good sign for us, so we are worried and we send them to hospital if we can. That is much safer. (Sai Kawn, March 2016)

He practised in another RCSS/SSA-S clinic on the Myanmar-Thailand border so could refer difficult obstetrics cases to a town in Thailand across the border, an option not available to all of the medics.

A significant consideration for the programme manager's ongoing development of the SHTP curriculum, was that the medics did not feel well prepared to treat the large number of patients presenting with non-communicable diseases (NCDs) such as diabetes, hypertension, and arthritis. This is likely explained by the fact that the curriculum focused more on communicable diseases as the programme managers had assumed the medics would encounter more of these. The medics were clear about the value of having regular refresher training each year. However, Partners' budgetary constraints may impact on them fulfilling this need.

#### **7.1.4 Medic experiences of community healthcare and community support**

Perhaps the most compelling aspects of the refresher training were the positive and negative stories that the medics shared about their experiences in their communities. Most importantly, it confirmed that the SHTP has enabled functioning capabilities in the medics, and some of the necessary skills to treat patients. Undoubtedly lives have been saved because of their interventions. It also highlighted the reality of the difficult conflict-affected context in which they work, and especially how important it is for the programme managers to understand this. The improved health outcomes also influenced the levels of community support for the medics.

One group of medics reported treating a woman who was very unwell with haemorrhagic dengue fever. She had sought paid treatment elsewhere but did not get better. Her family was unable to seek further treatment because they had no money to pay for it. The medics heard about the case and explained to her family that they could provide free treatment. The medics were anxious that if the patient died they would be blamed by the community. However, they proceeded to treat her and within a month

she had recovered. This was one of many similar stories told by the medics about the successful treatment of patients with the knowledge they had gained through the SHTP.

The medics reported that there were often high levels of distrust of their treatments and vaccination programmes when they returned to their communities. They encountered antagonism from traditional healers and Burmese trained medics who charged for treatment, whose business they were disrupting by providing free or cheaper treatment. Many of the communities maintain traditional beliefs and practices around illness and disease, including beliefs that “evil spirits are making them sick so they use sticks to try to beat the evil spirit out of the person, or they use traditional healers and medicines” (Nang Si Lont, April 2015).

What stood out was the different strategies used by the medics to overcome resistance and build the trust of the community. One medic told of treating a woman who had delivered twins, one stillborn and one live baby, but had suffered post-birth complications leading to her being unable to walk. The community believed she would not recover but the medic cared for her and treated her with the appropriate medication. Gradually she gained enough mobility that he was able to take her to the local market on the back of his motorbike to do her shopping. People witnessed from this demonstration that she was recovering, and now chose to seek treatment from the medic. Another medic told the story of treating a woman who had been diagnosed with HIV. Her husband also had HIV and had been referred to a Thai hospital where he died. When the woman became unwell her children were reluctant to seek treatment as their father had died in a hospital. The medic educated the family about HIV. Unfortunately, anti-retro viral medication is not freely available to the medics, but he was able to successfully treat her opportunistic infections and gain the family’s trust.

Another major issue for the medics is having to counter poor medical practice by other healthcare workers. The medics have identified a propensity for untrained medics, not associated with the Shan Health Department, to give intramuscular injections or IV fluids regardless of the indicated treatment, and often for a large fee. Communities now expect this treatment so will often demand it themselves. One medic commented that:

In our area, there are a lot of different healthcare workers so when someone is sick they’ll often call on different workers. These workers don’t really understand about proper medicine so they’ll put lots of the

wrong medicine into the patient. I saw one patient who received the wrong treatment by IV become unconscious. Other patients request vitamin injections no matter what is wrong with them. I saw one person die following the wrong injections, probably of hypertension. (Nang Shwe, May 2015)

The SHTP training has given the medics the knowledge that this isn't correct procedure, so they resist these requests and will only prescribe what is indicated. Some communities have given the RCSS/SSA-S clinics the epithet 'The Paracetamol Clinic' to express their disapproval of the medics' treatment, and they even "throw the medicine in front of the clinic" (Nang Than Nu, May 2015). Sai Laeng shared that "even the Loi Tai Leng clinic is called the 'Paracetamol Clinic'" (March 2016).

In some cases, the medics' own treatment was insufficient to deal with the severity of the health problem, or they had not been able to win the trust of a family, leading to negative consequences for the patient. Nang Than Nu illustrated this difficulty with a story of seeing a child with a very enlarged liver that she couldn't diagnose or treat. She showed us video of the patient from her phone where she'd kept a record.

I saw a two-year-old male who had ascites for about two months. His family first used herbs to try and treat him and then they brought him to our clinic. He was very weak and thin and hadn't eaten for eight days. We tested for malaria which was negative. He had no fever, no rash, nothing. But he had jaundice and a very hard abdomen and he wouldn't let us touch him without crying. I didn't know what medicine to give him. I was afraid that he had a liver problem so I couldn't even give him paracetamol. We referred him to a larger clinic. They said they couldn't treat him either and wanted to refer him to Lashio. But the family had no money so they brought the baby back home to see a traditional healer but he died. (Nang Than Nu, March 2016)

The programme managers made a point of teaching the medics to understand the limits of their own knowledge, experience, and treatment options. In sharing their negative stories, the medics also acknowledged their own limitations. They were prepared, where able, to refer patients to a higher level of care. In isolated communities where this wasn't an option the medics treated the patients as best they could within their current restrictions.

Most of the medics agreed that community attitudes towards them were slow to change. As Nang Khay said “We experience difficulty changing the minds of the people” (April 2015). Another medic responded that her biggest problem returning to her community would be “to make people trust us and trust our understanding” (Ying Kon Kham, November 2015). The Jao affirmed this (see section 5.4.1), suggesting that:

The reason we want to set up clinics at the village tract level is so that the communities will be able to accept the medics as they show their ability. That is why the training here is so important. (the Jao, November 2015)

On the whole, the medics felt that they were making some progress in garnering the trust of their communities by demonstrating their skills. When asked what helped the community trust them more, Nang Lao Lao said:

When we first went there the community didn't trust us. But now it's much better than before. We gave them public health education about hygiene and other things. They followed our education and it worked and after that the community trusted us more. (Nang Lao Lao, March 2016)

Another explained that the community trusted them because they were Tai, not Burmese:

Sometimes we cannot give them medicine but we talk to them about disease prevention. That area is Tai, so we can speak to them in Tai. The villagers trust us and think that we're good because we are Tai. (Sai Parn, March 2016)

Sai Kawn emphasised the importance of working with village leadership to facilitate trust:

We work together with the head villager and the leaders in the village. We work and we discuss. If we have some problems we come and sit and discuss what we are going to do. When the community sees me return they are very happy. (Sai Kawn, March 2016)

These examples show the importance of the medics' ongoing presence in the community in order to foster trust. It also reinforces the need for villagers to see the benefits of health education provided by the medics to help build that trust further.

Where there is trust for the medics, communities enacted their support by cleaning the clinics, helping the medics with their gardens, and providing food, firewood, and transportation. Commenting on the level of support for her, one medic said that “the villagers did not want to let me come here for the refresher training and some of them even cried” because they had grown to trust her and did not want to be without a medic during her time away (Nang Voe Phoung, March 2016). Another echoed this saying that her community had “supported me with money to use while I’m here for the refresher training” (Nang Phoung Sim, March 2016). Nang Zarm Tai agreed, commenting that “When I came to train here the community helped with my farming and looking after my family. They also gave me money for transportation to get here” (March 2016). These practical indications of community support are a crucial encouragement for the medics.

This section has described the high levels of medic agency and motivation to participate in the SHTP. It also demonstrated how the SHTP has given the medics opportunities for further training that are not readily available inside Shan State. The experiences and views of the medics of the approaches taken by the SHTP were presented, framed around their confidence and preparedness. They also described their positive and negative experiences of providing healthcare to their communities. The medics have increased in confidence and utilised their capabilities in order to provide necessary healthcare to their communities which indicates the effectiveness of the SHTP. Some of the difficulties they face in their practice were highlighted, such as the long process of fostering community trust.

Having examined the opportunities that the SHTP provides to medics, the section below reviews the approaches that Partners takes to implement of the SHTP. These include findings about the volunteerism model and Western technocratic approaches to curriculum development that they employ.

## **7.2 Volunteerism, volunteers, and the views of Partners Relief and Development**

### **7.2.1 The origins of volunteer involvement**

The approaches that Partners uses in the SHTP are crucial to enabling the capabilities of the medics and, consequently, the alternative health system. The primary approach

that Partners utilises is a volunteerism model for staffing its programmes, fostered primarily by its relational connections with Western churches where expatriate medical volunteers are drawn from. This section outlines the usefulness and limitations of Partners' volunteerism framework. The research has clearly identified an ongoing need for the involvement of these expatriate medical volunteers, due to the lack of trained and available Tai medical personnel (see section 7.3.2). However, it also found that there are major drawbacks when staff are selected based on their availability to volunteer rather than their possession of a specific set of skills and experiences required by the SHTP, and for the low resource and conflict-affected context. The MOU does not specify minimum requirements for volunteers (see Chapter 6, section 6.1.2). Many Partners staff have no international development programme management knowledge or experience. In the case of the medical volunteers, their medical abilities are necessary to foster medical capacity in the medics but often they too have had no prior experience in working and teaching in low resource, cross-cultural contexts. They don't possess Tai language skills so the teaching is conducted in English, with Tai translation provided by community members when this is available.

Dr Alison and Dr Ken were ill-prepared for the context they found themselves in on the Myanmar-Thailand border, despite their willingness to leave their life of comfortable semi-retirement in Aotearoa/New Zealand and move to a low resource context to work. Their inclusion in the programme was based solely on the ad hoc criteria of their relationship with a former Partners staff member, Stu, who oversaw all of Partners' work in Shan State. When asked how they initially became involved in the programme Dr Ken replied, "Relationships, is the very, very short answer. It is relationships. We started because we knew Stu and Ruth" (May 2015). Their introduction to the programme was when Stu invited them to visit and teach for a brief period of time in 2011. Their continued involvement from 2012 onwards depended upon their availability as semi-retired general practitioners rather than any previous experience either practising medicine or implementing primary healthcare training in a low resource, developing country context.

As well as a lack of relevant medical experience, the suitability of Dr Alison and Dr Ken for this work was also undermined by their lack of knowledge of the border context they would be working in prior to their arrival. As they put it, "We knew it was remote. Because Stu had told us they had to get out and walk and push the truck. He was one who had to push the truck out of the mud hole...really I think that was really all we

understood” (Dr Alison, May 2015). “And limited resources” (Dr Ken, May 2015). They started ongoing teaching in 2013 having undertaken a tropical medicine course that they acknowledge was not suitable preparation. Dr Ken pointed out, “OK I did tropical and infectious diseases, sure it was for travel. You did a tropical medicine course. Your tropical medicine wasn't about low resource environments. It didn't tackle low resource environments” (May 2015). Dr Alison concluded that it lacked any utility for a low resource environment, “It wasn't part of it. It was really just purist medicine” (May 2015). However, this example of the lack of careful selection and preparation of volunteers is symptomatic of the volunteerism framework operated by Partners. It is noted that since the completion of fieldwork, Dr Ken and Dr Alison have also completed an ultrasound training course meaning they are now able to use the donated ultrasound equipment in the Loi Tai Leng clinic. Dr Alison and Dr Ken's lack of initial preparedness does not diminish their commitment to and involvement in establishing a functional healthcare system in Shan State.

Clearly, Partners' volunteerism model did not include a recruitment process that effectively assessed the abilities and experiences of volunteers, or match them to specific programme requirements. One explanation for this is that Partners is a small international non-governmental organisation (INGO) without staff who have extensive international development experience responsible for the promotion and recruitment for volunteer roles. It is posited that larger INGOs such as the International Committee of the Red Cross, World Vision, International Rescue Committee and Médecins Sans Frontières, all of whom operate within Myanmar, are able to attract more appropriate and experienced paid medical staff for their activities. This leaves smaller organisations such as Partners reliant on those who are in a position to volunteer such as semi-retired general practitioners. The difficulty in accommodating these ill-prepared volunteers was also evident in my experience with an untrained volunteer who had come to Loi Tai Leng to teach English to the student medics. I (the researcher) had suggested to Dr Alison and Dr Ken that they ask her to prepare appropriate materials for Teaching English to Speakers of Other Languages (TESOL) before her arrival. She did not do this so her visit proved ineffectual as she could not give useful language lessons to the students. It was also burdensome for the programme managers who were also managing SHTP activities as well as her presence.

### **7.2.2 The lack of a monitoring, evaluation and learning culture and processes**

One of the approaches that INGOs use to assess their effectiveness is to conduct monitoring, evaluation and learning (MEL) within their programmes. A commitment in the memorandum of understanding (MOU; see Chapter 6, section 6.1.2) is to “supply teachers to effectively teach the Medic level 1 and Medic level 2 curricula” (Shan State Development Foundation & Partners Relief & Development, 2015). One key issue that emerged from these findings is that Partners had made little provision for the monitoring and evaluation of the effectiveness of their teaching in the SHTP. Consequently, they had little idea of their influence on medic capabilities, and impacts on community health outcomes. Partners also has no formal evaluation processes in place for the medics to provide feedback on their training to enable reflexive changes to be made. Sai Seng Wan, Partners’ Tai cultural broker, had some freedom to travel inside Shan State to informally evaluate how the medics were practising. He provided basic feedback to the programme managers that they incorporated into their six-monthly reports to donors. However, the reports contain very little information for Partners about how the goals and objectives of the programme are being met, but rather give detail about specific activities that have been undertaken. When asked how Partners evaluated the SHTP, the programme managers expressed their view that there was no requirement for them to be evaluated, arguing that:

We’re experienced GPs, self-employed GPs. If I had to report to someone I would find that really onerous because I’m not used to it and I don’t think I need it. I’m able to be self-accountable. But of course, there will be things that I can’t see...It would have to be someone that I trusted, not the organisation. (Dr Alison, May 2015)

Her position was supported by the lack of a wider monitoring, evaluation and learning organisational culture observed within Partners. Dr Ken considered that they undertook “self-evaluation through the regular reports, and working on the budgets” but Partners did not require more of them. He commented that their informal discussions with Paw Shar Gay, about the practise of the medics, constituted a form of evaluation and “we’ve asked informally if the health department and SSDF are happy with what we’re doing and get feedback that way” (May 2015). It was not until the first refresher course was held in Loi Tai Leng in March 2016 that the programme managers and Partners had an opportunity to directly evaluate the effectiveness of the SHTP by talking to medics who returned from their rural communities for the course. However,

they did not take up this opportunity. This may be because of a lack of development evaluation experience within Partners, including the programme managers, but also because they had to prioritise their available medical training time with the medics.

There is also an agreement in the MOU, from the SSDF, to “share relevant healthcare and clinic audit data” with Partners. The audit data would provide a crucial input into Partners’ monitoring activities. What was also striking was that these audits no longer take place, as Sai Laeng reported “...no, we don’t have the funds to keep doing that anymore” (March, 2016). It is necessary to note that Partners is not responsible to specifically monitor or maintain contact with the medics when they return to rural communities as the responsibility for this task lies within the health department’s purview, under the MOU. But, in March 2016, the programme managers were unaware of the lack of clinic audit data and still expected to rely on this data for information about the clinical performance of the border clinic medics. The programme managers mooted formalising a system of contact, clinic support, and refresher training via mobile technology that would enable them to engage in ongoing evaluation but, at the time of writing, this had not been established. The relational diagram Figure 6.1 (see page 134) indicates the relationships between the different actors.

Partners, is thus, heavily reliant upon anecdotal reports from Paw Shar Gay about medic activities inside Shan State which is partly explained by the fact that it had been unsafe for foreigners to travel to conflict-affected areas of Shan State. However, as previously noted, Dr Alison and Dr Ken hold some concerns that Paw Shar Gay lacks the capability to oversee the management structure for the medics, stating that:

There's a sense that you do send them out alone into these new locations...I doubt that she has studied models [of health system management] elsewhere but she's probably heard of them. (Dr Alison, May 2015)

This view suggests that the programme managers are not fully aware of Paw Shar Gay’s integral involvement in the Health Convergence Core Group (HCCG), introduced in Chapter 5, section 5.2.2. Her engagement with the HCCG provides her with key links to other ethnic groups who share knowledge and experience about their own alternative health system development. Rather than following Western health administration practices which the programme managers are familiar with, Paw Shar Gay oversees

informal management systems in the Loi Tai Leng clinic to maintain an overview of medic locations and collect community health information from them.

The ways in which Partners maintained accountability to the RCSS, SSDF and the health department were also explored in this research. When the Jao was asked whether the RCSS monitored Partners' performance to ensure it was working appropriately for the Tai, his view was that Partners did not maintain any direct accountability to the RCSS. He noted that "The RCSS does not check on Partners because they have come here and not given us any problems" (May 2015). He referred obliquely to earlier issues in their relationship but appeared to attribute it to Partners not having enough funds to do what the RCSS wanted them to. He said, "Sometimes Partners has their own problems with their staff. And sometimes the things that we need to do and that they can do are not a match. But I understand the budget is not enough..." (May 2015). This issue did not appear to have lessened Tai authorities' support of Partners or the SHTP. The question of the SSDF evaluating the SHTP to ensure it was meeting the needs inside Shan State was addressed to Sai Laeng, who thought that "I think that what we are doing is already great. But as you said, some of the training is not really relevant to the needs. This is partly because we have very little assessment from those areas" (May 2015). He considered the appropriateness of the training was not solely a reflection on Partners' programme design but also related to the unavailability of relevant health information from inside Shan State, which was partly outside of Partners' influence.

When asked how the health department ensures that Partners is doing a good job, Paw Shar Gay emphasised that:

We can discuss. For example, for two or three years the medics didn't have a doctor available to train them full time. So, we told them that they should prepare more, and find more teachers because too much of a holiday is not good for the students. But Partners is trying. They listen and change. They said we were right. Sometimes misunderstandings can happen but if we come and discuss those and listen to each other it's good. (Paw Shar Gay, May 2015)

The medics were also asked to reflect on their experiences of the SHTP, and their responses were overwhelmingly positive. However, to put this into perspective, Sai Seng Wan, Partners' Tai staff member and cultural broker, confirmed that cultural norms exist that prevent the medics from speaking negatively. He remarked that

“sometimes if you ask the students you will always get a positive answer” (November 2015). A very small number of medics, contemplating the programme changes in recent years, commented that “it is good that the doctors change and their ideas improve” (Sai Tun Sar, November 2015). One felt that moves to ensure the regularity and continuity of teaching throughout the programme year was a major improvement, compared to when “the doctors were coming and going and having days off in between” (Nang Mo Kham, November 2015).

### **7.2.3 Curriculum adaptation and technocratic problems**

Another key component of the SHTP that arose in interviews with medical volunteers was the evolution of the teaching curriculum. Dr Bert, a retired doctor from Aotearoa/New Zealand (described in Chapter 5), has had a prominent role in the programme since 2009. He too became involved through his relationship with Stu, when he was invited to assess the border clinic, then located at the Loi Tai Leng High School. He was pivotal in developing the training programme still used by the programme managers during the research. He utilised a curriculum originally devised by the International Rescue Committee (see Chapter 5, section 5.2.2) in the mid-2000s for use in refugee settings along the Myanmar-Thailand border. He made adaptations he felt were necessary, explaining:

But what had to be done was develop a curriculum and everything else...I'd come up here for roughly two weeks and go back to Chiang Mai for two weeks. And in Chiang Mai I would be writing up the notes, the handouts and printing out the booklets for the next two weeks teaching. The curriculum wasn't too bad, was easy to put together. I was really doing all the books for the students to have and write notes on and things. So that was Year One. (Dr Bert, April 2015)

At the time of writing, Dr Bert only visited Loi Tai Leng two or three times a year for very short periods, but he maintained significant influence on decision making in the programme, examined in greater detail in Chapter 6, section 6.1.2.

Dr Alison and Dr Ken continued to focus on enhancing the SHTP curriculum. Their perspective upon their preliminary visit in 2011 was that, “...there was very little curriculum...” (Dr Alison, May 2015). Dr Ken observed that the curriculum “...had very limited resources, just the little books. The PowerPoints and stuff, it was all picked up from the International Rescue Committee” (May 2015). When they began teaching in

2013, it was a competency based programme,<sup>83</sup> focused on the cases that the medics were observing in the border clinic. The doctors commented that this was “limited because what they saw in the clinic wasn't comprehensive” (Dr Ken, May 2015). The lack of training on health problems such as the large number of non-communicable diseases seen by medics in their communities was highlighted during the refresher training. The programme managers sought to improve upon this to ensure the medics learned about a wider range of health issues other than only those that present in the clinic. They also focused on improving the physical teaching resources, including purchasing appropriate training materials such as the MamaNatalie birthing simulator model<sup>84</sup> used in the much-needed obstetrics training module.

It's been an intellectual and rewarding challenge to figure it out. And changing those books, not the framework that we're trying to teach to, although we will start working on that. But changing the resources we use so that they are as good as they can be with what we have. Rather than, you know, just sort of got together. (Dr Ken, May 2015)

I observed that the programme manager's continual curriculum advancement has a tendency towards more technical teaching than may be appropriate for the medics in this context. This occurred most often when they used medical training resources that were not specifically designed for low resource contexts. These resources sometimes even advocated treatment protocols that are not available to the medics inside Shan State (Fieldwork notes, November 2015). The lack of contextualised resources, combined with the low education level of most of their students (as discussed in 6.1.2), makes this problematic. The medics reported struggling to understand the detailed information conveyed by some of the medical volunteers. There was clearly a reluctance on the part of the medics to directly express any negative opinions about the SHTP, as it is considered poor form in Tai culture to make negative comments about someone. However, occasionally a medic would mention this in response to me asking them what the worst part of the training was for them. Nang Voe Seng intimated this saying, “We just don't understand very much. The teachers are introducing medicine and that is difficult” (November 2015). Other medics shared similar sentiments commenting that there was “too much information and it is too difficult” (Nang Hleng Khong, March

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<sup>83</sup> Competency is “an individual's belief in his/her capability to perform task activities skilfully”, so the training targets specific skills for specific situations (Kane et al., 2016, p. 30).

<sup>84</sup> A model of a mother that is strapped onto a trainer to provide simulations of birthing scenarios. <http://www.laerdalglobalhealth.com/doc/2545/MamaNatalie>

2016), and “I don’t think I understand...it is difficult for me...too difficult and a lot of things that I have to memorise. It is difficult to remember lots of information” (Sai Aw, March 2016).

Dr Bert displayed some awareness of the need to ensure that the curriculum is context-specific, which contrasted with his instrumental shaping of the highly technical curriculum. He stated,

...my understanding is the Tai want Loi Tai Leng to continue and develop. My understanding is that the Tai want to use this as the model...of teaching elsewhere. And that's fine...it's just a question of improving things here. I think one of the things that Dr Alison and Dr Ken and I have talked about is that we've got to be careful about what we're teaching and make sure it meets needs but doesn't overpower the students. (Dr Bert, April 2015)

Dr Alison and Dr Ken are also somewhat aware of the dissonance between their often highly technical teaching and the low resource context. Dr Alison considered that the “...low resources are, in many ways, a challenge but we [Partners] are sometimes just too high resource” (May 2015). However, this observation did not lead to a shift in their teaching practice during the course of the research.

Concern about the technical nature of the training was shared by Gabby who spent four weeks in Loi Tai Leng in April-May 2015 as part of her Aotearoa/New Zealand medical school elective. She participated in teaching some of the modules. Her views were informative, being from the perspective of a person who had recently been involved in medical training herself. She reflected that, “...the curriculum is pretty good. I think there's definite room for improvement. There's still a lot of wordy medical things in there that you could probably remove. And maybe replace it with some more [hands-on] training” (May 2015). She also thought that Partners needed to ensure any medical volunteers had good teaching experience as well as their medical knowledge. As she put it:

They need experienced doctors and experts in their field. But that doesn't necessarily mean they'll have the best teaching techniques if that makes sense... Partners could do something where they could give them some resources or techniques. (Gabby, May 2015)

Dr Alison and Dr Ken do take a proactive approach to help the students apply their technical classroom teaching to a practical medical setting. They conduct ward rounds in the Loi Tai Leng clinic at the end of every week day (shown in Photograph 7.2 below), which replicates a model used in Aotearoa/New Zealand medical training practice. It ensures that the students have an opportunity to put into practice the information they are learning in the classroom. The doctors mentor the students in taking patients' medical histories, making diagnoses and organising appropriate treatment plans with the resources available in the clinic. Gabby thought that Dr Alison's and Dr Ken's experiences were invaluable in the clinic teaching context as:

...people with tonnes of experience like Dr Ken and Dr Alison are amazing because teaching on, for example, ward rounds they could do a much better job at that than me because I haven't actually seen enough patients with disease myself to give the students good techniques. (Gabby, May 2015).

The learning opportunities the clinic practicums provide to the students is critical in building their experience before returning to their communities. Gabby marvelled at the capacity the students already have for clinic tasks despite their low levels of education.

I guess it's a shock when you hear how little schooling they had, especially when you compare it to what I have. So, I have a full thirteen years of school, plus a bio-medical degree which is three years plus another five years of medicine. And I'm still not allowed to do what the second-year medics here are doing in a hospital. They're giving out medicine. They're running things by themselves. So, it is pretty shocking what we expect them to do after such a short period of time. At the same time after being with them in class for two or three weeks you see how quickly they're picking things up and grasping it. And you're actually like, oh if I can teach them how to take a blood pressure it doesn't matter whether they've only had five years at school or whether they've had five years at university. Both groups of people can still take a blood pressure if you teach them well. So, there's two sides to the coin. You feel a little bit shocked that they are capable of doing all these things with such little education but you also want to believe in them to know that they

can do it...yet you can teach them basic things that will save a lot of people. (Gabby, May 2015)



*Photograph 7.2: A medic and Dr Ken conducting a ward round in the Loi Tai Leng clinic (Source: Author, 2016).*

Despite undertaking a teaching and mentoring role in the clinic, I observed a tendency for the programme managers to revert to their role as experienced medical practitioners, especially with difficult cases. They are seen by Paw Shar Gay and the medics as experts and are often called upon to step into this role in the clinic. There were a number of occasions where the medics would fetch the doctors to assess and treat new patients, often in life saving situations. However, blurring the lines between teaching and practice is problematic as Partners' memorandum of understanding (MOU) with the SSDF and Shan Health Department only gives the programme managers a remit to provide medic training, not to practise medicine in the clinic (see Chapter 6, section 6.1.2 for a discussion of the MOU). They cannot legally practice medicine which places ethical limitations on their freedom to provide much needed medical care, despite the onus they feel to do so. During the months that the doctors are not living in the community the clinic staff manage without their expertise.

While the border clinic operates in a low resource setting without much of the necessary medical equipment and supplies to provide even a basic level of healthcare, as the findings in section 7.2 illustrate, it still enables the students to realise their capabilities as medics. Gabby had the view that the students take full advantage of the learning opportunities presented to them, “using every opportunity they have” (May 2015). This enables them to function as fully as possible within the bounds of the resource limitations placed on them. She explained:

...they've got a lot of what they need. They've got shelter. They've got plenty of space. They've got access to some basic medicines. They've got thermometers and stethoscopes...it's not like they've got nothing. They can do a lot. You can do a lot of medicine with just looking and asking questions and examining. So, all the fancy equipment, it isn't the end of the world for them. They can do so much without it. (Gabby, May 2015).

The programme managers do teach the medics to understand the limitations of their knowledge and the treatments available to them. This approach gives the medics some certainty about what they can provide, whereas highly technical training may lead to frustrations when those treatment options are not available in the medics' communities.

#### **7.2.4 Language difficulties**

Another significant finding was that of the impact of language problems encountered by the expatriate medical volunteers and the medics during the SHTP. The programme managers received little preparatory cultural training from Partners prior to their entry to the field, as described in 7.3.1. Partners required most long-term volunteers based in Chiang Mai, Thailand to undergo six months of intensive Thai language learning. Initially, Dr Alison and Dr Ken were considered a different category as they had to spend four months of each year working in Aotearoa/New Zealand to raise funds, and maintain their clinical registration with the Medical Council of New Zealand. Their location in a Tai speaking community on the Myanmar-Thailand border also meant they hadn't considered Thai language learning to be a priority. Proficiency in the Thai language is a benefit as it is closely related to the Tai language. Dr Alison and Dr Ken both shared their frustrations with the language difficulties. Dr Alison noted, “Another negative thing was just the language issues. Not negative so much as just annoying. It's really annoying that there is no standard spelling for things. That really annoyed me.

Even for the person's own name” (May 2015). Dr Ken acknowledged that their lack of language was a major difficulty but that it was their responsibility to learn it, sharing, “But that's our problem, in that we can't speak the language and we can't write the language. But it is a negative. It's huge” (May 2015).

The lack of Tai language ability in the doctors, and very few proficient English translators in the community, greatly reduces the utility of the technical training in the English language. Medics from inside Shan State are extremely unlikely to know English as Tai and Burmese are the language of education. Loi Tai Leng community members are more likely to use Thai, not English, due to their proximity to Thailand. A few of the students speak a little English so they serve as translators while they undertake the training. Most of the medical volunteers I interviewed felt frustrated with the language barrier. Dr Pilou remarked that “...we need a translator for all that we want to say, all that we want to explain, all that we want to teach. And this is perhaps the most difficult” (November 2015). Dr Les concurred saying, “I would agree from a very practical point of view, the language is always a barrier in medicine because so much of really having the right diagnosis is getting the history” (November 2015). Gabby also observed the language problems during her teaching:

I think maybe the language barrier is somewhat of a problem. For the Level 1 Medics it's OK because we currently have a good translator in class. But you can definitely see on the ward rounds that without a good English/Tai translator you know that only some limited teaching is happening. The patient isn't getting 100% quality care because we can't get a full history from them because of the language barrier. At the same time Dr Alison and Dr Ken struggle to impart teaching to the students because the students aren't understanding the English all the time. So of course, some of it is getting through and they're making do. But if they had more translators it could improve dramatically. They could teach a lot more and the patients may even benefit a lot more. (Gabby, May 2015)

The language difficulty also came up repeatedly in discussions with the medics. Nang Htar Kyi said that she found her medic training difficult as “we were just coming from inside and we couldn't speak and couldn't understand English. And we had no translator. We just had to translate by ourselves [as best we could]” (November 2015). Another medic agreed that it is “difficult to learn more because of English, because of

the language” (Nang Voe Phoung, March 2016). Sai Kawn recalled this as the most difficult part of his training as “English is a hard language” and it would have been improved by having “a good interpreter in the class” (March 2016). Another said that she was looking forward to doing the auxiliary midwife training in Taunggyi, Shan State as it was conducted in Burmese so “...we all learn from the Burmese school. And if we learn in the Burmese language it is easier for us” (Nang Voe Seng, November 2015). My research assistant, Nang Mo Kham, reflected positively on the language difficulties observing that for her “...it was a challenge and we fought that challenge. And that’s why today we can speak a lot more English” (November 2015).

### **7.2.5 The need for practical workshops**

Some of the medical volunteers maintained that placing a greater focus on practical training workshops would go some way towards mitigating the language difficulties, as English language proficiency is not required for hands-on activities. This has another fundamental benefit in that it enables the programme managers to tailor their training to what the medics encounter in their communities. As Gabby highlighted in 6.2.3, it would be appropriate to remove some of the technical medical English language components from the training and “replace it with some more [hands-on] training” (May 2015). Dr Les reported that any training in this particular context needs to be based primarily on practical workshops “...to give the students actual opportunity to use their hands to practice skills” (Dr Les, November 2015). Dr Pilou and Dr Les focus principally on hands-on teaching for their modules to accommodate the students’ low education levels. Dr Les recognises that the:

[The] theory is challenging...because it assumes a certain background of education and a context and an understanding. But focusing on developing skills that are needed, it seems to be more practical here. And the students are very bright and usually do very well in all of the workshops. (Dr Les, November 2015)

Dr Pilou shares this understanding saying, “...I believe it is the workshops that are the most important moment of the different courses” rather than lecture style teaching (November 2015).

Dr Pilou and Dr Les take an adaptive approach to their training modules each visit as they assess what material will be most responsive to the students’ community needs.

I've had a much better sense of what is appropriate and what is needed. The first year we really had no context of what the medical problems were that needed to be addressed. But as their system here has developed, we, and this year is even better yet, we see more of the diseases that they're facing. And so, we can focus and tailor the training to make it a lot more applicable. (Dr Les, November 2015)

And for me the same. I believe that the IMCI [Integrated Management of Childhood Illness] is not exactly what the students need. So, I have the prerogative to change it, to adapt it to the Tai population and to our Tai medic students. There are a lot of things to change. I shall do it. Next year. (Dr Pilou, November 2015)

Their approach was appreciated by the students, many of whom disclosed that Dr Les' trauma and first aid module was one of the easiest and most enjoyable for them. This was because:

Dr Les goes over and over it again. And he reviews the material every day and has workshops. Even if we don't understand what he is saying, we can still do it and watch what he demonstrates...I think that is good. And also, his topics are suited for the practical workshops. But for some of the lectures we just cannot do practical workshops. (Nang Htar Kyi, November 2015)

The obstetrics module was also reported as a favourite by the students. This is likely also due to its hands-on nature using the MamaNatalie birthing simulator model. These findings support the argument that practical workshops are of greatest benefit to the medics.

## **7.3 Positive developments in Partners' programme approaches**

### **7.3.1 Contextualising the training through language and culture**

The SHTP continues to undergo gradual improvements, in addition to the greater continuity of the training described in section 7.2.2, as the programme managers are increasingly reflexive about their work. Rather than expecting the medics to learn English, in 2015 Partners' human resources manager compelled Dr Alison and Dr Ken to learn Tai as an integral part of their job since they were based in Loi Tai Leng. To this end, moving on from their initial reluctance to learn the Thai language, Dr Alison

and Dr Ken undertook formal Tai lessons from mid-2015. Although their long absences from Loi Tai Leng (while back working in Aotearoa/New Zealand) means they don't retain all they have learned, they observed that speaking Tai helps to break down barriers in the clinic as patients feel more at ease when the doctors make an effort to speak to them in their own language. The language issue was incorporated into the most recent memorandum of understanding (outlined in Chapter 6, section 6.1.2), with the onus now on Partners to develop training materials in the Tai language. There has also been a positive development since my visits to utilise the English skills of Nang Kham Zarm, who spent a year in Aotearoa/New Zealand learning English in 2015. She now teaches the medics English. Nang Mo Kham is of the opinion that it is good for young Tai people to learn English as "English is the language that is used worldwide" (March 2016). Hopefully, it will help medic comprehension of the English medical terminology, as there are often no Tai translations available.

At the time of writing, Nang Kham Zarm had also started to translate the training materials from English into Tai which is a step towards ensuring that they are contextually appropriate as the materials are also simplified during the translation. The programme managers noted that this has prompted the "interesting challenge of using some translated PowerPoint slides which means that we cannot read the slide that we are teaching with" (Dr Alison and Dr Ken, newsletter, August 2016). The willingness of Dr Alison and Dr Ken to acknowledge their language limitations and work towards overcoming them is a constructive improvement. Another important transition has been the translation of the regular medic assessments into Tai. This has been accompanied by an increased focus on the practical aspects of training:

All of our assessments are translated as well, which has meant that we can be certain that we are assessing medical knowledge and not language skills. We have tried to make things as practical as possible, with practice at listening to heart sounds, regular practice at physical examination, and other skills. (Dr Alison and Dr Ken, personal communication/newsletter, August 2016)

However, at the end of the writing process, I received a newsletter from Dr Alison and Dr Ken that detailed a potential reversal of these positive developments, where they stated that "The compulsory English classes which [expatriate volunteers] run have been so fruitful – we conduct ward rounds solely in English now, and the students show us that they can now read the textbooks. English is essential for looking up Dr Google

– which they can all get on their cellphones” (McFarlane & McFarlane, 2017). This illustrates that the situation is still evolving.

Another development in the programme which may help to contextualise the training further has been visits from Partners’ SEED Learning Center<sup>85</sup> team from Chiang Mai to teach some modules. I observed these sessions in March 2016. The SEED team is composed of young Tai people who teach components such as community engagement, self-esteem and mental health awareness to the medics. There is much benefit in having trainers who speak Tai, understand the Tai culture and have some knowledge of the context that the medics practice in. The SEED trainers were able to make their training modules relevant to the experiences that the medics shared with them at the start. Dr Alison and Dr Ken appreciate the unique perspective that this team brings, sharing that this “...group of young Tai women are amazing, and significant as they are able to teach about difficult subjects in the Tai language” (McFarlane & McFarlane, 2016a).

This section has reviewed the approaches taken by Partners in the SHTP, including some of the problems with its volunteerism model for staffing. It outlined the problems with the often highly technical training resources, highlighting the student preference for a more hands-on approach to their learning. Language difficulties have caused issues for both the expatriate medical volunteers and the medics. Steps have been taken to mitigate their language difficulties in teaching and the clinic, such as language lessons for the programme managers and the translation of training materials into the Tai language. It is clear that Dr Alison and Dr Ken have made many positive changes in order to make the SHTP more appropriate to the medics’ context and experiences, although the full impact of these is yet to be seen.

### **7.3.2 The transition of the Community Health Worker Training Programme to Tai management**

While the preceding sections have outlined positive changes in the training itself, this research is particularly concerned with the role of the SHTP in the development of an alternative health system, so it is important to consider the wider impacts of the programme, and in particular its transition to Tai management. Indeed, one of the Jao’s pivotal goals is to see a transition from a focus on disease prevention through the CHW

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<sup>85</sup> SEED Learning Center is a collaborative project between Shan Youth Power civil society organisation and Partners, based in Chiang Mai. It provides vocational training and support to Tai migrants in Chiang Mai.

programme, to skilled medics providing quality healthcare to their communities, through to the ambition of Tai people teaching the SHTP. He explained that:

The first level is disease prevention. Tai people don't know how to prevent disease. For the next level, I want the medics to have the necessary skills to treat patients. For the final level, I want to have Tai people teaching Tai medics. I want Tai youth to have a place to study inside Tai State. If we have all of this then our Tai people can have development for themselves. (The Jao, May 2015)

Partners' approach to transitioning the management and teaching of the CHW training to Khu Tun Aye's leadership signals a major advance towards supporting the Jao's goal. Khu Tun Aye fosters promising Tai medics, especially women, into teaching roles within the CHW programme. This is a hopeful illustration of the potential of Tai capabilities to be enabled within the health system. However, a transition to a fully Tai-taught SHTP is some way off as the current ethnic education system inside Shan State is still under developed and under resourced, and therefore does not have the required teaching capacity.

Another important factor in the success of the CHW and SHT programmes has been the selection process for trainees instigated by Khu Tun Aye. The heightened profile of the SHTP inside Shan State has served to widen the pool of potential students. So, although student medics exercise their agency to choose the training, a more rigorous selection process has ensured that those selected are the most appropriate candidates. The process has proven one way to mitigate the low education level of many students. There are now stringent requirements to ensure that they have a basic level of literacy which leads to greater engagement with the training. It also appears to have improved the retention rate of medics once they have completed their training. Dr Alison noted that:

There wasn't any selection process [when the programme commenced]. So, the selection process has changed. Khu Tun Aye started introducing all this stuff. I told him that that is a good selection process - the fact that we still had 80%<sup>86</sup> of our trained medics practising inside Shan State! (Dr Alison, May 2015)

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<sup>86</sup> I note that this does not match the retention rate of 65% shown in Table 5.1 on page 128.

However, this is an anecdotal reflection as neither Partners or Paw Shar Gay keep thorough written records of the numbers of trained medics still practising to confirm this. The information is retained predominantly by Paw Shar Gay. She only collated this in a casual format. The programme managers replicated some of the information in their end of year report for 2016, as was shown in Table 5.1 (see page 128). One explanation for the limited amount of information on the medics practising has been the fears of Tai authorities for the safety of practising medics if this information became publicly available. This fear is well founded as medics had been arrested and harmed by the *Tatmadaw* and other local authorities for practising in the past.

One consequential finding was that there have been no Tai doctors or nurses involved in the SHTP. This is at odds with the Jao's desire to see Tai in teaching roles. Discussing this issue with Sai Laeng, head of the Shan State Development Foundation (SSDF), it became clear that there are many reasons for this, including the effects of a poor education system. He commented that, "...if we compare Tai to the Kachin and Karen, there are less educated Tai people" (March 2016). This means that there are less trained Tai medical personnel available to contribute. However, Tai medical personnel do assist in a small way with the auxiliary midwife training conducted by Nam Khone, a Tai civil society organisation based in Taunggyi<sup>87</sup> that some medics attend to gain official Myanmar MoHS certification. Another reason for the lack of Tai medical personnel participation is that they are unwilling to travel to Loi Tai Leng. Sai Laeng put this starkly, saying:

I don't think that they dare to risk their life to come to the border, with all the difficulty. The NCA was signed and then the RCSS was removed from the illegal organisation list<sup>88</sup> last year [2015]. But it hasn't been very long yet. So, I don't think they are able or that they dare to come. (Sai Laeng, March 2016)

He also explained that Tai personnel would not necessarily teach in a more context-specific way than the programme managers, and would also use highly technical terminology as they "do not know the Tai word for the technical [medical terms]." This

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<sup>87</sup> Capital city of Shan State.

<sup>88</sup> The Myanmar government holds a list of illegal organisations, predominantly ethnic armed groups. As noted in Chapter 5, section 5.1.3, the RCSS/SSA-S was removed from the list when it signed the NCA in October 2015.

suggests that expatriate medical volunteers will continue to be required in the SHTP in the immediate future, to overcome the lack of experienced Tai medical personnel.

This section has reviewed the findings about the Jao's vision for the alternative health system inside Shan State, and the positive transition to Tai management and teaching of the CHW programme. It has explained about the lack of involvement of Tai medical personnel in the SHTP. These findings support a mandate for the role of Partners and expatriate medical volunteers in the SHTP.

## **Conclusion**

This chapter has related the experiences and views of the different actors involved in the SHTP, elucidating the approaches that Partners takes. These approaches are critical to the effectiveness of the programme to enable medic capabilities. The medics were highly motivated to participate in the training in order to be able to serve their communities, and there was no compulsion on them to undertake the training. In the absence of any monitoring, evaluation and learning about the outcomes of the programme at a community level, one key indicator of its effectiveness is the growing levels of confidence and preparedness felt by the medics. The health topics where medics felt they lacked preparation indicated some gaps in the training curriculum. It was clear from the insights shared by the medics in the first section that their new knowledge and skills had given them the confidence to practise, and this was especially so if they were based in a team. They recounted meaningful stories about their lived experiences as healthcare workers in their communities that revealed their positive impact upon health outcomes in their communities. This is critical in a context with few Tai medical personnel and inadequate training opportunities. Medics had varied experiences of community support, with the medics acknowledged that building the trust of communities in their skills would take time.

The findings revealed that some approaches utilised by Partners restrict medic capabilities from functioning to their full extent. The problematic volunteerism model used to staff the programme is primarily based on the availability of expatriate medical volunteers rather than matching their skills to the needs of the SHTP. The lack of a monitoring, evaluation and learning culture means that Partners lacks the necessary information to be reflexive to what the medics and communities need from the SHTP. As well as Partners not undertaking monitoring and evaluation, the SSDF is no longer able to provide clinic audit data to Partners, leaving Partners to rely on the anecdotal

information collected by Paw Shar Gay. Language difficulties and a highly technical curriculum further constrain Partners' effectiveness. Regardless of these limitations, there were also some positive developments found during the research such as the transition of the Community Health Worker training programme to Tai management.

In the chapter that follows, I draw together the findings from Chapters 6 and 7, and analyse them using the capabilities framework for health system development in conflict-affected contexts, to understand how the approaches taken by Partners support the development of alternative health system capabilities in Shan State.



## **Chapter 8: An analysis using the capabilities framework for alternative health system development in conflict-affected contexts**

### **Introduction**

The aim of this chapter is to use the capabilities framework for health system development in conflict-affected contexts (health capabilities framework), developed for this research, to analyse the findings presented in Chapters 6 and 7. The chapter examines how two components of this framework, resources and conversion factors, contribute to the medics' and the health system's capabilities. It does this by drawing together the principal findings presented in Chapter 6 regarding the relationships of the key actors in the Shan Healthcare Training Programme (SHTP), and Chapter 7 that focused on Partners Relief and Development's (Partners) approaches. The chapter will also discuss these findings in relation to the overall aim of the research, in order to understand how the approaches of Partners support the development of medic capabilities and, consequently, the alternative health system in Shan State.

The chapter is divided into three sections using the components of the health capabilities framework: context, resources, and conversion factors, as shown in Figure 8.1 below. The chapter begins by exploring the impact of the wider conflict-affected context on the SHTP, and the Shan State Development Foundation (SSDF). In particular it examines the shift of international donor funding away from cross-border work in Myanmar and the effect that this has had on the development of an alternative health system. The second section addresses the two predominant resources that enable medic capabilities: Partners' SHTP and the support structures of the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), and analyses their limitations. Finally, the personal, environmental, and social conversion factors that act to enable medic capabilities are delineated, with a focus on the social factors that are within Partners' influence.

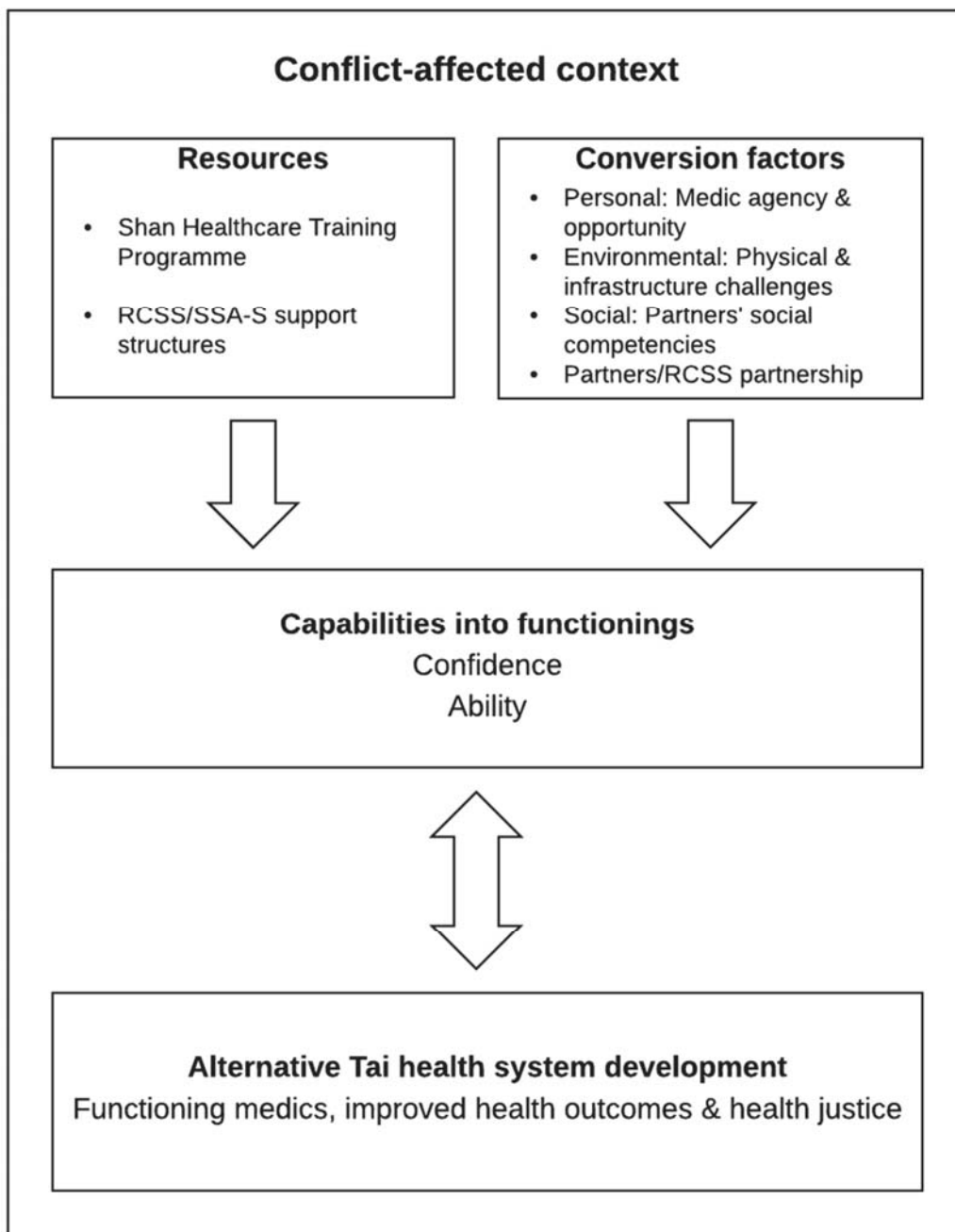


Figure 8.1: The capabilities framework for alternative health system development in Shan State, Myanmar (Source: Author).

## **8.1 The impact of the wider conflict-affected context on the alternative Tai health system**

Both the case study approach and the capabilities approach, which underpins the research through my health capabilities framework, necessitate understanding the impact of the “the whole social, institutional, and environmental contexts that affect the conversion factors and the capability set directly” (Crocker & Robeyns, 2010, p. 68; Robeyns, 2005b, p. 99). The alternative health system is embedded in the wider conflict-affected context of Shan State, Myanmar and this context acts upon the development and functioning of the health system. As detailed in Chapter 2, section 2.2.1, conflict is linked to poor health outcomes for communities in conflict-affected communities, such as poor life expectancy, maternal mortality and vaccination rates (PLoS Medicine Editors, 2011, p. 1; World Bank, 2011, p. 63), and increased susceptibility to communicable diseases (Waters et al., 2007, pp. 2–3). These poor health outcomes are evident in conflict-affected areas of Myanmar (Burke et al., 2017, pp. 31–32; N. L. Zaw & Pepper, 2016; P. P. T. Zaw et al., 2015), and the Southeast region where Shan State is located (Davis & Jolliffe, 2016) (see Chapter 5, section 5.2.2). This section addresses the influence that the conflict-affected context has had on flows of international donor funding, and the impacts that are borne by the Shan State Development Foundation and Shan Health Department.

### **8.1.1 The reduction in international donor funding: Impacts on the Shan State Development Foundation and Shan Health Department**

The approach of the international community to health system development in Myanmar is strongly oriented towards supporting the Myanmar Ministry of Health and Sports system (MoHS). This is a direct consequence of the ‘fragile states’ development agenda, discussed in Chapter 2, which prioritises state- and peace-building initiatives (see discussions by Barakat & Larson, 2014; Batley & Mcloughlin, 2010; Krasner & Risse, 2014; Newbrander et al., 2011). While this agenda is underpinned by a belief that state legitimacy can be increased by developing its service provision capacity, there is no direct evidence of a causal link between the two (Lemay-Hébert, n.d.; Mcloughlin, 2015; Slater & Mallett, 2017; Slater et al., 2012). Despite this, donor support that is extended to alternative health systems is tied to the political conditionality of ethnic systems’ convergence with the MoHS system. This has meant that, because of the difficulty in sourcing programme funding, ethnic groups are pressured to align with the state- and peace-building agenda of the international community, reinforcing the expectation

that they must “comply with donor programmes or standards, or their bureaucratic imperatives” (Mac Ginty & Richmond, 2013, p. 775).

Localised and hybrid approaches to development issues in peripheral areas of conflict-affected contexts, such as Shan State, are less understood. Podder (2014a, p. 216) notes that “international state-builders have routinely overlooked the positive contribution of non-state actors towards local legitimacy formation”. Likewise, Bøås (2017, p. 152) argues that, rather than the international community implementing top-down state-building strategies based on what conflict-affected states lack, we should study “how they actually work” and reorient towards working “in the peripheral provinces”. He also advocates for more funding for humanitarian programmes in conflict-affected contexts that have been underfunded for years (Bøås, 2017, p. 153), as has been noted by others (Ware & Ware, 2014, pp. 41–42), and evidenced by this research.

An example of the impact of the ‘fragile states’ agenda, and a major factor in the conflict-affected context which had significant ramifications for the SHTP, was a shift in international donor funding away from cross-border programmes and towards those operating inside Myanmar (described in detail in Chapter 5, section 5.2.1). This had acted to constrain the programmes of Partners, the SSDF and the Shan Health Department. The funding shift forms a critical part of the research context. The effects of this on the resourcing of Partners’ programmes is examined in section 8.2.1. This section considers the negative impacts on the SSDF’s activities.

The most consequential impact of the funding reduction was to SSDF’s cross-border programmes. They had been forced to reduce their paid staff to five people, who were responsible for managing their relationships with INGOs, and for monitoring and evaluating their health and education programmes. Sai Laeng expressed the SSDF’s concern about the focus of much of the healthcare funding going to Yangon:

One thing different now is that the support for programmes along the border, and the support for work inside Burma, don’t use the same model. Normally INGOs support clinic programmes along the border. This is an inclusive and holistic approach. But a lot of the international funding that goes to Yangon tends to focus on single health issues. This is not the same as supporting the primary healthcare that we are practising along the border. Ethnic health organisations along the

border are advocating for a focus on primary healthcare rather than just funding malaria, HIV and other single issues. (Sai Laeng, March 2016)

He underscored that a homogenous approach to healthcare would not work in all areas of Myanmar:

The funding that goes to Burma is mostly provided to the government sector. The capacity in this sector already exists. They have salaried staff, they have facilities. But there are a lot of places in ethnic areas where primary healthcare is not even addressed. So INGOs should use the same funding model for the whole country to support primary healthcare where there is none. (Sai Laeng, March 2016)

Since funding from many INGOs had ceased, the SSDF was struggling to replace it from other sources. Terre des Hommes INGO (<http://www.terredeshommes.org>) had previously provided clinic funding for “medicine, staff salaries, vaccination programmes and patient food costs” (Paw Shar Gay, May 2015), as well as conducting an annual evaluation of the clinic, but this had been withdrawn. Nang Lao Kham,<sup>89</sup> the Deputy Director of the SSDF and coordinator of their health and education programmes, reported that:

In the past INGOs helped our cross-border work through our office in Thailand. But now most donors don't want to support our cross-border work. As the situation inside Burma is changing they want to work directly inside Burma. Terre des Hommes funded the Loi Tai Leng clinic for 13 years but have finished as they want to fund work directly inside Shan State. We are trying to find new donors, but they also want us to expand from within Myanmar. The International Rescue Committee who have funded us for many years have pressured us this year to spend only 50% of their funding along the border and to work inside Shan State with the other 50%. (Nang Lao Kham, March 2016)

She also expressed that the SSDF required donor funding to support clinic operational costs and “technical support and the upgrade of [their] management skills” to bolster

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<sup>89</sup> Not her real name.

the development of their health system but this was not forthcoming from international INGOs (March 2016).

At the time this research was conducted, the SSDF were forced to source donor funding for fragmented elements of their development work rather than being able to implement their own integrated health and education strategies. Partners was limited to only funding the SHTP because of its own difficulties sourcing donor funding. Other INGOs were making their funding contingent on the SSDF working towards specific goals such as convergence with the MoHS (see Chapter 5, section 5.2.2). This was epitomised by a seminar hosted by USAID in March 2017 (shown in Photograph 8.1 below). As Sai Laeng put it:

Before we can set up a structure for our system, we need support from the Ministry of Health for our medics to be able to practise well. Those in political power, political actors, will have to coordinate with the Ministry of Health. We are aiming for the decentralisation of our health system. But this is a problem because organisations like the International Rescue Committee get funding from USAID to work with us, and they want us to prioritise converging with the Ministry of Health. (Sai Laeng, May 2015)



*Photograph 8.1: Convergence and Transition Seminar hosted by USAID (Source: Sai Laeng, 2017).*

The alternative Tai health system deviates from the ‘fragile states’ agenda, as its immediate goal is to improve health outcomes in conflict-affected communities. The Jao, Sai Laeng and other senior Tai authorities have expressed a desire to see the alternative health system decentralised from the MoHS system and under their control

(see Chapters 6 and 7). Boege, Brown, and Clements (2009, pp. 19–20) hold that recognising the legitimacy of hybrid approaches to service provision, such as the RCSS/SSA-S civilian-military health system, is essential to development efforts in conflict-affected contexts. Denney, Mallet, and Benson (2017, p. 20) critique development efforts in conflict-affected contexts that ignore the role of “alternative sources of authority and service provision...[instead of] searching for what local capacity does exist and may be worked with”, an approach that would allow for greater support of the SSDF.

### **8.1.2 The effects of the lack of funding to compile health information**

The World Health Organization (WHO) identifies health information as one of its six building blocks for health system strengthening, as discussed in Chapter 2 (de Savigny & Adam, 2009, p. 31; World Health Organization, 2010, pp. 44–58). Like the health workforce, health information systems are another aspect of health systems that are disrupted by conflict (see Pavignani et al., 2013, pp. 44–45; Percival, Richards, MacLean, & Theobald, 2014, p. 7; ter Veen & Commins, 2012, p. 159). Although the research is primarily concerned with the health workforce building block, health information provides the overall basis for good decision making in health system strengthening. As well as being “essential for monitoring and evaluation” health information is crucial for:

...health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery and financing. (World Health Organization, 2010, p. 44)

The discontinuation of international funding has meant that appropriate health information is not gathered to help ethnic CSOs in their decision making in order to strengthen the alternative health system. Previously, the five Shan Health Department clinics along the Myanmar-Thailand border (see Figure 5.2 on page 112) were audited annually by an experienced Tai health evaluator. This enabled the health department to evaluate the performance of their medics and make necessary improvements. However, the SSDF can no longer conduct clinic audits (see Chapter 7, section 7.2.), nor start auditing the new clinics that have opened inside Shan State. Sai Laeng candidly stated that:

No, we don't have funds anymore to keep doing that. This has been a really big change for the SSDF. There is not much funding left for us

anymore. We only receive some from USAID, Partners and one other organisation from Australia. It is not good. Other INGOs have shifted their funding to Yangon. (Sai Laeng, March 2016)

As well, a detailed health survey was conducted in the eastern part of Myanmar in 2016, funding by international donors. However, they chose to not seek data from the border clinics.

Today, I met with one of the donors for our Eastern Myanmar Health Survey. She doesn't want to include the five Tai clinics on the Thai-Burma border in the survey because international donors are not interested in supporting [internally displaced people] and refugees on the Thai-Burma border anymore. I think, at least, we can understand the health situation of people living in the Tai camps better by including Tai clinics on the border in our survey. However, she doesn't seem to be happy about it. (Anonymous Tai health researcher, personal communication, December 2016)

The lack of health information is an ongoing impediment to understanding the health status of communities in conflict-affected contexts and, accordingly, targeting the alternative health system where most needed.

In summary, research findings about the wider conflict-affected context clearly show that, as the international community shift their funding priorities away from cross-border programmes in favour of engaging predominantly with the Myanmar government, the 'fragile states' state- and peace-building agenda is further reinforced. This approach places top down conditionality on the alternative Tai health system to converge with the MoHS system, and ignores the legitimacy of the hybrid civilian-military health system. (Podder (2013) discusses the issue of legitimacy and outlines a typology in Figure 2.5 on page 38). It risks undermining the necessary and locally appropriate responses to development issues that are advanced by ethnic civil society organisations like the SSDF (Boege et al., 2009, p. 20; D. W. Brinkerhoff, 2014, p. 339; Lemay-Hébert, 2009, p. 41), that are struggling to obtain resources to:

...participate in activities that respond to their *basic needs, aspirations and capabilities* [emphasis added], as they may be efficient providers of security and basic services – especially in fragmented countries where

postcolonial state institutions lack legitimacy and authority over segments of the population...(Nay, 2013, p. 337)

Despite the initial hopes held in the NLD government, at the time of writing conflict had increased inside Shan State and other parts of Myanmar. The overarching ‘fragile states’ agenda intersects with this ongoing conflict to create a context that constricts opportunities for the development of the alternative health system. It places strictures upon the capabilities of both the SSDF and Partners to operate as they see necessary.

The research was focused on Partners’ approaches to developing medic capabilities within the alternative health system to improve health outcomes. Therefore, the research was delimited by not examining the converse issue of whether the RCSS/SSA-S’ association with Partners and the SHTP affects its perceived legitimacy, and related, whether this relationship impacts more broadly upon conflict trajectories and progress towards peace-building in Myanmar. This was also due to the difficulty of generating data from inside Shan State within the scope of this research.<sup>90</sup>

The following section explores the two main resources, the Shan Healthcare Training Programme and the support structures provided by the RCSS/SSA-S that contribute to enabling or hindering medic capabilities.

## **8.2 Resources that enable medic capabilities**

Resources are the first component of the health capabilities framework that contribute directly to the achievement of medic capabilities (see Figure 8.1). Resources are regarded as an instrumental means to an end (Hick, 2012, p. 306), meaning the availability of resources is an important but not a sufficient condition alone for medics to convert their capabilities into functionings. The research identified two critical resource inputs: the Shan Healthcare Training Programme (SHTP), funded and managed by Partners; and the support structures that are provided by the RCSS/SSA-S to the Shan Health Department and its medics. Funding for these support structures is provided through the RCSS/SSA-S’ own internal funding or the international funding sourced by the Shan State Development Foundation (SSDF). As noted above, the research found that the significant shift in international donor funding away from

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<sup>90</sup> The Secure Livelihoods Research Consortium addresses the crucial question of the relationship between service delivery and political settlements in the second phase of their research 2017-2019, asking “How can more inclusive and higher quality-service delivery be achieved in fragile states while supporting evolving political settlements?” (<https://securelivelihoods.org/what-we-do/>).

organisations working along the Myanmar-Thailand border since 2011 had direct negative impacts upon both resources. The negative impacts of the reductions in funding highlight the complexity of the context that the SHTP operates within, and which is largely outside of the control of Partners and the RCSS/SSA-S.

### **8.2.1 The Shan Healthcare Training Programme as an enabling resource**

The SHTP did function as an enabling resource for medic capabilities to function in many ways, as evidenced by the increase in confidence and abilities of the medics (see Chapter 7, section 7.1.3), with a promising start to improving health outcomes in communities. However, it has some fundamental limitations which impact upon its effectiveness as an enabling resource, which will now be detailed.

#### ***Lack of monitoring, evaluation and learning processes***

The lack of ongoing resources for the SHTP had wider programmatic impacts beyond a reduction in participant numbers. One finding that emerged from the research was that Partners, despite a commitment to effective teaching in their memorandum of understanding (MOU) with the SSDF, conducted little formal monitoring, evaluation and learning (MEL) regarding this (see Chapter 6, section 6.1.2). Partners did not have staff members with extensive experience in development programme planning and management, including in MEL. Although the programme managers exhibited some reflexivity in their efforts to enhance the curriculum, this was primarily based on their own views of what it should contain rather than in response to medic feedback about their training needs. Some writers hold the view that monitoring and evaluation is one of the processes which enable an organisation to engage in “reflection and planning” (Gready, 2013, p. 1342), and behave as a learning organisation (Lewis, 2014, p. 186). Similarly, O’Leary (2016, p. 19) makes the case for MEL practices to support “transformative outcomes” in programmes. This has happened to some degree in the SHTP, as Sai Seng Wan, Partners’ Tai cultural broker, provided basic evaluative information about how the medics were practising (as discussed in Chapter 7, section 7.2.2). The programme managers are aware of the need for greater evaluation, stating in a six-monthly report:

Any project needs to know if it is achieving its goals. In health, this kind of evaluation can be almost impossible because the gains in health are difficult to measure and to assign to any one activity. However, we plan to look at suitable methods of evaluation and incorporate them, so that

the project itself can continue to improve. By doing this, we are modelling the kinds of behaviour that we want the medics to develop. (McFarlane & McFarlane, 2016b, p. 14)

Yet, unless Partners specifically seeks staff or volunteers with MEL skills, it is unlikely the programme managers will have the extra resources to incorporate more extensive evaluation activities into the SHTP. The observation that Partners placed little importance on MEL concurs with other studies that show “...NGO culture tends to emphasize action over analysis [as] NGO staff...gain legitimacy by helping the poor [rather] than by conducting time-consuming and costly evaluations” (Ebrahim, 2003, p. 817). There is therefore a strong case for Partners to establish skills in this field as a matter of importance to the SHTP.

### ***Lack of downward accountability***

High levels of downward accountability<sup>91</sup> from INGOs to their programme partners fosters closer relationships with the local community (AbouAssi & Trent, 2016, p. 294). Possibilities for downward accountability are closely linked to INGO MEL processes (S. O’Leary, 2016). Neither the SSDF nor the health department, as programme partners, made accountability demands upon the programme managers in terms of Partners meeting the requirement to undertake effective teaching as agreed in the MOU. This is consistent with literature that addresses the reluctance of participants to demand accountability of INGOs (Boomsma & O’Dwyer, 2014, p. 160; O’Dwyer & Unerman, 2008, pp. 811–812). Partners’ lack of accountability contrasts with the transition made by some INGOs to prioritise downward accountability, as exemplified by INGOs working with Zapatista communities. These INGOs did this in response to “Zapatista communities and leaders [calling] for more say in their NGO partnerships” (A. Andrews, 2014, p. 102). Importantly, they regularly engaged with the participants of their programmes allowing them to clearly see the difficulties caused by top-down development management processes. They were also willing to risk their own legitimacy amongst their peers, as other INGOs could then criticise them for not doing this (2014, pp. 107–108). As well as “performance assessment and evaluation” acting as

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<sup>91</sup> Accountability is defined here as:

...the means by which individuals and organizations report to a recognized authority (or authorities) and are held responsible for their actions...NGOs have multiple accountabilities [including] “downwards” to their partners, beneficiaries, staff and supporters; and “upwards” to their trustees, donors and host governments. (M. Edwards & Hulme, 1996, p. 967)

a key mechanism for INGOs to foster “downward” accountability with their partners, it also functions as an internal learning tool (Ebrahim, 2003, pp. 816–818; O’Dwyer & Unerman, 2010, p. 467). Greater genuine downward accountability can support more equal power relationships between an INGO and its partners (Kilby, 2006, p. 953; Murtaza, 2012). To this end, the inclusion of MEL processes into the SHTP, that can be openly shared with the SSDF, would go some way to addressing the power asymmetry that exists between Partners, as the provider of resources and knowledge, and the SSDF and health department, as beneficiaries of those resources (Contu & Girei, 2014, pp. 217–218, 223; Fowler, 2016, pp. 572–573).

It is important to bear in mind that, in the constricted resource environment that both organisations operate within, Partners may struggle to give primacy to establishing new downward accountability mechanisms. INGOs working with the Zapatistas were able to access flexible funding which allowed them to more easily prioritise downward accountability (A. Andrews, 2014, p. 107), something Partners is unlikely to be able to do. However, Partners can still prioritise cost effective MEL methods, developed in collaboration with the medics, the health department, and the SSDF (as advocated for by George et al., 2015, p. 18). Cultivating more reflexive learning practices into the programme design creates space for the health department, as the local partner, to incorporate their needs and knowledge into evaluation processes (Lennie & Tacchi, 2014; Lennie, Tacchi, Wilmore, & Koirala, 2015). One approach may be to recognise the more anecdotal, subjective reports collected by Paw Shar Gay from the medics, as a fundamental component to include in the formal MEL processes of the programme. Dar (2014, p. 136). argues that incorporating these local forms of knowledge into more formal western INGO reporting and accounting practices produces a hybrid form of local and western accountability. I tried to model this practice by encouraging the medics to share positive and negative stories of their experiences at the start of the refresher training in March 2016 (described in Chapter 7, section 7.1.4). This practice of valuing Tai knowledge production may go some way towards equalising existing power dynamics between Partners and the health department (see George et al., 2015, p. 18).

### ***Limitations of the technical curriculum and language difficulties***

Another resource related factor that limits the development of medic capabilities is the issues with the SHTP curriculum itself, discussed in Chapter 7. Capacity building endeavours in conflict-affected contexts have been found to have misguided methodologies that are not appropriate for the context (Denney et al., 2017, p. 10).

Earlier studies have found that training provided by INGOs in these contexts is often of “of poor quality and having negligible impact” (Roome et al., 2014, p. 7). In this context, the medics, for the most part, found the SHTP to be an educational opportunity that boosted their confidence, and gave them much needed skills that they used upon return to their communities and they were reluctant to make negative comments. However, occasionally some reflected on their experience in less than positive terms. Their concerns corresponded to my observations of the highly technical and Western resource based nature of some of the curriculum materials (see Chapter 7, section 7.2.3). The original curriculum had been developed by the International Rescue Committee for use in the low resource Myanmar-Thailand border context and was continually adapted by Drs Bert, Alison and Ken, which meant they often duplicated material that could have been sourced elsewhere. (See for example Funes, Hausman, Rastegar, & Bhatia, 2012, pp. 25–27). Although the materials required updating and some sources were designed for low resource contexts, there was a tendency for the curriculum to be more technical which the medics found “too difficult” (Nang Hleng Khong, March 2016), particularly in light of the limited education levels of many of the medics.

The quality of training for CHWs and medics is globally recognised as a crucial element to improve their performance (Bright, Felix, Kuper, & Polack, 2017, p. 12; Funes et al., 2012, p. 15; Kok, Dieleman, et al., 2015, pp. 1217–1218; Naimoli, Frymus, Wuliji, Franco, & Newsome, 2014; Sudhinaraset, Ingram, Lofthouse, & Montagu, 2013, pp. 8–9), despite the difficulties of achieving this in conflict-affected contexts (Rowe, de Savigny, Lanata, & Victora, 2005, pp. 5–8). One method to make training contextually appropriate for low resource contexts is to focus more on practical workshops, and to avoid the use of technical teaching resources that others have already recognised as less effective (noted by Asgary & Junck, 2013, pp. 628–629; Funes et al., 2012, pp. 22–24; Rednick, Faich Dini, & Long, 2014, pp. 4, 13; Rowe et al., 2005, p. 1029; Willey, Smith Paintain, Mangham-Jefferies, Car, & Armstrong Schellenberg, 2013, pp. 91, 130). Rednick, Faich Dini and Long (2014, p. 13) emphasise that “effective CHW training must have interactive components that are repetitive in nature, using more interactive than didactic approaches”.<sup>92</sup> This reflects the preferences of the medics themselves, who indicated a

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<sup>92</sup> One practical example is the Ethiopia Public Health Training Initiative where the training was “done in a sustainable and capacity-building way, using locally available resources, and [was] tailored to the Ethiopian environment” (J. Murray, Wenger, Downs, & Terrazas, 2011a, p. 160).

strong preference for hands-on training modules, such as Dr Les' trauma and first aid module (see Chapter 7, section 7.2.5).

Partners shares the deficiency of many training programmes in failing to incorporate community input into the curricula, with De Vries and Pool (2017, p. 18) suggesting that there is little evidence that CHW training programmes do this. In Partners' case, an absence of formal programme MEL mechanisms means that, although Paw Shar Gay provides input, the medics have few opportunities to give their feedback to the programme managers. Introducing reflexive evaluation and feedback mechanisms would enable the programme managers to tailor the programme to training needs identified by the medics and their communities (Rednick et al., 2014, p. 13). The annual refresher training which started in 2016 now provides the programme managers an opportunity to do this with the medics that are practising, and thereby strengthen the SHTP.

The refresher training also means the SHTP also aligns more closely with best practice principles for CHWs that advocate in-service training of this nature (Funes et al., 2012, p. 15; Kok, Dieleman, et al., 2015, p. 1208; Walker et al., 2013, p. 17; World Health Organization, 2016b, p. 37), and supports previous research where "CHWs emphasised the importance of ongoing training, including refresher courses for familiar tasks" (Oliver, Geniets, Winters, Rega, & Mbae, 2015, p. 12).

One additional challenge raised by the programme managers and the medics is the use of English as the language of instruction for the SHTP, discussed in detail in Chapter 7, section 7.2.4. This is an issue that has been raised by numerous scholars (J. Murray, Wenger, Downs, & Terrazas, 2011b, p. 7; Rozier et al., 2017, p. 4), who have argued that medical practitioners engaged in global health training should "[l]earn appropriate language skills relevant to the host's locale as well as socio-cultural, political, and historical aspects of the host community" (Crump et al., 2010, p. 1180). Likewise, research and practice has established that the use of local languages is best global practice for CHW training programmes (Funes et al., 2012, p. 8; Lee, Mwaikambo, & Jayarajan, 2016, p. 3; Rednick et al., 2014, pp. 7, 14).

As noted in Chapter 7, a positive transition towards this was the programme managers commitment to taking Tai lessons from 2015, however most of Partners' expatriate medical volunteers still speak English as their first or second language, with none

speaking fluent Tai.<sup>93</sup> This raises both barriers and ethical considerations (Wilson et al., 2012, pp. 613–614). Stone and Olson (2016) point out:

Differences in culture and language can also complicate relationships between health care providers from different settings. Short-term volunteers may not understand how their decisions and recommendations conflict with the values and plans of local providers. (Stone & Olson, 2016, p. 240)

The problem is exacerbated by two factors: the lack of proficient translators and the unavailability of Tai medical professionals, both of which fall outside of Partners' control. Recognising this, the programme managers included the translation of training and assessment materials into Tai by Nang Kham Zarm<sup>94</sup> as a constructive change to the programme in 2016. The process had only started during my last fieldwork visit so the positive effects upon medic capabilities were yet to be realised. The translation of training materials, and a focus on practical hands-on teaching methods may mitigate the ongoing language difficulties.

### ***The positive transition of the Community Health Worker Programme to Tai management***

Despite these limitations, a positive finding was the transition of the management and teaching of the community health worker programme (CHWP) from Partners to the health department, under Khu Tun Aye's leadership. Two Tai women who had been through the SHTP are responsible for most of the teaching. Partners has responded to Tai desires, as expressed by the Jao (see Chapter 7, section 7.3.2), to have local ownership of the training, despite this often being difficult to establish in programmes that have previously had this externally provided (Lewis, 2014, p. 97). However, the CHWP requires ongoing financial support from Partners to further the development of its teaching and leadership capabilities. The question remains as to whether Partners will be able to provide sufficient resources to achieve this considering its own reduced

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<sup>93</sup> Linked to the interrelated issues of language skills and volunteerism (addressed later in this chapter), the programme managers made English lessons a compulsory part of the SHTP in 2017 to utilise the services of an American English teacher-volunteer. They did this in the hope that greater English skills will cultivate the confidence of medics to communicate with the leadership of their communities and foster greater trust. This curriculum development occurred outside the scope of the fieldwork but more research could usefully determine whether the medics' English language skills have the expected impact in rural Shan State communities where English is not widely spoken.

<sup>94</sup> Not her real name.

donor funding. Regardless, the transition of the CHWP management to the health department can be viewed as one incipient embodiment of downward accountability by Partners.

This section discussed the SHTP as one of the two critical resource inputs that contributes to the achievement of medic capabilities. It addressed the implications of a reduction in international donor funding upon this resource. The following section examines the second resource input in the health capabilities framework - the necessary support structures provided to the medics once they return inside Shan State by the RCSS/SSA.

### **8.2.2 RCSS/SSA-S support structures as an enabling resource**

#### ***The legitimacy of the RCSS/SSA-S as a development actor***

The RCSS/SSA-S fills an important role as a resource input for achieving medic capabilities. Once the medics have completed their training in Loi Tai Leng, they return to their communities in RCSS/SSA-S controlled areas of Shan State. The health department, through necessity brought about by its own lack of resources, utilises military structures to provide management, salaries, equipment and supplies to them. In return, the medics often report directly to local area commanders, especially where poor communications infrastructure limits direct contact with the Loi Tai Leng clinic. One third of all medics interviewed confirmed they were already members of the SSA-S and some of these accompany the SSA-S as backpack medics, rather than being based in clinics within communities. It is apparent that the emergent health system is heavily reliant on military structures to provide support to the medics that would usually be provided by civilian structures in non-conflict affected contexts. As the health system and its medics are effectively embedded in the military structures of the SSA-S I have designated it as a hybrid civilian-military system.

What was not surprising was that the local community and the medics consider the SSA-S to be their legitimate representative in the conflict-affected context, and this is reinforced by the SSA-S exhibiting, what South and Joll (2016, p. 188) term “state-like qualities”, in the provision of necessary health and education<sup>95</sup> services. There is a predominant view that non-state armed groups (NSAGs) are ‘spoilers’ that undermine

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<sup>95</sup> The SSA-S established Loi Tai Leng school (<https://www.facebook.com/loitailengschool.ssa/>), where children come from inside Shan State to board for their education. It was set up in response to the lack of education opportunities in rural communities, and as a place of safety for children when conflict was more prevalent.

peace processes (Hofmann & Schneckener, 2011a, p. 604; Podder, 2013, p. 32, 2014b, p. 1621), which overlooks their critical role as development actors in service delivery within areas they control. However, Podder (2013, pp. 31–32) proposes that NSAG commitments to the provision of services within their territories should be seen as a good gauge of the potential for partnering with these groups on state-building initiatives, rather than only being seen as a way they bolster their own legitimacy (Hofmann & Schneckener, 2011b, p. 3; Podder, 2014a, p. 222, 2014b, pp. 1622–1623).

Bottom-up forms of service provision by the RCSS/SSA-S, through the health department, may be the most appropriate form in conflict-affected contexts where the NSAG enjoys legitimacy and has structural reach into remote areas where the state cannot or will not provide services. This finding broadly reflects the precedent set by the Zapatista movement, an indigenous uprising for self-determination in Chiapas, Mexico. Both Chiapas and Shan State are marginalised communities with limited access to healthcare which has led to poor health outcomes. Following their uprising in 1994, the Zapatistas began to develop their own autonomous health system using an approach similar to CHWs to provide basic health services (Forbis, 2016, p. 371). They extended this to larger clinics that provide more advanced health services such as minor surgery. Gregorčič (2017, p. 66) concludes that the Zapatista development of autonomous health and education systems is a way to “recreate and reconstruct politics of self-determination and autonomy”, a goal shared by the RCSS/SSA-S. Similarly, Gallegos and Quinn (2017, p. 3) argue that the improvement in health outcomes is due to the Zapatista women who function as health promoters, or CHWs, resisting the health injustice they have experienced through their practices. They posit that this approach serves as a model for marginalised communities experiencing similar poor health outcomes. While providing an exemplar, the Zapatista health system also shares similar problems to the Tai health system in that it is “hampered by limited funds, insufficient medical supplies, lack of infrastructure, and few professionally trained medical personnel” (Gallegos & Quinn, 2017, p. 3).

### ***Limitations of the hybrid civilian-military system***

I observed the RCSS/SSA-S’ involvement in SHTP activities while I was in Loi Tai Leng, but it was difficult to obtain a full picture of the relationship that the medics experience with the SSA-S because I was unable to travel to clinics inside Shan State to observe this. While the medics accept the legitimacy of the SSA-S’ involvement in managing their practice through the health department and local army leadership, the medics at

the refresher in March 2016 described some limitations of this situation. These included problems obtaining supplies, medicines and equipment through military supply lines. This was often because local area commanders did not have the financial resources to purchase these locally. This extended to not being able to supply food and bedding for their own soldiers requiring medical treatment. There is an expectation that the medics will provide these themselves.<sup>96</sup> For some medics, a key difficulty was the lack of salary from either the health department or the local area commander who was supposed to support them. There were also inconsistencies between the salaries of medics who were civilians and those who received more as they were SSA-S medics. Again, following the Zapatista health system model (Blas et al., 2008, p. 1687; Gallegos & Quinn, 2017), there may be opportunities for the health department and RCSS/SSA-S to develop more local and community-based resources as an appropriate method to support the emergence of an alternative and localised health system, and to mitigate the need for the SSDF to source international funding.

An additional drawback was that commanders often had little understanding of appropriate healthcare and still chose traditional medicine for themselves, meaning they lacked a willingness to support the medics (Nang Mo Kham, March 2016). Of greater impact were the restrictions placed on the medics' decision making by commanders, as explained by Sai Yawd Khur: "I want medics to be able to make our own decisions. Sometimes if villagers call for help, we don't have permission from the local commander, so we can't go to help the patient" (March 2016). Counter to this were commanders who saw the benefits of the medics, and requested one to be assigned to their area. They signalled their ongoing support by providing the funding for them to travel to Loi Tai Leng for the SHTP.

There are also contradictions in the medics' association with the SSA-S in that it both confers protection upon them, but also increases their safety risk if their affiliation is discovered by the *Tatmadaw* in conflict-affected areas. The SSA-S provides crucial intelligence as to what communities are safe for the medics to be deployed to, informing the decisions made by Paw Shar Gay and Khu Tun Aye. On some occasions, medics went into hiding or withdrew from communities on the advice of the local SSA-S. In contrast, when I asked Nang Mo Kham how the medics keep themselves safe, she

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<sup>96</sup> The problem extends to medics being required to accommodate the anti-narcotic activities of the SSA-S. Drug producers and addicts are arrested by the SSA-S and forced to undergo detoxification with the support of medics who do not have adequate training or appropriate medical supplies.

replied “Sometimes it is safer to not be with the SSA-S” (November 2015). It is likely that the medics will have to accommodate the inconsistencies of their SSA-S association alongside the protective element while the peace process is ongoing in Myanmar.

The uneven experiences of the medics of their management by the SSA-S is reflective of the lack of health system management and administration capability within the emergent health system. This lack of capacity is recognised as a common obstacle to health system development in conflict-affected, post-conflict and low income country contexts (Najafizada, Labonté, & Bourgeault, 2014, p. 15; Roome et al., 2014, p. 10; Zulu et al., 2014, p. 8).<sup>97</sup> Problems with salary and supplies are also consistent with those experienced by CHWs globally (Durham, Pavignani, Beesley, & Hill, 2015, pp. 7–8; Kane et al., 2016, p. 31; Kok, Dieleman, et al., 2015, pp. 1219–1220; Kok, Kane, et al., 2015, p. 9; Naimoli et al., 2014, p. 6,9; Oliver et al., 2015, p. 3; Perry et al., 2014, p. 402; Walker et al., 2013, p. 4). The difficulties of adequate health system management and resourcing are symptomatic of those faced by NSAGs in “transitioning from armed resistance to governance and service delivery” (South & Joll, 2016, p. 186). Partners has no direct influence over these issues as they fall outside the mandate of their MOU with the SSDF to provide training. However, a greater appreciation of the obstacles faced by the medics could be incorporated into the SHTP, especially as Partners is likely unable to extend its health administration training due to a lack of resources.

This section has discussed the two key resources of the alternative health system: the SHTP and the RCSS/SSA-S support structures. Although incipient possibilities opened for the health department to work more openly inside Shan State, the shift in international donor aid away from cross-border activities in Myanmar has had negative consequences on both resources. Partners’ opportunities to incorporate MEL into programme activities is inhibited by the precarity of donor funding. However, I argue that Partners could still integrate local forms of knowledge production into its programme management processes. Despite the limitations placed on Partners, the transition of CHWP management to Tai leadership is a positive development for the programme. It is also important to note that, even as Partners has experienced

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<sup>97</sup> Roome, Raven and Martineau (2014, p. 10) point out that further research is required “on human resource management in post-conflict health systems”, including a focus on “gender equity, task shifting to optimise service delivery, and leadership and governance” to improve health outcomes. These issues directly concern the Shan Health Department and RCSS/SSA-S and so were outside the scope of this research with its focus on Partners’ approaches.

difficulties obtaining secure funding for the duration of their MOU with the SSDF, they have remained committed to the partnership. Likewise, the RCSS/SSA-S' provision of appropriate health system management support, salaries, and supplies is affected by their lack of resources. This, combined with the safety contradictions experienced by the medics, has led to their experience of practising within a hybrid civilian-military health system being a difficult one. A transition to a fully civilian health system is unlikely in Shan State while conflict is ongoing.

The following section examines the influence of personal, social and environmental conversion factors upon the achievement of medic capabilities.

### **8.3 Conversion factors that enable medic capabilities**

A primary focus of the health capabilities framework is to evaluate the action of conversion factors upon medic capabilities. These factors may determine whether a medic is able to achieve their capabilities, so understanding their influence is critical. Findings from the research are explored through the three categories of conversion factors: personal factors internal to a person including aspects such as their agency; social factors including relationships; and environmental factors concerning the physical environment (Crocker & Robeyns, 2010, p. 68).

#### **8.3.1 Personal factors: Medic opportunity and agency**

The health capabilities framework can be used to identify the influence of personal conversion factors such as agency on medic capabilities. The SHTP provides an important opportunity for the medics to engage in a training programme that uses their abilities, in a context where these opportunities are scarce. The SHTP offered those who had received little education the effective opportunity to expand their own capabilities, and opened the “possibility of transforming limitations into resources” for themselves and their communities (Biggeri & Ferrannini, 2014, p. 69). This has included giving those with limited personal factors, such as low levels of education and literacy at the start of their CHW training, the chance to make a very real contribution to the expansion of wellbeing in their communities.

The research was concerned with the level of agency exhibited by the medics, and in particular their ability to choose whether or not to participate in the SHTP. A person's agency can be defined as “the freedom to so decide and the power to act and be effective” (Crocker & Robeyns, 2010, p. 75). All of the medics reported that they participated of their own free will, rather than experiencing pressure from village

headmen, families or the SSA-S, which was an unexpected finding. Instead, village headmen and communities provided ongoing supportive social arrangements to aid their participation, including financial support. This accords with Deneulin (2008, p. 107) who maintains that personal agency is enabled by the “crucial role of social arrangements”. However, the medics were less able to choose where they would practise once they had finished training. For the most part, they returned to their own communities, but the decision was made by Paw Shar Gay as head of the health department. Sometimes she responded to requests from other villages for medics, as one medic reported, “if another village wants a medic, and our own village cannot build a clinic yet, then she will send us to that area” (Nang Mo Kham, May 2015). This shows that the medics’ ability to exercise personal agency is constrained under some circumstances.

The findings related to opportunity and agency confirm other research using the capabilities approach, which found that programmes need to provide opportunities in combination with participants’ agency, their “internal reflective decision-making ability”, to ensure the sustainability of programme activities (Muñiz Castillo, 2014, p. 80). In the case of the SHTP, the provision of the training opportunity, in concert with supportive social arrangements which allow medics autonomy to participate means that even medics with previously limited experiences have transformed the resource of the SHTP into functionings that they and their communities value.

### **8.3.2 Environmental factors: Physical and infrastructure limitations**

Although I was not able to travel to the communities where the medics practice, medics reported on their experiences of their physical environment during the refresher training in March 2016. They provided feedback on the difficulties caused by the limited physical infrastructure in rural areas, caused by conflict and government neglect (as outlined by Bornemisza et al., 2010, p. 84; d’Harcourt et al., 2017, p. 157; Davis & Jolliffe, 2016, pp. 7–10; Krasner & Risse, 2014, pp. 546, 554). Physical access to and from rural communities remains problematic as some roads have not been upgraded since the British left Myanmar in the 1940s. It is especially hard during the rainy season when the roads turn to mud. One medic reported that the “journey from our village to the nearest clinic is one and a half hours. It takes three hours in the rainy season. Transportation is hard. It is difficult” (Medic report back, 7 March 2016). Another stated that “It is 40 km to the nearest clinic. If it is the rainy season we can’t use a motorbike for transport. We have to use an oxen and cart which is very slow. What we need is a midwife” (Medic

report back, 7 March 2016). Another reiterated the difficulty of having a large territory to cover saying “It takes us two months to cover all five village tracts that we are responsible for because we have to walk” (Medic report back, 7 March 2016). The difficulties also extend to power and water supplies as sometimes:

...the water stops for up to seven or eight days. We need a tank for water. We use solar panels for electricity but it is not enough in the rainy season. It is difficult to cook for the patients or ourselves. When patients come at night we don't have enough light. (Medic report back, 7 March 2016).

Infrastructure problems also apply to mobile phone network coverage. Although this is rapidly expanding throughout Myanmar, like other services, this does not always extend to remote rural areas. This creates problems for the medics who need to be able to report back to the Loi Tai Leng clinic. For example, one medic explained that “to be able to send the information here we have to go to [another town] as where we live does not have a phone signal” (Medic report back, 7 March 2016). Likewise, another medic said that “We report monthly to the SSA-S army officer. If we wanted to contact the Loi Tai Leng clinic we would have to use a satellite phone which we don't have” (Medic report back, 7 March 2016). The lack of regular contact with the Loi Tai Leng clinic was a common problem, with another reporting that “I don't stay in contact with the clinic as there is no phone connection. I just report to the local SSA-S” (Medic report back, 7 March 2016). Many reported having to travel to a nearby town to use the mobile network or access the internet which may impact upon their personal safety if these towns are not located in RCSS/SSA-S controlled areas. As explained in section 7.2.2, the programme managers hoped to develop mobile training mechanisms for continuing medic education to overcome the remoteness of the medics, but this will have limited impact in the foreseeable future while the infrastructure remains poor.

These environmental factors must be considered when examining the contribution of medic capabilities to the alternative health system. There is a risk of inflating what the medics are able to achieve without accounting for the restrictions that environmental factors clearly place on medic functionings (see George, Scott, Sarriot, et al., 2016, p. 43). Partners has little influence over these wider environmental factors. Communities, the RCSS/SSA-S, and Partners, all have few resources with which to mitigate the infrastructure difficulties that communities and medics experience (George, Scott, Mehra, et al., 2016, p. 50). However, Partners can incorporate an understanding of the

impact of these factors into their programme design so as not to place too high expectations on the medics once they return to their communities. More research on the challenges that these environmental factors pose to medics would be useful. This would also help to develop a better picture of their impact upon the alternative health system. It would be especially useful to gain access to the communities where the medics practice, and incorporate community and medic understandings of the problems into the research (as suggested by George et al., 2015, p. 18; George, Scott, Sarriot, et al., 2016, p. 45).

### **8.3.3 Social factors: Enabling relationships and hindering approaches**

#### ***The partnership between Partners Relief and Development and the RCSS/SSA-S***

The research explored the approaches that Partners takes in its partnership with the RCSS/SSA-S to develop medic capabilities, so the social conversion factors that impact upon and reflect those approaches are examined here. The social conversion factors differ from the personal medic factors and the wider environmental factors, as they are the ones that Partners has some influence over. This section examines the positive and problematic aspects of the relationship between Partners and the RCSS/SSA-S, SSDF and health department.

It is important to note that the Jao, as head of the RCSS/SSA-S, holds Partners and the SHTP in high regard. Partners has accumulated high levels of good will, trust, and positive social capital<sup>98</sup> in its relationship with the leadership of the RCSS/SSA-S because the SHTP supports the Jao's vision for an alternative Tai health system, and in part due to the longevity of their commitment to the SHTP. A positive view of the partnership is also held by Sai Laeng, from the SSDF; and Paw Shar Gay and Khu Tun Aye of the health department. There is some possibility that negative aspects of the partnership were not revealed to me as an outsider (see Chapter 4, section 4.2.3 for considerations of being an outsider-researcher), but I held a number of conversations with these Tai authorities and observed the RCSS/SSA-S leadership enacting their support through their attendance at SHTP activities during my four visits. Ibrahim (2006, pp. 409–411) maintains that external development actors have a role, through partnerships like this, to foster a form of social capital which enables collective

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<sup>98</sup> Greco, Skordis-Worrall, Mkandawire and Mill distinguish between 'bonding' social capital "(being networks among homogenous groups)" and 'bridging social capital' "(social networks among heterogeneous groups)" (2015, pp. 74–75).

capabilities. So, the Partners-RCSS/SSA-S partnership does act as a positive social conversion factor for collective medic capabilities.

One interesting observation was that the programme managers held an apolitical stance towards their partnership with the RCSS/SSA-S. The relationship was mediated by Partners' MOU with the SSDF, meaning it was a partnership by proxy (see Chapter 6, section 6.3.1). The programme managers dealt with the SSDF and health department rather than directly with army leadership. They downplayed the RCSS/SSA-S being an NSAG by describing them as the “government of Shan State”<sup>99</sup> (Dr Ken, May 2015), and “a bunch of guys in uniforms [carrying] a few guns” (Dr Alison, May 2015). By doing this, the programme managers fail to recognise the integral role of the RCSS/SSA-S as one of the actors in the development of the alternative health system. There are widely held concerns that NSAGs are not legitimate development actors, as discussed in section 8.2.2, so they may be attempting to disassociate from the RCSS/SSA-S in reaction to these concerns. However, although Partners' focus is on improving health outcomes through enhanced medic capabilities is appropriate, they should acknowledge that “reforming human resource management and development practices is an inherently political process—a fact that donors ignore at their peril” (Witter et al., 2015, p. 9). Rather than depoliticising the partnership, acceptance of the hybridity of the civilian-military health system that Partners is supporting through the SHTP may enable them to incorporate training modules to assist the medics in overcoming some of its limitations, that are described in section 8.2.2.

### ***The disadvantages of Partners Relief and Development's volunteerism model***

The concept of organisational capabilities, or social competencies: “what social institutions can do or be” (Stewart, 2013, p. 1), is useful when examining the limitations of Partners' approaches in determining the capabilities of the medics. In this regard, Partners' use of expatriate volunteers raised interconnected practical and ethical issues that indicated the need to foster improved social competencies. Like many INGOs (see discussion in Chapter 2, section 2.3.1), Partners operates based on a volunteerism model using expatriate staff in its programmes, often drawn from Western churches where there is an existing relationship with Partners. The SHTP utilises expatriate medical volunteers from many disciplines including general practice, midwifery and paramedicine. The SHTP is dependent on the skills of these medical professionals to

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<sup>99</sup> The RCSS/SSA-S was an illegal organisation in Myanmar until October 2015 when it signed the Nationwide Ceasefire Agreement.

fill capacity gaps that exist in the Tai health system; and as Sai Laeng pointed out (see Chapter 7, section 7.3.2), Tai doctors and nurses are reluctant to travel to Loi Tai Leng to contribute to the SHTP. The disadvantages of this reliance on expatriate, volunteer medical professionals were discussed in Chapter 7, section 7.2, and includes concerns with the recruitment process, knowledge and experience, and language.

The finding of this research, that Partners' volunteers are selected primarily based on their availability to volunteer, rather than their ability and possession of skills appropriate for the context, is consistent with other research into medical volunteerism that identified the ethical issue of medical practitioners being inadequately prepared for the volunteering context, and practising inappropriately or outside their expertise (Asgary & Junck, 2013, pp. 625–626; Loiseau et al., 2016, p. 11; McLennan, 2014, p. 168; Rozier et al., 2017, p. 2; Stone & Olson, 2016, pp. 239–241; Wilson et al., 2012, pp. 613–614). Medical volunteering practices such as Partners' thus risk negating the primary responsibility of medical practise of 'first do no harm' (Logar, Le, Harrison, & Glass, 2015; Stone & Olson, 2016, p. 243; Wilson et al., 2012, p. 616).

The lack of a formal recruitment process that assesses the volunteers for the required skills and appropriate experience, is also in line with observations from other research (Rozier et al., 2017, p. 4). This leads to the recruitment of volunteers who often lack the required skills (Saksida, Alfes, & Shantz, 2017, p. 2067). The programme managers have to identify an appropriate module for the volunteer to teach, regardless of whether their skillset is appropriate. Prior research posits that "compatibility of knowledge, skills and abilities" must be included as a condition of volunteer recruitment (Fee, Heizmann, & Gray, 2017, p. 1256), and Saksida et al. (2017, p. 2078) maintain that "training specific to the volunteer role should be conducted". Some authors argue that international volunteering reinforces paternalism, power imbalances within partnerships and acts as a form of neo-colonialism (Devereux, 2008; Fee et al., 2017, p. 2039; Lasker, 2016, p. 577; Lopez Franco & Shahrokh, 2015, p. 22; McLennan, 2014, p. 176; Rozier et al., 2017, p. 2; Wilson et al., 2012, p. 614). They also suggests that there is a role for the involvement of community partners in the volunteer selection process (Fee et al., 2017, p. 1256; Stone & Olson, 2016, p. 241), something that the SHTP and other volunteer programmes don't often do (Rozier et al., 2017, p. 4). Ensuring that Paw Shar Gay and the health department contribute their requirements into the volunteer selection processes may overcome this and allow for a more equitable partnership between Partners and the health department to emerge (Schech, Mundkur, Skelton, & Kothari, 2015, p. 363).

As resources remain constrained, Partners will continue to rely on volunteers to maintain its programme activities for the foreseeable future. For volunteer involvement to act as both an appropriate resource factor and a positive social conversion factor, Partners could develop their social competencies to ensure that these contribute to the SHTP, and that volunteer involvement doesn't reinforce inequitable power relations in the community. First, Partners could adopt a more responsible and rigorous volunteer selection process to ensure there is a skills match for the needs of the SHTP. They could require volunteers to have cross-cultural awareness or undergo training. Second, and crucially, they could provide opportunity for Paw Shar Gay and Khu Tun Aye to be involved in the selection process to identify necessary skills and appropriate volunteers. Despite its limitations, the use of expatriate medical volunteers is still a necessary element of the SHTP while the Tai health system has capability gaps and a shortage of willing Tai medical professionals. Paw Shar Gay and the medics expressed appreciation for the expatriate volunteers, especially those who return regularly with appropriate skills, refine their training modules for the context, and exhibit cultural awareness, all desired elements in medical volunteering.

#### ***Enabling community support for the medics***

Another crucial social conversion factors that the research found was the level of community support for the medics. Communities signify this by contributing towards the financial cost of the medics attending the SHTP training, and by providing food, firewood, and transportation once the medics returned to their communities. Central to that support has been Paw Shar Gay's efforts to foster this when she meets with communities to decide where is most appropriate to locate the medics and new clinics. Her role involves travelling through RCSS/SSA-S controlled areas of Shan State and meeting with communities to explain about the Tai health system, and the role of the CHWs and medics within it. This has cultivated the emergence of important forms of "bonding" social capital (Greco et al., 2015, pp. 74-75). It confirms the association found in other research that when CHWs and medics are embedded within supportive communities and health system structures their motivation and practice benefits (Baatiema, Skovdal, Rifkin, & Campbell, 2013, pp. 10-11; de Vries & Pool, 2017, p. 20; George et al., 2015, p. 15; Kok, Dieleman, et al., 2015, p. 1221; Zulu et al., 2014, p. 12). This finding also goes some way to addressing a research gap identified by de Vries and Pool (2017) about the need for information on:

...the extent to which the [CHW] program forged ongoing relationships and connections to community processes and dynamics to sustain motivation or create opportunities for input on program implementation by the community. (de Vries & Pool, 2017, p. 19)

One of the major challenges reported by the medics was a lack of trust from communities when they returned. This is expressed through reluctance to utilise their services and distrust of the medics' treatment options.<sup>100</sup> The medics conceded that the process of establishing trust can be slow, especially in communities where traditional beliefs about evil spirits causing disease are maintained, and in those where healthcare workers with insufficient or no training used incorrect medical practises. Other research notes that "distrust between traditional healers and medically trained professionals" exists (de Vries & Pool, 2017, p. 22), as reported in some medics' communities. This is exacerbated by the SHTP medics providing their services for free or a small fee, whereas some healthcare workers charge exorbitant fees. However, the Jao believes that trust will be established and "communities will be able to accept the medics as they show their ability" (November 2015). Paw Shar also explained that "...sometimes it is very difficult to treat people inside. We need a stronger relationship with the people to build their trust and then they will think we are right" (May 2015). Paw Shar Gay's continued efforts to promote community trust lay a good foundation for the medics to build upon, but this will take time and the evidence of gradual improvements in community health outcomes.

Further research could investigate in depth the role of community support as a social conversion factor for medic capabilities and, by extension, the sustainability of the Tai health system. What is clear is that, although existing support for medics allows their capabilities to flourish, the programme managers could do more to collaborate with Paw Shar Gay and the health department on strategies to incorporate community input into the design of the SHTP (de Vries & Pool, 2017, pp. 16–17). The importance of taking a participatory approach to include community input has been highlighted in other research (Ekirapa-Kiracho et al., 2016, p. 94; George, Scott, Mehra, et al., 2016, pp. 51–52; M. A. Mercer, Thompson, & de Araujo, 2014, p. 329; Naimoli et al., 2014; Peters, El-Saharty, Siadat, Janovsky, & Vujicic, 2009, pp. 255–256–263). Training modules on

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<sup>100</sup> There is a widespread practise of healthcare workers charging for intramuscular injections of vitamins, glucose, and other substances even if these are not medically indicated. The SHTP medics resist this incorrect practise and have become known as the 'Paracetamol clinics' instead (see Chapter 7, section 7.1.4).

mechanisms that “develop community engagement to achieve programmatic gains” would be useful to amalgamate into the SHTP (de Vries & Pool, 2017, p. 19).

This section has examined the conversion factors that form an integral component of the health capabilities framework, to allow for an analysis of what factors influence the functioning of medic capabilities, and more broadly, the alternative health system. Each of the three conversion factors: personal, environmental and social conversion factors have been addressed.

## **Conclusion**

Using the health capabilities framework, this chapter has analysed factors that contribute to, and hinder, the development of capabilities of the medics, and the alternative health system. The first section of the chapter established that the wider conflict-affected context of Myanmar has influenced governments and INGOs of the Global North to conform their development agenda to work with the newly democratic Myanmar government to increase its legitimacy, in preference to supporting the work of ethnic civil society organisations. As the SHTP and Tai organisations are situated within this context of fluctuating funding preferences, it has constrained their ability to conduct meaningful development activities that align with local priorities, due to a lack of international donor resources. As noted earlier in the chapter, the research focus on specifically understanding Partners’ approaches to health workforce training in the SHTP meant that the correlated question of the impact of the programme’s activities upon conflict and peace dynamics was outside the scope of this research.

Findings have shown that the two key resources that are involved in enabling medic capabilities are Partners’ SHTP and the support structures that the RCSS/SSA-S can provide to the medics once they return to their communities. The research identified a number of limitations in Partners’ approaches to the SHTP. These included the dwindling of its own donor support for its programmes in Myanmar, and the lack of a monitoring, evaluation and learning culture, linked to an absence of downward accountability mechanisms. The combination of resource and approach obstacles contributed to limitations in the technical approach of its SHTP curriculum. Despite this, there is evidence of the positive transition of the leadership of the initial community health worker training programme to Tai leadership under the Shan Health Department, an improvement that supported the Jao’s desire to see Tai in teaching roles.

The research also raised important questions about the embeddedness of the alternative health system within the second key resource of the military structures of the RCSS-SSA-S. The hybrid civilian-military health system is limited by its own lack of resources and health system management experience which accordingly restricts the capabilities of the medics. The benefit to the health system is its ability to take advantage of the military's infrastructural reach into remote areas under its control. Importantly, the legitimacy of the RCSS/SSA-S in the eyes of local Tai populations means that medics will need to be deployed within the hybrid civil-military system for the foreseeable future.

Personal, environmental and social conversion factors, and their actions upon medic capabilities, are a critical component of the health capabilities framework. The research indicated that the medics exhibited personal agency in choosing to participate in the SHTP, and in return, the SHTP provided the medics with an important training opportunity in a context where these are limited. It is incumbent upon Partners and the health department to mitigate the restrictions placed upon medic capabilities by the difficult geographical and infrastructural environment that they practise in. Expectations of what the medics can achieve should be reasonable in light of this.

An important finding was that social conversion factors had both enabling and disabling effects upon medic capabilities. The partnership between Partners and the RCSS-SSA-S was regarded very favourably by all parties, despite the programme managers disassociating themselves from the political nature of their relationship with a non-state armed group. The positive social capital engendered by Partners' long-term involvement in Loi Tai Leng bodes well for the continuation of the SHTP. However, the research highlighted the need for Partners to improve its social competencies as part of its volunteerism model by selecting appropriately skilled and experienced expatriate medical volunteers. Finally, the research confirmed findings of other research into health system development that community support is a critical social conversion factor for the functioning of medic capabilities.

The next chapter brings the discussion together to demonstrate how the three research objectives have been met and to draw conclusions about how the approaches of Partners support the development of an alternative Tai health system.



## Chapter 9: Health justice for all

### Introduction

This final chapter presents the conclusions of the research which aimed to understand how the approaches taken by an international non-governmental organisation (INGO) support the development of alternative health system capabilities in the conflict-affected context of Shan State, Myanmar. The research used the case study of a health workforce training programme run by Partners Relief and Development (Partners) INGO, in partnership with the Restoration Council of Shan State/Shan State Army-South (RCSS/SSA-S), on the Myanmar-Thailand border. The Shan Healthcare Training Programme (SHTP) is designed to enable the capabilities of medics from inside Shan State to provide healthcare to their communities that will improve poor health outcomes, and to support the development of an alternative health system. The first section presents the key conclusions by bringing together the discussion of the research findings from Chapter 8 demonstrating how the three research objectives have been met. Five ways in which this research contributes to knowledge are summarised in the second section. Implications for the policy and practice of INGOs working in health system development in conflict-affected contexts are addressed in the third section, which also describes the limitations of the research, and identifies areas for further research. Finally, more general comments are offered about the importance of alternative health systems in conflict-affected contexts to contribute to health justice and the achievement of Sustainable Development Goal 3 (SDG 3), to “ensure healthy lives and promote well-being for all at all ages” (United Nations General Assembly, 2015, p. 16).

### 9.1 The enabling of alternative health system capabilities

#### 9.1.1 The importance of positive relationships in the Shan Healthcare Training Programme

The first research objective set out to explore the relationships of the different actors in the delivery of the SHTP. The findings in Chapter 6 clearly indicate that the relationships between Partners and the RCSS/SSA-S, the Shan State Development Foundation, and the Shan Health Department are all predominantly positive, however there are limitations and tensions (see Chapter 6, section 6.1.2). Contu and Girei (2014, p. 228) note “the ethical value of partnership and its importance in promoting the goodness of development initiatives and policies”, so it is worth Partners building on the relationships they have and addressing the tensions and power relationships in

order to foster more equitable partnerships. The research did not explore the ways in which Partners collaborates with other INGOs or Tai civil society organisations to strengthen its activities. Regardless, Partners could also cultivate more extensive cooperation with other Tai civil society organisations inside Shan State, as a way of building the capabilities of Myanmar civil society more widely, but also to ensure their programmatic approaches are appropriate to the conflict-affected context.

The legitimacy of the RCSS/SSA-S and its support structures in the eyes of communities inside Shan State is crucial to them acting as one of the two key resources that enable medic capabilities to provide the necessary “bottom up...indigenous, locally developed responses” (Podder, 2014b, pp. 1629–1630) to poor health outcomes in areas they control. However, the research found limitations of the hybrid civilian-military system associated with a lack of physical resources and management knowledge and capacity. The ability of the SHTP to overcome these limitations is restricted by the limited resources the Shan Health Department has to manage the medics and establish a more independent civilian health system. It is also essential for the Partners’ programme managers to recognise Paw Shar Gay’s integral role in the management of the Tai health system. The ways in which Paw Shar Gay fosters relationships between the Tai health system and communities is critical to ensure increased community trust and support structures are available to the medics. This goes some way to establishing trust in the medics which aids their efforts improve health outcomes. Further research could usefully explore how Paw Shar Gay builds this support for the medics among communities inside Shan State.

The relationship between the emergent alternative Tai health system and the Myanmar Ministry of Health and Sports (MoHS) system is more problematic. It is entangled in the context of the ongoing and delicate peace process between the RCSS/SSA-S and the Myanmar Government. The SSDF currently has little capacity to negotiate greater collaboration and convergence with the MoHS. Partners supports the notion of the convergence of the Tai health system with the MoHS system. However, the strong desire of the RCSS/SSA-S, supported by the negotiations of the SSDF, is for an independent health system that is grounded in federalism (see Chapter 5, section 5.2.2). Perhaps the most appropriate approach for Partners to support this goal is to continue to enable sustainable healthcare capabilities through the SHTP, while tentatively exploring collaboration opportunities with the MoHS that may arise. This approach still allows for the possible convergence with the MoHS system if it is eventually

negotiated. Partners could also find avenues to support the Shan Health Department's efforts within the Health Convergence Core Group to establish an independent ethnic health system (see Chapter 5, section 5.2.2), as the group has a more context-specific and realistic understanding of the possibilities of convergence. There are positive signs of incipient collaboration at the grassroots level between medics and local MoHS officials and healthcare workers on vaccination programmes and patient referrals. This would be better enabled by a more positive working relationship at senior levels with the MoHS.

### **9.1.2 The effectiveness of Partners Relief and Development's approaches**

The second research objective was to examine the effectiveness of the approaches used by Partners in the SHTP and evaluate whether they enabled the capabilities of the medics. The evidence from this research, detailed in Chapter 7, strongly suggests that the SHTP enables medic capabilities in important ways, particularly as indicated by increased medic confidence and preparedness for their work inside Shan State. The central component of the health capabilities framework was the conversion of medic capabilities into functionings (see Figure 8.1). These functioning capabilities were attested to by the positive stories shared by the medics about promising improvements to health outcomes in their communities where there had been limited or no healthcare previously. A note of caution is due here because no evaluation of the health outcomes at the community level has been conducted. The medics embraced the personal and professional opportunities that the SHTP provided, in a context with a poor education system and limited training opportunities.

However, the findings also raise important concerns about the effectiveness of the approaches that Partners takes, as these approaches may restrict the potential of the SHTP to enable medic capabilities more comprehensively. Central to this are the constraints of Partners reliance on a volunteerism model to staff the SHTP. As a small INGO, Partners relies on volunteers based on their availability, rather than their ability for the conflict-affected context. The inclusion of minimum requirements for specific medical teaching skills and context-specific experience and training into the memorandum of understanding (MOU) that Partners has with the SSDF and the Shan Health Department would go some way to overcoming the difficulties caused by unskilled and inexperienced volunteers, and assuring they have the necessary social competencies. Adapting Partners' selection processes to ensure that volunteers meet the requirements of the MOU, and including Paw Shar Gay's input, would also address

some of the limitations of the volunteerism model. The MOU could also more overtly clarify what tasks the programme managers and expatriate medical volunteers can perform in the Loi Tai Leng clinic to ensure they do not overstep ethical and legal medical boundaries

The effectiveness of the SHTP is also inhibited by Partners' approach to the training curriculum. The SHTP, alongside RCSS/SSA-S support structures, is one of the two resources that directly impacts upon the ability of medics to have functioning capabilities. The curriculum should be appropriate for the low resource and conflict-affected context. However, it currently has a technical focus, which the students struggle with. Simultaneously, the use of English as the language of instruction also alienates the students, although one positive development during the research was the start of the training materials being translated into Tai. The lack of a strong monitoring, evaluation and learning culture within Partners also hinders its effectiveness, and the possibilities for greater equality in its partnerships through increased downward accountability.

One positive outcome of Partners' approach that can enable capabilities through the SHTP has been the transition of the management of the Community Health Worker training programme to Tai leadership. This indicates that there is the potential to see the Jao's vision for all of the programmes taught by Tai fulfilled. However, the capabilities of Tai personnel to lead programmes is greatly impacted by the wider conflict-affected context addressed in the following section.

### **9.1.3 The constraints of the conflict-affected context**

Finally, although the research was primarily concerned with understanding the approaches of Partners, the third research objective identified some of the impacts of the conflict-affected context on the capability of the alternative health system to deliver primary healthcare. Chapter 2 introduced the international community's focus on the 'fragile states' development agenda, the consequence of which has been the shift in international donor funding away from cross-border work in Myanmar, in favour of state- and peace-building initiatives with the government. The specific conflict-affected research context of Shan State was further detailed in Chapter 5. The reduction in funding has had substantially negative impacts on the programmes of Partners, the SSDF, and the Shan Health Department, the key resources which enable medic capabilities (see the discussion in Chapter 8, section 8.1).

Partners' programmes in Myanmar were affected by donor fatigue, noted by research in other contexts (see O'Dwyer & Unerman, 2008, p. 811), as its donor base was under the impression that the situation in Myanmar had improved following the National League for Democracy's victory in the November 2015 election. Although there had been a relaxing of some of the restrictions on the activities of the RCSS/SSA-S and its associated organisations after the signing of the Nationwide Ceasefire Agreement (NCA) in October 2015, the lack of donor funding was also constraining their activities. Complicating ongoing peace negotiations is the unilateral conduct of the *Tatmadaw* inside Shan State which has led to skirmishes with the RCSS/SSA-S. At the time of writing, conflict was continuing inside Shan State and other parts of Myanmar, especially Kachin and Rakhine states. In light of this, it is difficult for the SSDF, and indeed Partners, to effect real change to health outcomes and health justice for communities inside Shan State while conflict persists.

Returning to the health system development diagram introduced in Chapter 2, section 2.2.2 (see Figure 2.4 on page 29), I have adapted it in Figure 9.1 below to illustrate my conceptualisation of the current status of the alternative Tai health system. It is slowly transitioning towards a strengthened and sustainable system through the development of its health workforce, while bypassing the Myanmar MoHS system.

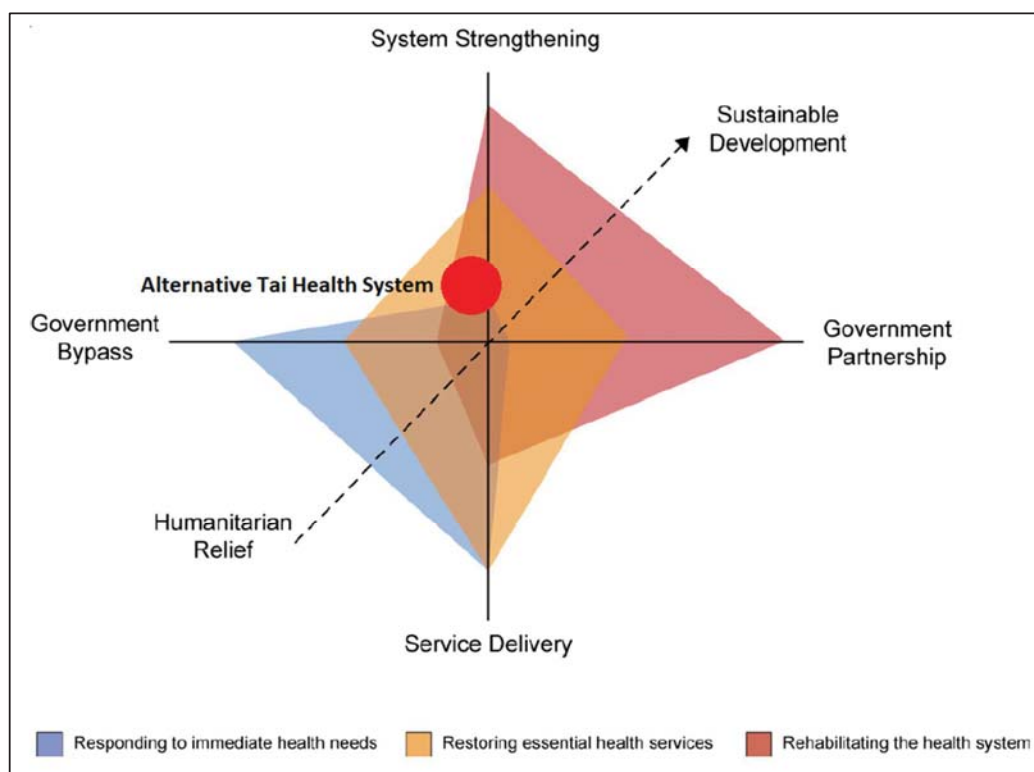


Figure 9.1: The transition of the alternative Tai health system (Source: adapted from D. W. Brinkerhoff, 2008, p. 3).

Overall, the constitution of the positive relationships between the different actors, and the enabling of medic capabilities by the SHTP, provides a strong mandate for Partners' continued involvement with the Tai health system on the Myanmar-Thailand border. The implications of this research conclusion for policy and practice, including recommendations that may enhance the effectiveness of the SHTP are addressed in section 9.3.

## 9.2 Contributions to knowledge

The research contributes to our understanding of how the capabilities of alternative health systems can be developed in conflict-affected contexts in a number of ways (e.g. R. J. Haar & Rubenstein, 2012; Kruk et al., 2010; Witter et al., 2015). First, to analyse the effectiveness of Partners' approaches, I developed the capabilities framework for health system development in conflict-affected contexts (health capabilities framework; see Figures 3.2 and 8.1), based on the capabilities approach (Nussbaum, 2003, 2011b, Sen, 1999, 2005). To date, little research has been done using the capabilities approach as a lens through which to evaluate the effectiveness of development programmes specifically in conflict-affected contexts. My framework underscored some of the

resource and conversion factors that may be necessary to enable the capabilities of the health workforce, and to contribute to health system development more broadly. It also provided important insights into the critical influence of the context in which health systems are embedded. The framework makes a theoretical contribution to the capabilities approach by expanding its relevance to conflict-affected contexts, and provides a tool for future researchers interested in assessing health workforce development in low resource and conflict-affected contexts.

Second, by evaluating the effectiveness of Partners' approaches, the research also adds to the recent research agenda on the best, contextually appropriate practices for INGOs to employ in health workforce development in low resource and conflict-affected contexts (see Martineau et al., 2017; Roome et al., 2014; Woodward et al., 2016b). It reinforces what we already understand to be best practice for INGOs: fostering equitable partnerships, using the local language for teaching and materials, focusing on practical workshops that are appropriate to the context, and using trainers, whether expatriate volunteers or local staff, that are trained and experienced for low resource and/or conflict-affected contexts (see for example Crump et al., 2010; Rednick et al., 2014; Rowe et al., 2005; Schech et al., 2015) (see also Chapter 8.2.1 and the recommendations in Section 9.3 that follows).

Third, it fills a gap in understanding how partnerships between INGOs and non-state armed groups (NSAGs) can develop the capabilities of alternative health systems. The research has examined how the SHTP has begun to enable medic capabilities to improve health outcomes through its partnership with the RCSS/SSA-S (as evidenced in Chapter 7.1). This responded to an identified need to better understand the roles and power relationships of different actors in the health system development process (Woodward et al., 2016b), and showed that INGO-NSAG partnerships can be an appropriate means to strengthen the health workforce in areas that NSAGs control. A note of caution is warranted as this research has also detailed some of the limitations of embedding a civilian health system within military structures (see Chapters 6.3.2 and 8.2.2). This demonstrates that involvement with development actors such as NSAGs is not straightforward, especially when these actors may be implicated in such things as human rights violations. However, NSAGs are a present reality in conflict-affected contexts so the international community needs to find suitable ways to engage with them in health system development. This may include fostering interim hybrid civilian-military health systems to meet SDG 3, until such a time as sustainable peace is

achieved.<sup>101</sup> As Denney, Mallet and Benson (2017, p. 31) contend, overlooking these alternative forms of capacity and authority in conflict-affected contexts risks making development programmes irrelevant.

Fourth, this research demonstrated that in the face of the reprioritisation of donor funding – something which arguably happens too often (see Chapter 5, section 5.2.1 and Chapter 8, section 8.1) - alternative partnerships in conflict-affected contexts, such as that between the INGO and the NSAG, can contribute to “indigenous, locally developed responses” to development issues (Podder, 2014b, pp. 1629–1630). Globally, this supports the opportunities to learn from these alternative forms of development that arise in conflict-affected contexts, rather than viewing these contexts from a deficit model, as ‘fragile’ and in need of outside intervention (see Chapter 2.1). These development alternatives open possibilities for improved health outcomes, the achievement of SDG 3, and a move towards health justice for communities.

Lastly, the research has shed light on the value of health justice (Venkatapuram, 2011, 2013) as an approach to developing health system capabilities and achieving SDG 3 (see Chapter 3, section 3.2). A health justice lens prioritises health outcomes and suggests that it doesn’t have to be the state system delivering healthcare to bring about improved health and wellbeing in contexts with an absence of health justice. Importantly, health justice sees health as a meta-capability that gives people the opportunity to transform their capabilities into a collection of functionings (Venkatapuram, 2011, p. 271). Health justice, linked to Sen’s advancement of health as a human right “is a demand to take action to promote that goal...” (Sen, 2008, p. 2010). This action can be taken by prioritising SDG 3.

### **9.3 Implications for policy and practice**

The broad recommendation advanced by this research is that greater efforts are needed from the international community to fund health system development programmes in conflict-affected contexts that prioritise improved health outcomes (Philips & Derderian, 2015), the achievement of SDG 3 (Buse & Hawkes, 2015), and greater health justice for communities. Acknowledging the legitimacy of localised and hybrid responses to development issues in these contexts, such as the Shan Health Department’s hybrid civilian-military alternative health system, allows for culturally

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<sup>101</sup> The Health Core Convergence Group outlined the possibilities for convergence of health systems in concert with the peace process towards sustainable peace (see Figure 5.4 on page 117).

appropriate, sustainable, and “indigenous creative responses to the problems, [that strengthen] their own capacities for endurance” (Boege et al., 2009, p. 14). Programmes that strengthen these alternative approaches mitigate the vagaries of international donor funding (AbouAssi, 2012), such as those that ethnic civil society organisations on the Myanmar-Thailand border are experiencing.

The research suggests several practical courses of action for Partners specifically, and the INGO sector more generally. Directly related to the limitations of the current memorandum of understanding between Partners, the SSDF, and the Shan Health Department, is that Partners could include more overt boundaries around the role of expatriate medical volunteers in the clinic to ensure that they don’t overstep the roles and responsibilities of Shan Health Department staff. This recommendation is also applicable to the INGO sector more broadly, as there is widespread need for a more rigorous framework around the principles, selection and orientation of volunteers for staffing development programmes to mitigate the pitfalls of these endeavours (see McLennan’s (2014, p. 168) list of some of the limitations of medical volunteerism). The volunteerism framework must incorporate community input into the types of people and skills that are appropriate and necessary from their perspective (Rozier et al., 2017), so that they “augment and support local priorities and values” (Stone & Olson, 2016, p. 241). Importantly, a component of volunteer training and orientation should also emphasise the need for volunteers to practice the “same ethical and professional standards” as in their home country (Asgary & Junck, 2013, p. 629).

Ensuring the use of health workforce/community health worker training programmes that have been identified as best practice for low resource and/or conflict-affected contexts is fundamental for INGOs engaged in this work. These programmes recommend the use of the local language for training and materials (see for example Lee et al., 2016), and hands-on workshops (Rowe et al., 2005, p. 1029) to overcome literacy problems and skills shortfalls. Partners’ programme staff could usefully participate in global consortia to learn from others and share their particular experiences of work on the Myanmar-Thailand border.<sup>102</sup>

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<sup>102</sup> These include organisations such as Community Health Worker Central (<http://www.chwcentral.org/>) and Health Systems Global (<http://www.healthsystemsglobal.org/>), which has a specific working group on health systems in ‘fragile’ and conflict-affected states.

The integration of monitoring, evaluation and learning (MEL) processes into INGO development programmes is essential in order to ensure that not only are programmes effective, but that they are also cultivating downward accountability to their partners (see for example AbouAssi & Trent, 2016; Boomsma & O’Dwyer, 2014; S. O’Leary, 2016). Culturally appropriate practices of MEL should be incorporated (Lennie et al., 2015), such as Paw Shar Gay’s relational methods for monitoring the medics inside Shan State.

#### **9.4 Research limitations and recommendations for future research**

A number of limitations of the research need to be considered, along with the concomitant research recommendations. First, the generalisability of the case study is subject to it being bounded by one INGO programme in the one conflict-affected context of Shan State, Myanmar. However, the findings provide useful lessons for INGO practice that can be transferable to similar conflict-affected contexts, including the need for a greater focus on the embeddedness of civilian systems, such as health, education and justice, in military structures in conflict-affected contexts. Some of this research has been undertaken in the Myanmar context (Davis & Jolliffe, 2016; Jolliffe, 2014; Jolliffe & Speers Mears, 2016; McCartan & Jolliffe, 2016), and more is needed in both Myanmar and elsewhere.

Secondly, the scope of data generation was limited as I was not able to access rural communities inside Shan State where the medics practised to explore the programme impacts and health outcomes, due to safety concerns related to the ongoing conflict. However, the medics shared their views and experiences (see Chapter 7) to allow an understanding of how their capabilities had been enabled by the SHTP, and consequently, how this benefited their communities. Woodward et al. (2016b, p. 1) emphasise the need for research, such as this thesis, as “Without both a higher profile and deeper focus for this area, there is a real risk that fragile and conflict-affected states will continue to fall behind in global health and development goals”. Therefore, further research is needed at the community level to better understand how to improve the effectiveness of programmes like the SHTP in conflict-affected contexts. Exploration of the mechanisms that foster greater community trust and support would be useful.

The scope of the research was also limited as I did not examine gendered experiences and health equity in both health workforce training and health service provision (see Chapter 6, section 6.3.2). Partners could undertake research to explore this issue to better help them understand the extent to which gender inequities impact health

service provision in the Loi Tai Leng clinic, as there is some evidence from this research that indicates there are gender-related concerns in the SHTP and in the provision of healthcare more generally. They could extend this investigation to the training of the Tai health workforce by the SHTP and mitigate the negative impacts, including the problem of safety for women medics, and issues of women's access to healthcare. Research is required more broadly into how to promote gender equity in health system development in conflict-affected contexts (see Bornemisza et al., 2010; Morgan et al., 2016; Percival et al., 2014).

Lastly, opium and methamphetamine addiction and production, as a critical issue for communities inside Shan State (see Meehan, 2015), was outside of the scope of the research. More research is required to determine its impact on medic practice and health outcomes for these communities, to suggest appropriate responses to tackle these issues. Ensuring contextually appropriate training resources and support for the medics to address this should be a priority for Partners.

## **9.5 Health justice for all in conflict-affected contexts**

Towards the end of this research the conflict situation in many parts of Myanmar had deteriorated. The initial hope for Aung San Suu Kyi and her government, following the National League for Democracy's victory in the 2015 elections, had waned as conflict continued and she failed to speak out against *Tatmadaw* atrocities committed against the Rohingya people in Rakhine state (Selth, 2017). It is apparent that the state- and peace-building efforts of the international community will be a lengthy and challenging exercise in Myanmar. Waiting for a political resolution to the peace process means communities in many areas continue to experience poor health outcomes. In an interview in 2016, Sai Laeng, head of the Shan State Development Foundation, summarised the complexity of cooperating with a Myanmar government that was still reluctant to share power with the ethnic groups. He emphasised the need for international support to develop the capabilities of the alternative health system, wanted by the Tai people:

What we are creating is a community based health system. We see that it benefits the people. We prefer to support its development from the Myanmar-Thailand border. So, we provide healthcare to the community by the community. This is what we are trying to achieve. For a long time, we have advocated for the international community to support, not only

the government, but also the ethnic groups. We have to work with the government which is not very easy to negotiate and causes conflict because they don't want to lose power. It is hard to do this before the political problems are solved. We also try to encourage the participation of the community. Without their participation, the health system cannot be sustained. (Sai Laeng, March 2016)

This signals the complexity of what the Shan State Development Foundation and Shan Health Department are trying to achieve with limited resources.

Reflecting on my experiences doing this research, my mind always turns to the birth I witnessed during my last field visit in March 2016 that I described in Chapter 6. Thankfully, the medics had been able to safely deliver the first baby, and Dr Ken had saved the mother's life, but when the surprise twin girl was finally delivered by Dr Ken, the Loi Tai Leng clinic did not have the necessary experience or equipment to maintain her life. She and her family then had to endure the two-hour drive over substandard roads to the nearest small hospital across the border in Thailand. Unfortunately, the damage had been done during the long and difficult birth and she passed away. This starkly contrasts with my own experience when my third child arrived purple, floppy and unresponsive. He was rapidly resuscitated by a team of specialised doctors and nurses with all the necessary equipment to hand, and is now a healthy twelve-year-old.

The difference between these two births highlights the current absence of health justice for communities in conflict-affected Shan State. The situation for mothers and children is worse in these communities than what I witnessed on the Myanmar-Thailand border. Infant mortality rates in Myanmar are 62 per 1,000 live births, and child mortality rates are 72 per 1,000 (Department of Population, Ministry of Labour, Immigration and Population, & UNFPA, 2016, p. 2). These rates are more than twice that of other countries in Southeast Asia. In order to address this, SDG 3 has the target:

By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births. (United Nations General Assembly, 2015, p. 16)

For Myanmar and other conflict-affected contexts to have any hope of attaining this target for the 2030 Agenda, governments and the international community must make every effort to focus on health system development. As this thesis has demonstrated, enabling the capabilities of alternative health systems in conflict-affected contexts is a hopeful contribution to better health outcomes and a transition towards health justice for communities. It supports Sen's (2008, p. 2010) contention that in "seeing health as a right, we acknowledge the need for a strong social commitment to good health".

I will leave the last words of this thesis to my wonderful friend, research assistant, and medic, Nang Mo Kham. I asked her what opportunities the Shan Healthcare Training Programme had given her. Rather than think of herself, she contemplated the situation of the community she was returning to inside Shan State:

If I return to my community without the training I am not confident to deliver babies. If I have the training and the right equipment then I think I can save lives. The clinic I am going back to is in the jungle and it is too far to refer emergency patients. They might die on the road. So, it is good that I have the training. (Nang Mo Kham, March 2016)



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# Appendices

## Appendix 1: Research partnership memorandum of understanding

### Research Partnership Memorandum of Understanding (MOU)

This Memorandum of Understanding (hereafter called 'MOU') is agreed upon on 18 March 2015 between **Partners Relief & Development Thailand** (hereafter called 'PRAD Thailand') and **Sharon Bell, PhD candidate/researcher, Massey University, New Zealand** clarifying the agreements and expectations between PRAD Thailand and Sharon Bell. It is accompanied by the University's approved ethics information.

#### Terms of this Agreement:

This MOU agreement begins 1 April 2015 and continues to 31 December 2017 (the expected completion date of the PhD), a period of 33 months at which point it will be reviewed. Any extension or alteration to this agreement or change in its terms will be discussed and agreed to between the parties.

#### 1. Research Program

- The researcher identifies the research as Developmental Evaluation which focuses on "learning to inform action that makes a difference" for the community involved (Patton, 2011, p. 11).
- It will follow a Transformative Mixed Methods paradigm which "serves as an umbrella for research theories and approaches that place priority on social justice and human rights" (Mertens, 2010, p. 473).
- PRAD can reasonably expect that the research will have a useful impact on changing practice for PRAD.
- The researcher can reasonably expect that the research will generate data that will be appropriate and useful for the PhD research.

#### 2. Confidential Information and privacy

- De-identifying of interview and observation data and ensuring safe data storage, including encryption of electronic information, will be undertaken by the research to ensure confidentiality.
- The researcher will use all reasonable efforts to limit the exchange, unauthorised use, dissemination or publication of confidential information provided to her.

#### 3. Publication

- The basic purpose of this PhD research is the generation of new knowledge, the building of theory and its dissemination for public benefit.
- The researcher retains her rights to publish results of the research and agrees to provide PRAD Thailand with a copy of any manuscript prior to publication for the sole purpose of:
  - a) To ensure confidential information will not be made public.
  - b) To confirm that confidentiality and privacy of individuals is protected.
- The researcher will consult with PRAD Thailand about the best way to make the research results relevant for wider dissemination to stakeholders.

#### 4. Intellectual Property Rights

- The researcher acknowledges that primary ownership of the research data belongs to the participants.

Research Partnership Memorandum of Understanding (MOU) continued

- Any intellectual property created through the analysis of this data belongs to the researcher.
- 5. Financial**
- The researcher is responsible for all financial costs incurred by the research activity.
- 6. PRAD Thailand policies**
- The researcher agrees to sign and follow PRAD Thailand's Corporate Code of Conduct, Child Protection Policy, Waiver of Liability and Security Policy.

**Revision and termination of this MOU:**

This MOU agreement will remain in place and effect for the specified time period above or until such a time as it is cancelled, in writing, by any of the parties.

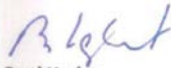
(Digital signatures are acceptable)

Signed:



Sharon Bell  
PhD candidate  
Massey University, New Zealand

Signed:



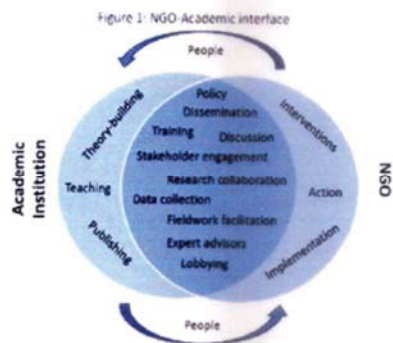
Brad Hazlett  
Chief Operating Officer, PRAD Thailand

Signed:



Drs Ken and Alison McFarlane  
Project Managers, Loi Tai Leng Medic  
Training Project, PRAD Thailand

**NGO-Academic Interface model**



(Aniekwe et al., 2012, p. 4; Stevens, Hayman, & Mdee, 2013)

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## Appendix 2: Massey University Human Ethics Committee Low Risk Notification



MASSEY UNIVERSITY  
TE KUNENGA KI PŪREHUROA

9 April 2015

Sharon Margaret Bell  
1 Ross Grove – Trentham  
UPPER HUTT 5018

Dear Sharon:

**Re: How can NGOs facilitate the development of sustainable community capacity in 'fragile states'? A case study of primary healthcare training on the Thai-Burma border**

Thank you for your Low Risk Notification which was received on 2 April 2015.

Your project has been recorded on the Low Risk Database, which is reported in the Annual Report of the Massey University Human Ethics Committees.

You are reminded that staff researchers and supervisors are fully responsible for ensuring that the information in the low risk notification has met the requirements and guidelines for submission of a low risk notification.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research."*

*"If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Hinch, Director (Research Ethics), telephone 06 355 9099, extn 85615, or mail: humanethics@massey.ac.nz"*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Brian Hinch (Dr)  
Chair, Human Ethics Chairs' Committee and  
Director (Research Ethics)

cc: Dr Rachelle Stewart-Wilkes  
School of People, Environment & Planning  
PN 331

Prof Regina Schoeyens  
School of People, Environment & Planning  
PN 331

Dr Sharon McLennan  
School of People, Environment & Planning  
PN 331

Dr Alanah M Ryan, MSc  
School of People, Environment & Planning  
PN 331

Massey University Human Ethics Committee  
Accredited by the Health Research Council

Research Ethics Office, Research and Enterprise

Massey University, Private Bag 11242, Palmerston North 4442, New Zealand. T: 06 355 9073; 06 355 6126 F: 01 350 9822  
E: humanethics@massey.ac.nz | hinc@massey.ac.nz | hinch@massey.ac.nz | www.massey.ac.nz

## Appendix 3: Research information sheet



**Massey University**

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Institute of Development Studies  
School of People Environment and Planning  
Private Bag 11 222  
Palmerston North, New Zealand  
T 64 6 3569099 extn 83623  
F 64 6 350 5737  
[pepadmin@massey.ac.nz](mailto:pepadmin@massey.ac.nz)

**How can non-governmental organisations (NGOs) facilitate the development of community capacity in ‘fragile states’? A case study of primary healthcare training on the Thai-Burma border.**

### INFORMATION SHEET

#### Researcher introduction

My name is Sharon Bell and I am a PhD candidate in International Development at Massey University, Palmerston North, New Zealand. I have a background working with an international aid and development agency, and also home educating my children. I am married to Marty and we have three children; Maggie (15), India (13) and Angus (10).

#### Research aim

My research aims to understand the approaches an NGO uses to facilitate the development of community capacity in a ‘fragile state’ context (Burma/Myanmar). A case study of NGO primary healthcare training will be conducted in a community on the Thai-Burma border. I am interested in the partnership between the NGO and the ethnic civil society organisation. I will be exploring issues of participation, sustainability, and empowerment with a specific focus on women’s stories and experiences.

#### Participant identification, recruitment and invitation

I have already travelled to the community where the primary healthcare training takes place and met some of the previous Medic trainees and local staff. I would like to invite you to take part in my study. It will involve being interviewed by me, with a translator if needed. This will take place at a place that is suitable to you. This will most likely be the classroom if you are a Medic trainee.

#### Project procedures

The interview consists of a number of open-ended questions. The interview will last for 45-60 minutes. There is no anticipated risk to you. Your identity will remain private and confidential to me. You may feel uncomfortable talking about personal issues related to your life experience. You do NOT have to answer all the questions if you do not want to. You may stop the interview at any point. You can decide to leave the research at any point. Your consent is all that is required to take part in this study. You can give this to me verbally if you prefer to not sign a form.

#### Data management

All of the information (data) I gain from spending time with you and interviewing you will be used for my research purposes only. The data will be stored as password

protected digital files. After the completion of the field research, a summary of the project findings will be made available to you by email. Please note that for privacy purposes, no names will be used. This means that your identity will not be known to anyone else.

## **Participant's rights**

You do not have to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any point;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is finished;
- ask for the voice recorder to be turned off at any time.

If at any point you feel uncomfortable during the interview, you may ask for the recorder to be turned off.

**Thank you for your willingness to be involved in my research.**

## **Project contacts**

Should you have any further questions, please contact me, Sharon Bell:

+66 931821971 (Thailand)

+64 212946890 (New Zealand)

[S.M.Bell@massey.ac.nz](mailto:S.M.Bell@massey.ac.nz)

Alternatively, you may contact my supervisor at any point during the study:

Dr. Rochelle Stewart-Withers

Institute of Development Studies, Massey University

+64 6 356 9099 ext. 83657

[r.r.stewart-withers@massey.ac.nz](mailto:r.r.stewart-withers@massey.ac.nz)

## **Committee Approval Statement**

*"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher please contact Dr. Brian Finch, Chair, Director (Research Ethics) telephone 06 350 9099 x 84459, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz)"*

## Appendix 4: Letter of introduction and support



**Massey University**

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

01/04/2015

Dr Rochelle Stewart-Withers

Institute of Development Studies

School of People Environment and Planning

### Letter of Introduction and Support for Sharon Bell

To whom it may concern,

Please accept this letter of introduction and support for Sharon Bell, ID 98060197. Sharon is currently enrolled in the PhD Programme in Development Studies with the School of People, Environment and Planning at Massey University, Palmerston North, NEW ZEALAND.

The title of Sharon's thesis is **'How can non-governmental organisations (NGOs) facilitate the development of community capacity in 'fragile states'? A case study of primary healthcare training on the Thai-Burma border'**.

As part of the university's requirement towards fulfilling doctoral studies, Sharon is required to undertake field research. Sharon will be in Thailand in the Chiang Mai region for this purpose.

This research is guided under the supervision of myself Dr. Rochelle Stewart-Withers and Professor Regina Scheyvens and we thank-you in advance for any support you are able to provide to Sharon.

Yours sincerely

A handwritten signature in black ink, appearing to be 'R. Stewart-Withers'.

Dr Rochelle Stewart-Withers



## Appendix 6: Participant consent form

How can non-governmental organisations facilitate the development of community capacity in ‘fragile states’? A case study of primary healthcare training on the Thai-Burma border.

### PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being digitally recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

Date:

---

Full name (printed):

---

Organisation (not required):

---



## **Appendix 8: New and advanced medics interview guide April/May 2015**

### **New and advanced medic interview guide April/May 2015**

#### **Personal information**

NO NAME: Participant #

Gender:

Age:

Marital status/children:

Education level/type of schooling (temple/state):

Languages spoken:

Approximate, but not specific, location of community in Shan State (show map):

How long does it take you to travel to Loi Tai Leng from your home? How do you travel?

What did you do before the Medic training?

#### **Pre-knowledge of training and selection – opportunities/choice**

- How did you find out about the Medic training?
- How were you selected to participate? Did you put yourself forward or were you selected by someone else? Who?
- If Advanced, how were you selected to become Advanced?
- What do you know about the training so far?
- If advanced, have you had a time of practicing as a medic inside Shan State or at LTL Clinic? How long for?
- What made you want to be a medic?
- Had you heard of the Shan State Army-South? Do you see them in your community? Can you tell me more about them? How are you involved with the SSA-S?
- What about the Restoration Council of Shan State? Partners Relief and Development?

#### **Health status in community – functionings/capabilities**

- Can you describe the current health problems in your community?
- Can you describe the current health system/providers in your community? Shan/Burmese? Modern/traditional? Clinics/nothing?
- How easy/difficult is it for different members of the community to access healthcare?
- Do you have any stories you would like to tell me about health issues in your community?
- Why do you want to be a Medic?
- What difficulties/problems do you anticipate when you return as a Medic? Or have experienced so far?
- Describe how you think you will find it practicing as a female medic.
- What does the community think of you being a Medic?

- What strategies are you aware of to ensure your security and safety in communities?
- If advanced and have practiced, describe how it has been for you in your clinic/location.
- What have you heard from other medics about how they are finding it in their communities? Their experiences – positive/negative?
- How would you define a good health system in your community/Shan State?
- What do you think needs to happen to achieve this?
- How do you think you being a medic will help the community to achieve this?

#### **Finish off**

- Do you have anything else you would like to add or clarify?
- Do you have any questions for me?
- If you would like a copy of my research findings later in the year are you happy to give me your email address which I will keep separate from your interview information?

## **Appendix 9: Medic follow up interview guide November 2015**

### **Medic follow up interview guide November 2015**

#### **Personal information**

NO NAME: Participant #

Gender:

Age:

Basic/Advanced Medic:

#### **Reflections on medic training in 2015**

- How was the training this year?
- What did you find hard/difficult/not easy to understand?
- What did you find easy to understand/simple?
- What was your favourite/most interesting part?
- What was the worst part?
- What do you think could be changed/made different?
- What do you think should stay the same?
- Do you have any stories about your training you would like to tell me?
- Do you have any stories about working in the clinic you would like to tell me?
- Do you have anything else about the training or living in LTL that you would like to tell me?

#### **Thoughts on returning inside Shan State to practice in 2016**

- Are you going back inside Shan State in 2016 to be a Medic?
- Do you know where you will be going? [I won't write down the place but you can show me on the map.]
- Will you be in a home or in a clinic building or somewhere else?
- Who else will be working with you?
- How do you think you will find it being a female Medic?
- What will you do to keep safe?
- Are you doing the extra Burmese training (auxiliary midwife) to get a Certificate?
- What problems do you think you will find/experience working in communities?
- How well prepared by your training do you feel? How confident do you feel?
- What have you heard from other Medics about working inside?
- What will be good about returning inside? What are you looking forward to?
- How will you get your supplies and medicines?
- What reporting do you need to do?
- How will you stay in contact with the clinic here?
- If you are going as a Medic with the SSA-S what will you be doing?
- If you are staying in LTL, what will you be doing?
- If you are going back inside Shan State, but not as a Medic, what will you be doing?

#### **Finish off**

- Do you have anything else you would like to add or clarify?
- Do you have any questions for me?

## **Appendix 10: Refresher medic interview guide March 2016**

### **Refresher medic interview guide March 2016**

#### **Personal information**

NO NAME: Participant #

Gender

Age

Marital status/children

Year of Basic/Advanced Medic training/how long a medic

Approximate clinic location [I won't write down but you can show me on the map.]

#### **Reflections on medic training**

- How were you chosen/did you decide to be a medic?
- Tell me about the training the year you did it?
- What was your favourite/most interesting part?
- What was the worst part?
- What do you think could be changed/made different to make it better?
- What do you think should stay the same?
- Tell me a story about your training and/or living in LTL.
- How long after your training did you go inside? Did you work in LTL for a while first?

#### **Thoughts on practicing as a medic inside Shan State**

- What sort of clinic are you in? A building? A home? Backpack medic? SSA-S?
- Who decided where you would be based? Are you in your own community?
- Do you work with other medics? How many of you?
- Did you do extra Burmese training to get a certificate? Where and when?
- How well prepared and confident did you feel going back inside as a medic?
- What did the community think when you returned? How did they treat you? Tell me about that.
- How do you find it being a female Medic? What is good about being a female medic? What is bad? Tell me about that. [Gender.]
- What things do you do to keep safe?
- Tell me about the health problems you are seeing and treating.
- What problems and issues are women in communities having? Tell me about contraception & reproductive & child health. [Gender.]
- Tell me how you are able to deal with these? As a female medic? As a male medic?
- Do you think your medic training prepared you to deal with them? [Context specific training.]
- Tell me about the problems you see that you weren't trained or aren't confident to treat?
- How does the community support you in your role?
- How do you get your supplies and medicines? [Supply chains/structures.]
- Do you always have enough supplies and equipment? Tell me about that.

- What reporting do you do? Do you feel confident that you know how to report? [Audit and performance appraisal.]
- Is it easy or hard to talk about the problems and mistakes? Tell me about that.
- How do you stay in contact with the clinic here? [Supervision structures.]
- How well supported are you by the LTL clinic/RCSS?
- What could the RCSS do to help you more?
- How well supported are you by Partners and the doctors?
- What could Partners do to help you more?
- What other healthcare providers are there in your community? How do you work with them? [Emergent collaboration.]
- What do you want to learn during the Refresher course? [In-service training.]
- What will you be telling the new medics about being a medic? Do you recommend it?
- What is the best thing/makes it easy to stay being a medic? What makes it hard?
- Tell me how being a medic has given you more opportunities in your life.
- How long do you think you'll be a medic for? [Retention.]
- What will you do if you are not a medic?

#### **Finish off**

- What else would you like to tell me?
- Do you have any questions for me?

## Appendix 11: Partners Relief and Development interview guide 2015

### Partners staff interview guide 2015

#### Personal information

Check if ok to name otherwise NO NAME: Participant #

Gender:

Role/Organisations (if ok to describe):

Education level/type of schooling (temple/state):

What did you do before your current role?

#### **Medic training involvement – opportunities/choice – higher level/power**

- What is your involvement in the Shan State health system?
- What is your involvement in PRAD Medic training or LTL clinic?
- Can you describe your current role and responsibilities you hold?
- What training and background have you had for your role?
- What is your involvement in the Restoration Council of Shan State? Partners Relief and Development?

#### **Health systems in Shan State – functionings/capabilities/agency/power**

- Can you describe the current health and health system problems in Shan State? What about barriers to access to healthcare?
- Can you describe the current health system/providers in Shan State? Tai/Myanmar? Modern/traditional? Clinics/nothing?
- What data/information do you gather about health problems and provision?
- Do you have any stories you would like to tell me about health issues in Shan State?
- Have you heard from Medics how they are finding it in their communities? Their experiences – positive/negative?
- What strategies are you aware of to ensure Medic security and safety in communities?
- How do communities feel about the Medics?
- How do you/your organisation cooperate with PRAD on the Medic training? Can you describe how this works/doesn't work?
- How do you/your organisation cooperate with other organisations involved in health in Shan State?
- How do you/your organisation cooperate with other international NGOs? ICRC, IRC, FBR, etc?
- What about the Myanmar Ministry of Health and Sports (MoHS)?
- How do you monitor and evaluation the health system in Shan State? How do you get information about what is happening in communities? Improved community access to healthcare?
- How do you monitor and evaluate your partnerships with other organisations such as PRAD or other INGOs?
- What can you tell me about supply chains of medical supplies and medicines for the Medics?
- How would you define a good health system in your community/Shan State?

- How do you see the future of health system development in Shan State?
- What do you think needs to happen to achieve this?
- What level of cooperation do you think is possible with the MoHS health system?  
What about a form of MoHS certification of Medics?

**Finish off**

- Do you have anything else you would like to add or clarify?
- Do you have any questions for me?
- If you would like a copy of my research findings later in the year are you happy to give me your email address which I will keep separate from your interview information?

## **Appendix 12: Expatriate medical volunteers interview guide 2015**

### **Expatriate medical volunteers interview guide November 2015**

#### **Personal information**

Check if ok to name otherwise NO NAME: Participant #

Gender:

Role/Organisations at home (if ok to describe):

#### **- Medic training involvement**

- How long have you been involved in the PRAD Medic training/LTL clinic?
- How did you get involved in the PRAD Medic training/LTL clinic?
- What is your specific role in PRAD Medic training/LTL clinic?
- What changes have you seen take place over the time of your participation?
- What is your favourite/most interesting part?
- What is the worst/most difficult part?
- What do you think could be changed/made different?
- What do you think should stay the same?
- What do you think of the relationship between PRAD and the Shan in LTL?
- Do you have any stories about your participation you would like to tell me?

#### **Health systems in Shan State**

- Can you describe the current health and health system problems in Shan State from your perspective?
- What do you understand to be some of the barriers to access healthcare?
- How do you think the Medic Training will contribute to overcoming these?
- Do you ever hear from Medics how they are finding it in their communities? Their experiences – positive/negative?
- How would you define a good health system for Shan State?
- How do you see the future of health system development in Shan State?
- What do you think needs to happen to achieve this?
- What level of cooperation do you think is possible with the Burmese health system?

#### **Finish off**

- Do you have anything else you would like to add or clarify?
- Do you have any questions for me?
- If you would like a copy of my research findings later in the year are you happy to give me your email address which I will keep separate from your interview information?

# Appendix 13: Memorandum of understanding between Shan State Development Foundation and Partners Relief and Development October 2015



## Memorandum of Understanding

### The Parties

Shan State Development Foundation

Partners Relief and Development

### Purpose

That Shan State Development Foundation and Partners Relief and Development continue to work together for the benefit of the people of Shan State to:

1. Support the restoration and development of an effective health system in Shan State
2. Enable the students in the teaching programme to reach their full potential

### Agreement

This agreement outlines the roles and responsibilities of each party. It is not legally binding.

#### Both parties agree that

#### 1. Partners Relief and Development will:

- 1.1. Develop, supply and continually improve appropriate curricula and supporting materials based on best clinical practice in low resource settings.
- 1.2. Where appropriate and over time develop curricula and supporting materials in Tai language.
- 1.3. Supply teachers to effectively teach the Medic level 1 and Medic level 2 curricula and other curricula that are developed.
- 1.4. Support the Shan teachers with teaching the Community Health Worker curriculum.
- 1.5. Supply teachers as clinical mentors for students and medics working in the Loi Tai Leng Clinic and at other teaching sites.
- 1.6. Develop new curricular areas, based on best practice in low resource settings, as agreed between the two parties. Funding for each new curricular area will be negotiated between the two parties. Two initial areas agreed for development are:
  - a. Continuing Healthcare Education
  - b. Health Administration
- 1.7. Fund Shan State Development Foundation for Student Support and Teaching Support, according to an annually agreed budget. The extent of this funding will be jointly reviewed in two years from the date of this agreement to assess the possibility of devolving some or all of the responsibility for funding Student Support to Shan State Development Foundation.
- 1.8. Provide clinical, policy and quality advice as requested by Shan State Development Foundation.

#### 2. Shan State Development Foundation will:

- 2.1. Fund and operate the Loi Tai Leng Clinic to:
  - a. To function effectively as a model clinic of excellence.

- b. Provide appropriate clinical exposure for the students
- 2.2. Provide Student Support (clause 1.7) according to the annually agreed budget – including for:
  - a. Student allowance
  - b. Student meals
  - c. Fuel for generator use for training and clinic
  - d. Firewood for cooking
  - e. Stationery for training purposes
  - f. Costs of Opening and Closing ceremony
- 2.3. Provide financial support for the Teachers and Translators – according to the annually agreed budget – including for:
  - a. Teacher salaries
  - b. Translator salaries
- 2.4. Provide monthly and end of year reports including financial accounts to Partners Relief and Development.
- 2.5. Share relevant healthcare and clinic audit data with Partners Relief and Development
- 2.6. Provide translation services for teaching and preparation of support materials
- 3. Together the parties will:
  - 3.1. Define an ideal Model Clinic including aiming for excellence in:
    - a. Clinical Care
    - b. Clinical Systems and Standards
    - c. Administration Systems and standards
    - d. Auditing
    - e. Standards of quality
    - f. Quality improvement programs
      - i. Clinical
      - ii. Operational
  - 3.2. Establish the Loi Tai Leng Clinic as a Model Clinic
  - 3.3. Define a Teaching clinic including:
    - a. Clinical Care
    - b. Clinical Systems and Standards
    - c. Administration Systems
    - d. Communication and Information Technology Standards
    - e. Accessibility
    - f. Auditing
    - g. Standards of quality
    - h. Quality improvement programs
      - i. Clinical
      - ii. Operational
  - 3.4. Establish the development of one or more Teaching Clinics within Shan State
  - 3.5. Advocate for and work to gain accreditation for the Community Health Worker Program.
  - 3.6. Plan future health educational developments together.
  - 3.7. Evaluate current programs and work to improve their quality, effectiveness and efficiency.
  - 3.8. Develop a process of Shan Medic teacher development
  - 3.9. Continue to communicate clearly and freely with each other

## Term of Agreement

Partners Relief and Development acknowledges the importance of continuity and long term involvement for an effective relationship between the two parties. In particular this is important to the success of the programme and to enable sustainable devolvement of the program over time.

Clauses 1.7 and 2.2 will be reviewed as indicated in two years from the date of this agreement.


The term of the full agreement is for 5 years from the date of this agreement. Both parties will review the full agreement together in 2020

Signed:   
Partners Relief and Development

Date: 22/10/2015

Signed:   
Shan State Development Foundation

Date: 23/9/2015

Signed:   
Health Department – Restoration Council of Shan State

Date: 22/10/2015