

A Migrant Clinic at the Thailand - Myanmar Border: Legitimacy, Partnerships, and Cross-border Health Care Mobility*

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I. Introduction

This study examines how an unauthorized Burmese migrant clinic, named the Mae Tao Clinic (MTC) or Dr. Cynthia clinic, in Mae Sot, a Thai border town accommodating around 200,000 Burmese migrants as of 2016 (Karen News 2016), serves as an essential health care provider not just for migrants in the town but also people from Myanmar. Since its establishment as a makeshift clinic by Dr. Cynthia Maung and a small group of students in 1989 who crossed the border to escape the then military regime's brutal crackdown on democratic movements, the clinic has increased its capacity and become an influential health care institution and the symbol of human rights advocacy in the border region over the years. Now it has developed to treat over 100,000 cases a year nearly half of which are from the

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Myanmar side (MTC Annual Report 2016: 17). This clearly shows that the clinic promotes migrants' health in general and also induces the transnational health care seeking of the Burmese across the border. Although officially "illegal," it has become socially legitimate in the border town, strengthening partnerships with local, national, and international health organizations. The study argues that the partnerships provide a strong foundation so that the clinic can overcome illegality and vulnerability and in turn generate cross-border health care mobility.

This study comprises a longitudinal research that spans from the mid - 2000s to 2016. It includes a full scale year-round stay in Mae Sot from July 2004 to July 2005. Subsequent research was carried out in July 2009, February and July 2010, February 2011, December 2012, February 2014, and July 2016. My main research methods included participant observation, and organized and informal interviews with patients, medics and Dr. Cynthia Maung. Association with migrants, in particular Karen migrants, allowed me to observe the pattern of migrants' health care seeking as well as cross-border health care mobility. My interviews also involved the officials of the local government as well as NGOs that engaged in the clinic. A crucial merit of this longitudinal ethnographic research was to observe the trajectory where this "illegal" clinic has become socially legitimate as an indispensable health care institution at the border in collaboration with various partners over the years, and serves as an essential health care.

The paper first discusses how the clinic provides a new source of theoretical understanding on migrant health care. Second, the study

explores the development history of the MTC. Third, it deals with how the clinic has become a legitimate health institution in the local society. Fourth, it investigates how it treats migrant patients in their everyday lives in Mae Sot, thus forming a community. Fifth, it deals with how it provides medical treatment across the border, engaging in cross-border patient mobility and medical services. Lastly, the paper considers transnational partnerships that have strengthened the capacity of the clinic.

II. “Illegal” but Legitimate Health Care Institution

The MTC provides a unique case in studies of migration in general, migrants’ health care, and transnational health care seeking because this unauthorized migrant clinic was initiated and has now run under the ownership of migrants themselves, providing health care services across the border. This study first builds upon structural approaches of existing studies that concern how the health care system of a particular host society integrates migrant patients (Castañeda 2012; Chavez 2012; Marrow 2012; Pavlish et al. 2010; Seo 2016; Viladrich 2012). Scholars critically review structural discrimination and racism (Huffman et al. 2012; Viruell-Fuentes et al. 2012) and medical policies of entitlement and exclusion (Mladovsky 2009; Sargent and Larchanché 2011). The vulnerability of unauthorized migrants, children and women in this discriminatory system attracts particular attention (Adanu and Johnson 2009; Dettlaff and Rycraft 2010; Johnson and Marchi 2009; Willen 2012; Wolf et al. 2005). Scholars

point out that even legal migrants, who are entitled to the health care system of host societies, cannot afford to pay for medical treatment and many obstacles such as language problems, clinicians' attitudes, and uncomfortable environments restrict their access to the health care providers of host societies (Holmes 2012; Horton 2011). In the unfavorable environments of host societies, migrants' health conditions deteriorate. Overall, the main concern of this structural approach to migrants' health conditions tends to center around the domestic health care system of host countries that discriminate against migrants.

Like other migrants, Burmese migrants in Mae Sot also experience similar restrictions in the Thai health care system. In particular they live unstable lives exposed to arrest and deportation and encounter many obstacles such as language problems in their pursuit of medical treatment in host society. However, what distinguishes them from others is that they do not necessarily rely on the Thai health care system but have an alternative health institution of their own. Thus, even though they are discriminated against by the host society's health care system, they can easily pursue medical treatment in the MTC. Indeed we can find similar cases in other countries, such as Israel (Gottlieb et al. 2012) and Germany (Castañeda 2009) where migrant clinics treat migrant patients. However, in Israel, the establishment and operation of an "open clinic" was solely initiated by domestic humanitarian NGOs, not by migrants themselves. In Germany too, German volunteers, not migrants, set up and run a "Berlin clinic" to treat unauthorized migrant patients. The building trajectory of the MTC sharply differs from the two cases where

migrants' role in the establishment and operation of the clinic is not conspicuous. Migrants played a crucial role in creating and operating the MTC even in a precarious situation.

This points leads to another stream of research that emphasizes migrants' agency apart from the aforementioned structural approach. This agency-centered approach sheds light on how migrants maintain and seek health care despite structural constraints. Here scholars pay attention to the transnational health care seeking strategies of migrants. Their behavior can be divided into two types. One type, while staying in a host country, is to maintain and consume the home country's traditional remedies, such as herbal medicines and spiritual consultation. This behavior can be seen in the cases of southern African migrants in London (Thomas 2010), Surinamese migrants in the Netherlands (van Andel and Westers 2010), Karen migrants in Thailand (Bodeker and Newmann 2012) and Bengali immigrant women in New York (Chakrabarti 2010) through "transnational therapy networks" (Krause 2008). The other type is to return to the home country or go elsewhere to seek health care treatment in a more affordable, comfortable, and perhaps effective environment as seen in the cases of Mexican migrants in the United States (Bergmark et al. 2010; Brown 2008; Chavez et al. 1985; Wallace et al. 2009), Korean immigrants in New Zealand (Lee et al. 2010), and Cape Verdean immigrants in the Netherlands (de Freitas 2005).¹⁾

1) This type can be related to the sector of medical tourism where people pursue cross-border health treatment. However, as Glinos et al. (2010: 1146) mention, "the industry-driven term 'medical tourism' insinuates leisurely travelling and does not capture the seriousness of most patient mobility" across the border. Thus they suggest the term "cross-border patient mobility" and define it as "the movement of a patient travelling to another country to seek planned health care."

The MTC epitomizes the cross-border patient mobility or transnational health care seeking that the agency-centered approach highlights. The clinic caters not just to the needs of migrants in Thailand but also to those of Burmese patients from the other side of the border. However, the context where cross-border patient mobility takes place in the clinic is very different from other cases. In other cases, it is typical for people in the host societies to return to their home countries to seek health treatment in a familiar context. Mexican, Korean, and other ethnic immigrants in the aforementioned cases adopt this pattern. In contrast, in the case of the MTC, people in a home country cross the border to seek health treatment in the unauthorized migrant health institution of their own nationals in a foreign country. It also differs from typical cases of medical tourism where patients travel to another country to seek health treatment in a foreign health care institution. It is a case never dealt with in the existing studies of transnational health care or migration in general. The uniqueness of the MTC expands the scope of understanding migrants' health treatment as well as transnational health care seeking.

How has the migrant clinic become a prominent medical institution for the Burmese on both sides, generating cross-border health care mobility? Given that illegality is often associated with deportability and temporality (De Genova 2002), the case of the MTC invites further investigation in regard to its constitution. Here, building upon Abraham and van Schendel (2005), I put forward an alternative distinction that concerns the "licit" or what is socially legitimate, and the "illicit" or what is otherwise beyond the legal - illegal categorization, to understand the constitution of the migrant clinic.

Although “illegal” according to legal standards, the clinic is “licit” and accepted as a legitimate institution in the particular locality. The clinic has strengthened its legitimate position by practicing humanitarianism that often invalidates the state’s regulation in the context of the emerging discourse of “health as human rights” (Meier and Onzivu 2014).

Humanitarianism, in particular in the area of health care, not just empowers a refugee doctor to legitimize her medical treatment, but opens up an opportunity for the state to promote its humanitarian image by allowing the operation of the clinic, and also induces global players such as NGOs to engage in the less-privileged clinic. This entanglement that the global norm promotes has consequently developed into partnerships that legitimize the presence of the clinic despite its illegal status. The case of the clinic features a crucial aspect of global political economy that overcomes nationalistic binary divisions between the legal and illegal. Alongside this global norm, I identify a geographical factor that concerns the Thailand - Myanmar border. While standing at the border, the clinic plays a prime role in mediating this type of transnational flows. This role in turn strengthens its position in the border locality. I argue that this legitimacy encourages migrants to practice their agency in building up the clinic and seeking health care although I do not dismiss structural conditions that influence the trajectory of institution building and the pattern of their health care seeking.

III. Development of the Mae Tao Clinic

The establishment of the MTC²⁾ was directly related to political instability that happened in the latter part of 1988 when the military took power and brutally cracked down on democratic movements. A Karen medical doctor named Cynthia Maung fled with a group of her colleagues to Thailand to seek sanctuary. At first, they arrived in a nearby area of the current Mae La refugee camp which is located 60 kilometers north of Mae Sot. After a month or so of working at a small hospital, Cynthia's group moved to Huay Ka Loke refugee camp³⁾ 10 kilometers north of Mae Sot. While staying there, they collaborated with Karen leaders, local Thai authorities, and church groups to organize more treatment for refugee patients. Eventually in February 1989, they opened a makeshift medical clinic on the dusty outskirts of Mae Sot.

At that time, the clinic had virtually no supplies, no money, and no medical staff (except Cynthia Maung) formally trained in medicine. Furthermore, they were staying in Thailand illegally and did not speak Thai. Thus, the clinic was expected to only run for a short while. At a meeting that I attended on December 8 - 9, 2004, Cynthia Maung recalled, "When I first started the clinic, I thought it would run for three to four months." She and her colleagues hoped

2) This section mainly draws from a book that commemorates the 20th anniversary of the Mae Tao Clinic (2010) as well as Dr. Cynthia Maung's various speeches and interviews that I observed and conducted during my stay in Mae Sot.

3) This camp was attacked by the Burmese military in 1997 and 1998 and subsequently moved to Umphiem Camp, a newly built camp, 87 kilometers south of Mae Sot in 1999 (Human Rights Watch April 14, 2007).

that the military junta would negotiate peace talks with pro-democracy groups and ethnic minorities under international pressure. But that was not realized and the history of the clinic unfolded on the Thai side of the border.

From the beginning, the MTC stood in partnerships with various organizations. Among the first groups were Mae Sot Catholic Church and Christ Church Thailand which arranged safe accommodation and helped the clinic set up initial partnerships with Mae Sot Hospital. International partners such as Médecins Sans Frontières, Planet Care, Global Health and Access Program, Brackett Refugee Education Fund, and Burmese Relief Center extended crucial assistance to the clinic. Ethnic groups and pro-democracy groups cooperated with the clinic from the early days. Indeed, the clinic was the first outcome of cooperation between ethnic resistance groups and the All Burma Students Democratic Front. Some of the students were founding members and others later joined the clinic as medics and staff. Among Karen civil groups, the Karen Department of Health and Welfare was a crucial partner in delivering health care inside Burma. In addition, the Burma Medical Association, an interethnic cooperation group, cooperated with the clinic to provide medical care in ethnic areas and organize various training programs. Above all, the Mae Sot Hospital was an indispensable partner. In the beginning, the clinic was able to do little more than dress minor wounds and treat simple malaria; all severe cases were referred to Mae Sot Hospital (MTC 2010: 35).

In the mid - 1990s, the clinic became more stabilized and expanded its capacity and facility. Development included the issue of delivery certificates in 1994, setting up a maternal child health program in

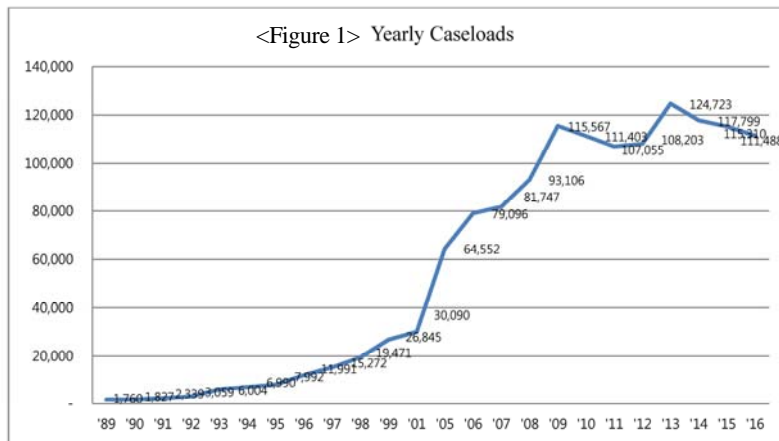
1995, and a blood lab in 1996 to screen pregnant women for HIV, hepatitis B, and syphilis. In 1998, the child outpatient department officially opened. In 1999, as the patient population continued to grow, inpatient departments became more specialized and divided into medical, pediatric, reproductive health, and trauma/surgery inpatient departments (MTC 2010: 39 - 56).

The MTC continued to build up its capacity in the early part of the 2000s. The dental clinic was set up in 2001 as an adjunct to the clinic's surgery department. Now it has substantially developed an administrative sector as well. It began to use an electronic database program for its inpatient department in 2000 and came to centralize the database that was transmitted from each of the clinic's departments by 2004. In 2003 - 04, the public health authority of Tak Province helped the clinic improve its database's ability to monitor major infectious diseases. With the advancement of the database system, the work of the department of registration and medical records improved. In addition, to efficiently expand and strengthen partnerships, it formed a public relations center in 2003 (MTC 2010: 61 - 79).

Throughout the latter part of the 2000s, the clinic broadened its scope. In 2006, the counseling center was officially opened in a new building, and mental health services became part of the primary health care in the clinic. In 2008, the infection prevention unit was set up though the activities of the unit had started long before the official establishment. Until 2008, each department of the clinic had its own small pharmacy area. But in 2008, a new central pharmacy was formed and a networked computer system allowed each department

to order medications from the central pharmacy (MTC 2010: 80 - 91). During the 2000s, the clinic strengthened partnerships with international and local organizations. I often heard Dr. Cynthia emphasize these partnerships as a cornerstone to strengthen its presence and promote health conditions when she delivered speeches on various occasions.

The impressive development of the clinic throughout the years is illustrated in Figure 1, which shows the increasing caseload.



(Sources: Mae Tao Clinic Annual Reports from 1989 to 2016)

In the first year (1989), the clinic dealt with 1,760 cases. From then on, it constantly increased up to 2009 when it dealt with 115,567 cases. The number of cases then stabilized between 100,000 and 125,000 from 2010 to 2016. Nearly half of the patients were from Myanmar; for instance in 2016, among 54,521 total clients, the number of the clients from Myanmar was 25,950, comprising 48%

(MTC Annual Report 2016: 18). It demonstrates that despite democratization of Myanmar regime since 2011, people on the Burmese side kept crossing the border to seek health treatment in the clinic.

IV. Legitimate Presence in the Locality

Despite impressive growth, the clinic remained “illegal” because Dr. Cynthia Maung did not hold a medical license authorized by the Thai authority and the clinic was established without any legal permission from the host state. Thus, the Thai authority could easily dismantle it. When I met the head (*nay amphoe*) of Mae Sot District on May 8, 2005, I asked how he viewed the clinic. He answered, “I know the clinic is illegal. I could arrest them. But I let them run the clinic since they do good things for the society.” From a humanitarian stance, the MTC is tolerated by the Thai authority. Indeed local Thais that I met showed a great respect for Dr. Cynthia Maung. Bunni,⁴⁾ one of my Thai informants told me on February 4, 2014, “Cynthia is very famous. She is more famous than anyone in Mae Sot in the world. Actually her name is more widely known to the outside than Mae Sot.” Somsak, Anan, and other local Thais whom I associated with showed a great respect for her humanitarian work although all of them knew about the unauthorized status of the clinic. In a conventional understanding, “illegality” is often associated with clandestine, unstable and, in the end, deportable activities (De

4) Names in this article are pseudonyms.

Genova 2002). But the “illegal” MTC has been open and persistent since its establishment. Doing humanitarian activities has legitimized the presence of the clinic in the eyes of local Thai people and even the authorities.

Above all, close cooperation between the MTC and the Mae Sot Hospital that began from 1989 when the former was established has contributed to the legitimate presence and operation of the clinic, which the clinic acknowledges:

Considering that MTC is not a legally recognized establishment in Thailand, the level of support it has received from the Mae Sot Hospital (MSH) and the Ministry of Health (MoH) is remarkable. The local support provides a certain amount of stability, and thus the ability of work effectively (MTC 2010: 36).

The director of the MSH also acknowledges the achievements of the clinic, saying:

Mae Tao Clinic has successfully been providing health services to the migrant population, which normally has poor access to health care. We have been working and supporting each other to reduce the health burden in the population since the establishment of the clinic. The cooperation between the clinic and the Mae Sot General Hospital has long been excellent. (MTC 2010: 35).

Since 1989, a medical referral program between the two sides has been in operation. For instance, in 2016 too, a total of 862 referrals, about 0.8% of cases to MSH (MTC Annual Report 2016: 22). However, the clinic was not a free rider in the Thai health institution.

For instance, referrals cost the clinic 14.2 million baht (468.6 million won) in 2012, representing 25% of the clinic's health expenditure in 2012 (MTC Annual Report 2012:32). The Thai Public Health Ministry said that most of the hospitals in the five provinces along the border shouldered the burden of providing health care services to migrant workers and non-Thais crossing the border (Nation June 15, 2013). In fact, the MTC shoulders the burden to a great extent. In its absence, the Thai health authority would have to take on a greater burden. The Thai authority at times relies on the clinic to implement policies, including a recent drug rehabilitation project. The department of probation under the Justice of Ministry consulted with Dr. Cynthia on the project. Probationers can seek counseling as well as medical treatment from the clinic (Bangkok Post January 25, 2014).

Alongside the practical cooperation between the clinic and the Thai authority, the visits of people in high office to this "illegal" clinic strengthen its legitimate position as a humanitarian institution. For instance, former Thai Prime Minister, Abhisit Vejjajiva, visited and gave encouragement to the clinic on December 6, 2012. At that time, the clinic took the opportunity to explain the health situation at the border and its own activities (Karen News December 6, 2012).⁵⁾ The clinic made use of this visit to emphasize its presence in the border town as an indispensable health institution to the border society, which accommodates migrants and cross-border health seeking

5) See also Burma Children Medical Fund (2012: 31 - 33). <http://burmachildren.com/wp-content/uploads/2013/04/Burma-Children-Medical-Fund-Annual-Report-2012.pdf>(accessed June 7, 2015).

travelers.

On the other hand, the host society makes use of the clinic's recognition as a means to promote its own image as a guardian of humanitarianism, as we can grasp from the statement of the head of the Mae Sot District and the visits of people in high office. Indeed, not just for those officials and politicians, but also for local Thais the clinic has become a popular destination to observe how humanitarianism is actually practiced in their locality and how they are benign enough to let this unauthorized clinic operate. It has become a humanitarian site for field trips. I often encountered groups of Thais, including students, who visited it for that purpose. Though unauthorized, the presence of this humanitarian health institution provides a source of promoting self-esteem for Thais in general.

At a practical level, the clinic has done good things for local Thais, including creating many job opportunities. The entrance to the clinic is full of Thai motorbike taxi drivers and food vendors, who rely on migrant and cross-border patients for their livelihood. Thai motorbike taxi and bus drivers at river piers are always busy transporting Burmese patients to the clinic. Ironically, the livelihood of many local Thais is heavily dependent on this "illegal" clinic.

To sum up, alongside the main factor that is the clinic's partnerships with local and international health institutions, humanitarian appeal and practical contributions have provided a strong foundation for it to be regarded as a legitimate institution in the local society.

V. Migrants and the Clinic

In Mae Sot, although there is no exact data on the number of migrants, many officials and migrant organizations that I interviewed assume that there are about 200,000 migrants among whom half stay in the absence of legal documents. Indeed, legal migrants are entitled to the Thai health insurance scheme. As of 2016, the health insurance fee was 2,200 baht (72,600 won) per year. In addition, migrants are required to pay 600 baht (19,800 won) as the health examination fee. Thus it costs an adult migrant 2,800 baht (92,400 won) to access the insurance scheme (Yan 2016). Apart from this, the Thai government has initiated a new scheme - the social security board card - which costs 8% of a worker's wage, half of which is paid by employers. Migrants who are entitled to this scheme pay 550 baht (18,150 won) for health insurance and also 600 baht (19,800 won) for health examinations, in total 1,150 baht (37,950 won) (IOM 2013).

However, in any scheme, the fee is not affordable for migrants in general given their income levels, which range from 3,000 to 6,000 baht (99,000 to 198,000 won) per month. In the case of the scheme of the social security board card, employers are reluctant to contribute 4% for each person. Thus in reality, the structural constraints prevented migrants from accessing Thai health institutions. In addition, unfriendly hospital environments, language barriers, and consequent communication difficulties with Thai doctors all discouraged seeking health treatment in Thai hospitals.

I often associated with Seni and Tamul both of whom were Karen migrants, had work permit, and were thus entitled to the Thai health

insurance scheme. However, each time they were sick, they went only to the MTC, and never considered Thai clinics or hospitals as options. First of all they were not confident in speaking Thai before Thai doctors. Their choice was also partly influenced by their fear of the Thai authorities and, in particular, the police that intimidate, arrest, and deport unauthorized migrants. Migrants, unauthorized or legal, have been exposed to this intimidation in their everyday lives. Since the late 1980s when migration took place on a large scale, the police have often checked migrants and deported “illegal” ones. Fear is deeply ingrained into their mind regardless of legality. In this situation, although legal migrants have access to Thai hospitals, they cannot be comfortable in them. Thus, Seni and Tamul, though legal migrants, deliberately choose to the MTC where they feel at home, can easily communicate and are only charged the registration fee of 30 baht (990 won)⁶⁾ without additional payment for any kind of treatment. They are even provided with food and shelter for free during their stay in the clinic.

Unlike Seni and Tamul, Hserku and Gido did not hold any legal documents. The married couple lived in a makeshift house in a migrant compound, and earned some money by taking care of the buildings of a Karen church. One day Hserku became pregnant and thereafter made regular visits to the MTC for prenatal checkups. In the end, she gave birth to a daughter at the clinic on January 29, 2005. A few days later, many people from a Karen community with

6) The registration fee was introduced in 2006 to have patients keep their registration chart under the same name; otherwise, they can easily change their names, in part because of security reasons (Interview with an official of the MTC, February 6, 2014).

whom the couple and I often associated came to the clinic to see her and the new born baby. They chatted with each other and the baby was the source of their happiness. It was evident that the social bond among Karen migrants was strengthened, and it centered on the clinic. Indeed, the clinic has served as an important community center for migrants in general, accommodating the visits of family members, relatives, friends, and villagers. It also organizes cultural events such as a New Year's festival and promotes the sense of community for migrants beyond simply providing medical treatment.

Those migrants who are hired as domestic workers and thus do not closely associate with migrant communities also rely on the clinic for their health treatment. In this case, their Thai employers encourage and send them to the clinic. In February 2014, I revisited my former Thai landlord who had hired a same Burmese worker for over 10 years. I was very familiar with the worker as I had often talked to him during my initial stay in the mid - 2000s. The landlord told me, "My employee was sick a couple of days ago and got treatment in the MTC. He always goes there whenever he is sick." The Thai landlord very much appreciated the clinic for always taking care of his employee.

A study of Burmese female factory workers shows that the majority gave birth in the clinic (Person and Kusakabe 2012: 162). All over Mae Sot, whether migrants are living within a community or individually making a living, whether they are unauthorized or not, it is usual for them to go to the clinic. This story does not apply just to migrants. Those Thai Karen who do not have a Thai identity card also seek health care treatment at the clinic. Refugees who

temporarily stay in the town outside of refugee camps rely on the clinic.

Apart from treating migrant patients, the clinic regularly reaches out to migrant schools,⁷⁾ which are usually located within migrant living compounds, and conducts various types of programs, including first aid treatment and basic hygiene and sanitation education to promote the health condition of the migrants and their living environments. For instance, on April 1, 2014, the staff of the clinic offered first aid training to 45 students in the migrant Thoo Mae Kee school, raising awareness about communicable diseases (TB, pneumonia, diarrhea, worm infestation, malaria, and dengue fever), and HIV/AIDS.⁸⁾ All of this evidence indicates that, in general, the clinic has become an indispensable health institution for migrants in Mae Sot. Furthermore, it highlights that the presence of the clinic has stabilized the presence of migrants whose life otherwise might have been fragile in the lack or absence of proper treatment. The clinic contributes to the constitution of migrant lives in the locality regardless of legality.

VI. Cross-border Health Care Mobility

As mentioned earlier, about half of the patients are from the Myanmar side of the border. In 2016, 25,950 out of 54,521 clients

7) As of 2014, there were 65 migrant schools with around 13,000 students. <http://karennews.org/2014/08/migrant-schools-struggle-to-keep-going-as-international-funders-pull-out.html/> (accessed June 18, 2015).

8) The information was obtained from the Facebook page of the clinic.

were from Myanmar (MTC Annual Report 2016: 17). The reason behind this cross-border health care seeking is obvious. “[The] health sector in Myanmar still fails to provide most basic health services for patients. Although the national health budget has increased fourfold for 2012/2013, most of the new budget was for salaries. Health attracts less than 3% of overall government expenditure” (The Lancet 2012: 2313). Life expectancy remains at 56 years and 40% of all Myanmar children under the age of 5 years are moderately stunted. The country has more than half of all malaria-related deaths in Southeast Asia. Furthermore, most health services are concentrated in larger cities although the majority of people live in rural areas. Rural patients often travel to big cities like Yangon but this turns out to be unaffordable. Widespread corruption and a lack of reliable health indicators prevent the development of the health care system (Bangkok Post June 24, 2013). The option for people, in particular in rural areas along the border, is to cross the border to seek health care in the MTC. The clinic is well known all over Myanmar. Even doctors in Yangon recommend that some patients go to the clinic, said a clinic staff member.

The story of a 7-year-old boy Saw Paw Yaw⁹⁾ whom I met in February 2014 exemplifies the trajectory of cross-border health care seeking. He was born with the help of a traditional birth attendant at home in No Nae village, Karen State in Myanmar. When he was a few months old he began to often get sick with fever, coughing, and fatigue, so his parents took him to the medic in their village.

9) I saw him on February 5, 2014 and heard the story from the Burma Children Medical Fund that has an office in the MTC and closely cooperated with it.

The medic did not recognize his condition, and thus Saw Paw Ta Yaw received medication pertaining to the symptoms he presented. However, this did not work and his condition became more serious. He was then sent to a traditional healer for a massage with holy water but this did not help either. In October 2012, his grandmother took him to Pa-an Hospital and he received various checkups. The results showed that he had a heart problem. The doctor at the hospital said that Saw Paw Ta Yaw needed heart surgery but must wait until he grew up and could get surgical treatment in Yangon. In the meantime, his parents left for Bangkok to find better jobs and his grandparents had to take care of him. His symptoms did not improve and hospital costs became unaffordable. When he was next very sick and blue, his grandmother decided to bring him to the MTC. She asked for help to come to Mae Sot as she had to pay for transportation services. When he eventually arrived in the MTC on July 10, 2013, the clinic realized this was a serious case and referred the child to a large hospital in Chiang Mai, where, after an operation, he recovered.

As in the case of Saw Paw Ta Yaw, people inside Myanmar first seek treatment in local clinics and then move to a hospital in a big city. But the lack of hospital facilities, delayed treatment, and unaffordable hospital fee put a great burden on them. In the end, they often decide to cross the border to seek treatment in the MTC. The case highlights the presence of the MTC encourages people who are under domestic structural constraints to practice their mobility across the border.

On the one hand, people in Myawaddy and its vicinity have relatively easy access to the clinic because there are no critical

geographical restrictions on their journey to the clinic. With proper travel documents, they can cross the bridge and get on a bus that frequently operates between the border post and the clinic. Some patients, in particular pregnant women about to give birth, arrange a private car directly from Myawaddy to the clinic. People without legal documents cross the river by boat and get a bus from the pier to the clinic. It is an everyday scene that the front gate of the clinic is congested with buses, motorbike taxis and their passengers. It seems part of everyday practice for people in Myawaddy and its vicinity to cross the border to receive medical treatment at the clinic. The scale of their cognitive and health care seeking extends beyond the state boundary. The presence of the clinic activates and accelerates this transnational patient mobility.

Meanwhile, the MTC regularly sends mobile medical teams inside eastern Myanmar, including to Karen, Mon and Kayah states, and in particular to those areas that international humanitarian organizations cannot reach to provide primary health care. The clinic began sending the teams in 1996 in response to serious humanitarian crises there as a result of increasing attacks from the Myanmar government. It cooperated with many groups of ethnic health workers, and eventually became a cornerstone in forming the Back Pack Health Worker Team in 1998.¹⁰⁾ The mobile medics, after receiving training in the clinic, carry and distribute medicine to internally displaced people inside Myanmar, at times conducting basic operations on the spot. They also provide food and school textbooks (Horstmann 2011: 514). As well

10) See the webpage of the BPHWT. http://backpackteam.org/?page_id=31 (accessed June 22, 2015).

as sending these medics, the MTC has set up a remote clinic, the Pa Hite clinic, in Karen State to which the MTC provides medicines and supplies. At times, the Pa Hite clinic refers serious patients to the MTC.

The MTC has strengthened cross-border health care cooperation among ethnic groups and has offered various types of medical trainings to ethnic medics. They return to their areas after completing the programs and continue to cooperate with the MTC. This interethnic cooperation resulted in the formation of the Health Convergence Core Group in May 2012. The members include Chin, Karen, Kayah, Mon and Shan ethnic health organizations, BPHWT, the MTC, the National Health and Education Committee, and the Burma Medical Association. Through this cooperation, cross-border health care mobility has become strengthened (Health Information System Working Group 2015: 12). All of these activities show that the MTC has been a pivotal player in promoting cross-border mobility among patients and ethnic groups inside Myanmar.

VII. Transnational Partnerships

One day in February 2014, I saw that the eye treatment department was far more crowded with patients than usual. I asked a staff why it was so. He answered, "It is a period for an eye surgeon from Scotland to conduct operations and thus more patients came here. The Scottish surgeon visits the clinic in this period every year." As in this case, many foreign medical volunteers support the clinic. Next

to the eye department, I saw a Taiwanese acupuncturist treating patients. A Korean acupuncturist whom I know of has been working there since 2015. In 2016, there were 27 foreign volunteer doctors working in the clinic (MTC Annual Report 2016: 39). While staying there, they concentrated on conducting operations and, at times, training sessions. Medical students from many countries visit and do internships. In 2016, the clinic hosted medical students from 18 universities from various countries including Australia, the UK, the USA, France, and Sweden (MTC Annual Report 2016: 51).

Above all international partners provide considerable financial support to the clinic. These groups include the International Rescue Committee, USAID, Norwegian Church Aid, Burma Relief Centre, AusAid, Terre Des Hommes - Netherlands, the Open Society Institute, Global Fund for Malaria, and Union Aid Abroad - APHEDA.¹¹⁾ In addition, individual donors regularly or irregularly support the clinic. This financial support from foreign organizations and individuals has empowered the clinic to expand its capacity even under precarious conditions.

Apart from medical and financial support, many foreigners work as technicians, researchers, administrators, and advisors. For instance, foreign volunteers work on annual reports and other reports that are published in English. Others work on public relations, running social network services such as Facebook and the Internet homepage. Apart from volunteers, other foreign visitors including students, journalists,

11) According to the clinic's financial report in 2013, the amount of funding from foreign partners is 106.6 million baht (3,517.8 million won), a dominant revenue source for the clinic.

human rights activists, and others stop by the clinic to see its activities.

What draws particular attention is that foreign Christian missionaries and churches are very active in assisting the clinic. This is partly associated with the fact that the religious background of Dr. Cynthia and many staff, in particular Karen staff, is Christian. Indeed, we can see the widespread influence of Christian missionaries and churches along the border (Horstmann 2011) who, from the early days of the clinic, have engaged in helping displaced people. Above all, missionaries and churches from Asian countries including Korea, Taiwan, Singapore, and the Philippines have strengthened relations with the clinic. Korean missionaries and churches can be singled out as the most conspicuous figures. For instance, a church in Seoul dispatched a missionary whose main work centers on the clinic. He has mediated collaborations between the clinic and Korean churches, delivering assistance and, at times, guiding the summer fieldtrips of church groups to the clinic. His activities are regularly updated and announced among his church members back in Korea.

However, there have been some contentious issues over collaborations with foreign partners. For one thing, different management styles between native staff and foreign volunteers at times become a source of tension and dispute. As the clinic relies on assistance from foreigners, its administration and governance is obviously influenced and constrained by them. Furthermore, it is difficult to coordinate and regularize the engagement of foreigners, who come from various groups and countries. Another issue is that the foreign connection has promoted the exodus of individual medics

in the clinic to a certain degree. I witnessed this in particular, in the mid - 2000s, when a large scale of resettlement programs began to be implemented and many medics departed the clinic. Some individuals may have taken opportunities to restart their lives in foreign countries with the support of foreigners. Obviously, from the clinic's perspective, this represents a drain of human resources although the clinic soon recovered with another group of medics and staff moving from Myanmar. From a different perspective, this shows that transnational flows of resources, including even the exodus to third countries, are part of the constituents of the clinic.

Transnational partnerships have become enhanced as Dr. Cynthia has visited various countries. For instance, she visited Korea to receive Ilga Foundation Award and deliver speeches including the one at Yonsei University at my invitation in September 2015. Before coming to Korea, she visited the USA in March 2015 and delivered at the UCLA Fielding School of Public Health. On this kind of occasions, she has always emphasized the presence of the MTC on the border and its collaborations with partners. Her overseas visits are also intended to promote fundraising. She has received many human rights awards and become a symbol of human rights.¹²⁾ Certainly her fame has contributed to the expansion and consolidation of transnational partnerships.

However, the recent democratization of Myanmar has directed the attention and funding of international organizations away from the

12) This information largely comes from the MTC's website. <http://maetaoclinic.org/> (accessed September 20, 2017) and Facebook page (<https://www.facebook.com/MaeTaoClinic> (accessed September 22, 2017).

clinic and refugees to Myanmar in an expectation that migrants and refugees would return to their home country. For instance, Australia's confirmation that AusAid would not continue its funding shocked the clinic (Karen News November 6, 2013). The clinic has been trying to diversify funding sources and persuade international organizations to keep paying attention to the plight of migrants and refugees. It is now said that the funding crisis of the clinic has been overcome as a result of the combined efforts of the concerned parties.

In the lack or absence of legality and resources, the MTC has made use of transnational partnerships to cope with the state and build up its capacity. The MTC knows how to ride on the wave of global human rights movements that are useful in legitimizing and strengthening its position.

VIII. Conclusion

This study has demonstrated how the MTC has evolved as a conspicuous health care institution over the years in Mae Sot, a Thai border town that accommodates a substantial number of Burmese migrants. Although it started as a humble clinic in 1989 after its founders escaped from political turmoil in Myanmar, it has built up its capacity to deal with over 100,000 cases a year. What particularly draws our attention is that although it is technically illegal, it has become licit, socially legitimate in the local society (Abraham and van Schendel 2005). The recognition of the clinic as a legitimate institution first developed from partnerships with local health care

authorities and the appeal of human rights to Thai officials and politicians. In practice, the clinic benefits many local Thais, and creates job opportunities, which strengthens its licit position in local society. Meanwhile the clinic has developed partnerships with various transnational organizations and individuals, which have become important resources in its finance and operation.

The case of the MTC expands the understanding of migrants' health care seeking in general. Unlike conventional studies that often emphasize the structural constraints of the host society's health care system that discourage migrants' use, this study highlights the agency that migrants have developed in their own health care institution even in the face of structural restrictions. The study also sheds new light on the understanding of transnational patient mobility. While conventional cases concern the return of migrant patients to their origin (e.g., Lee et al. 2010), this study demonstrates the migration of patients in the country of origin to an unauthorized migrant clinic in the host country. The different direction and pattern that this study highlights also prompt us to rethink the association between class and transnational medical mobility in general (Connell 2006 and 2013; Sobo 2009). Cross-border health care mobility is not just the story of affluent patients but is also about less privileged ones. The legitimate presence of the migrant clinic in the border town mediates and strengthens less privileged people's health care mobility across the border. Above all, partnerships with various individuals and organizations that pay attention to the promotion of health as human rights have empowered the clinic to undertake a legitimate role in the border society even in the absence of proper legality.

However, a recent democratization of Myanmar has put the clinic at a critical juncture. Refugees along the border are expected to return to their homes (Reuters July 14, 2014). International donors have begun to focus more on the development inside Myanmar than on assistance to refugees and migrants. The funding crisis that the MTC once experienced reflects the changing political situations in Myanmar. How would the clinic carry on its mission in the face of such crises? The clinic has decided to remain at the border town rather than return to Myanmar. It finds its rationale as a health care institution at the border where it can continue to mobilize and strengthen collaborations with various ethnic, national, and international partners.¹³⁾ As in its history, partnerships are to play important roles in its future. In particular, in the process of regional integration in the name of the ASEAN Community, the clinic is expected to take care of the likely explosion in numbers of migrants (Bangkok Post November 14, 2014). The clinic will continue to be located at the central stage of transnational health care mobility of underprivileged migrants in collective partnerships.

⟨References Cited⟩

Abraham, Itty and Willem van Schendel Willem. 2005. "Introduction: The Making of Illicitness." W. van Schendel and I. Abraham

13) It is manifested in its document named "MTC Strategic Plan 2014 - 18." <http://maetaoclinic.org/wp-content/uploads/2014/10/Mae-Tao-Clinic-Strategic-Plan-2014-20182.pdf> (accessed July 2, 2015).

- (eds.), *Illicit Flows and Criminal Things*. Bloomington and Indianapolis: Indiana University Press. 1-37.
- Adanu, Richard and Timothy Johnson. 2009. "Migration and Women's Health." *International Journal of Gynecology & Obstetrics* 106(2): 179-181.
- Bangkok Post. 2013. "Myanmar's Healthcare System in Critical Condition." June 24.
- Bangkok Post. 2014. "Getting Clean in Mae Sot." January 25.
- Bangkok Post. 2014. "Cynthia Muang Warns of Border Migrant 'Explosion'." November 14.
- Bergmark, Regan, Donald Barr and Ronald Garcia. 2010. "Mexican Immigrants in the US Living Far from the Border May Return to Mexico for Health Services." *Journal of Immigration and Minority Health* 12(4): 610-614.
- Bodeker, Gerard and Cora Neumann. 2012. "Revitalization and Development of Karen Traditional Medicine for Sustainable Refugee Health Services at the Thai - Burma Border." *Journal of Immigrant & Refugee Studies* 10(1): 6-30.
- Brown, Henry S. 2008. "Do Mexican Immigrants Substitute Health Care in Mexico for Health Insurance in the United States? The Role of Distance." *Social Science & Medicine* 67(12): 2036-2042.
- Burma Children Medical Fund. 2012. *Annual Report*. Mae Sot: Burma Children Medical Fund.
- Castañeda, Heide. 2009. "Illegality as Risk Factor: A Survey of Unauthorized Migrant Patients in a Berlin Clinic." *Social Science & Medicine* 68(8): 1552-1560.

- Castañeda, Heide. 2012. "'Over-foreignization' or 'Unused Potential'? A Critical Review of Migrant Health in Germany and Responses toward Unauthorized Migration." *Social Science & Medicine* 74(6): 830-838.
- Chakrabarti, Ranjana. 2010. "Therapeutic Networks of Pregnancy Care: Bengali Immigrant Women in New York City." *Social Science & Medicine* 71(2): 362-369.
- Chavez, Leo R. 2012. "Undocumented Immigrants and Their Use of Medical Services in Orange County, California." *Social Science & Medicine* 74(6): 887-893.
- Chavez, Leo R., Wayne A. Cornelius and Oliver W. Jones. 1985. "Mexican Immigrants and the Utilization of U.S. Health Services: The Case of San Diego." *Social Science & Medicine* 21(1): 93-102.
- Connell, John. 2006. "Medical Tourism: Sea, Sun, Sand and ... Surgery." *Tourism Management* 27(6): 1093-1100.
- Connell, John. 2013. "Contemporary Medical Tourism: Conceptualisation, Culture and Commodification." *Tourism Management* 34: 1-13.
- de Freitas, Cláudia. 2005. "'Health Has No Borders': Cape Verdean Immigrants in the Netherlands and the Transnational Quest for Health Care across Europe." *International Journal of Migration, Health and Social Care* 1(1): 19-36.
- De Genova, Nicholas. 2002. "Migrant 'Illegality' and Deportability in Everyday Life." *Annual Review of Anthropology* 31(1): 419-447.
- Dettlaff, Alan J. and Joan R. Rycraft. 2010. "Adapting Systems of

- Care for Child Welfare Practice with Immigrant Latino Children and Families.” *Evaluation and Program Planning* 33(3): 303-310.
- Glinos, Irene A., Rita Baeten, Matthias Helble and Hans Maarse. 2010. “A Typology of Cross-border Patient Mobility.” *Health & Place* 16(6): 1145-1155.
- Gottlieb, Nora, Dani Filc and Nadav Davidovitch. 2012. “Medical Humanitarianism, Human Rights and Political Advocacy: The Case of the Israeli Open Clinic.” *Social Science & Medicine* 74(6): 839-845.
- Health Information System Working Group. 2015. *The Long Road to Recovery: Ethnic and Community-Based Health Organizations Leading the Way to Better Health in Eastern Burma*. Mae Sot: Health Information System Working Group.
- Holmes, Seth M. 2012. “The Clinical Gaze in the Practice of Migrant Health: Mexican Migrants in the United States.” *Social Science & Medicine* 74(6): 873-881.
- Horstmann, Alexander. 2011. “Ethical Dilemmas and Identifications of Faith-based Humanitarian Organizations in the Karen Refugee Crisis.” *Journal of Refugee Studies* 24(3): 513-532.
- Horton, Sarah and Stephanie Cole. 2011. “Medical Returns: Seeking Health Care in Mexico.” *Social Science & Medicine* 72(11): 1846-1852.
- Huffman, Samantha A., Jaap Veen, Monique M. Hennink and Deborah A. McFarland. 2012. “Exploitation, Vulnerability to Tuberculosis and Access to Treatment among Uzbek Labor Migrants in Kazakhstan.” *Social Science & Medicine* 74(6):

864-872.

- Human Rights Watch. 2007. "Burma: Army and Its Proxies Threaten Refugee Camps." April 14.
- International Organization for Migration. 2013. "Migrant Information Note." Issue #21. September 2013.
- Johnson, Michelle A. and Kristen S. Marchi. 2009. "Segmented Assimilation Theory and Perinatal Health Disparities among Women of Mexican Descent." *Social Science & Medicine* 69(1): 101-109.
- Karen News. 2012. "Abhisit Promises to Push for Education Funding for Border Groups." December 13.
- Karen News. 2012. "Peace Prize Recipient Honoured for Burma Border Clinic: Australia Cuts Her Funding." November 6.
- Karen News. 2016. "International Workers Day Raises Concerns about Equality, Rights and Pay for Burmese Workers." 3 May. <http://karennews.org/2016/05/international-workers-day-raises-concerns-about-equality-rights-and-pay-for-burmes-e-workers.html/> (accessed March 27, 2017).
- Krause, Kristine. 2008. "Transnational Therapy Networks among Ghananians in London." *Journal of Ethnic and Migration Studies* 34(2): 235-251.
- Lee, Jane YeonJae, Robin A. Kearns and Wardlow Friesen. 2010. "Seeking Affective Health Care: Korean Immigrants' Use of Homeland Medical Services." *Health & Place* 16(1): 108-115.
- Mae Tao Clinic. 1989-2016. *Annual Reports. Mae Sot: Mae Tao Clinic.*

- Mae Tao Clinic. 2010. *From Rice Cooker to Autoclave at Dr. Cynthia's Mae Tao Clinic: Twenty Years of Health, Human Rights and Community Development in the Midst of War*. Mae Sot: Mae Tao Clinic.
- Marrow, Helen B. 2012. "Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Healthcare Model." *Social Science & Medicine* 74(6): 846-854.
- Meier, Benjamin Mason and William Onzivu. 2014. "The Evolution of Human Rights in World Health Organization Policy and the Future of Human Rights through Global Health Governance." *Public Health* 128(2): 179-187.
- Mladovsky, Philipa. 2009. "A Framework for Analysing Migrant Health Policies in Europe." *Health Policy* 93(1): 55-63.
- Seo, Bo Kyeong. 2016. "Patient Waiting: Care as a Gift and Debt in the Thai Healthcare System." *Journal of Royal Anthropological Institute* 22(2): 279-295.
- Nation. 2009. "Pradit Floats Idea for a Regional Health Fund." June 15.
- Pavlish, Carol Lynn, Sahra Noor and Joan Brandt. 2010. "Somali Immigrant Women and the American Health Care System: Discordant Beliefs, Divergent Expectations, and Silent Worries." *Social Science & Medicine* 71(2): 353-361.
- Pearson, Ruth and Kyoko Kusakabe. 2012. "Who Cares? Gender, Reproduction, and Care Chains of Burmese Migrant Workers in Thailand." *Feminist Economics* 18(2): 149-175.
- Reuters. 2014. "Thai Junta's Pledge to Send Back Myanmar Refugees Sparks Concern." July 14.

- Sargent, Carolyn and Stéphanie Larchanché. 2011. "Transnational Migration and Global Health: The Production and Management of Risk, Illness, and Access to Care." *Annual Review of Anthropology* 40: 345-361.
- Sobo, Elisa J. 2009. "Medical Travel: What It Means, Why It Matters." *Medical Anthropology* 28(4): 326-335.
- The Lancet. 2012. *Burma: Health and Transition*. 379(9834): 2313.
- Thomas, Felicity. 2010. "Transnational Health and Treatment Networks: Meaning, Value and Place in Health Seeking amongst Southern African Migrants in London." *Health & Place* 16(3): 606-612.
- van Andel, Tinde and Paul Westers. 2010. "Why Surinamese Migrants in the Netherlands Continue to Use Medicinal Herbs from Their Home Country." *Journal of Ethnopharmacology* 127(3): 694-701.
- Viladrich, Anahí. 2012. "Beyond Welfare Reform: Reframing Undocumented Immigrants' Entitlement to Health Care in the United States, A Critical Review." *Social Science & Medicine* 74(6): 822-829.
- Viruell-Fuentes, Edna A., Patricia Y. Miranda and Sawsan Abdulrahim.. 2012. "More than Culture: Structural Racism, Intersectionality Theory, and Immigrant Health." *Social Science & Medicine* 75(12): 2099-2106.
- Wallace, Steven P., Carolyn Mendez-Luck and Xóchitl Castañeda. 2009. "Heading South: Why Mexican Immigrants in California Seek Health Services in Mexico." *Medical Care* 47(6): 662-669.

- Willen, Sarah S. 2012. "Migration, 'Illegality,' and Health: Mapping Embodied Vulnerability and Debating Health-related Deservingness." *Social Science & Medicine* 74(6): 805-811.
- Wolff, Hans, Hans Stalder, Manuella Epiney, Angela Walder, Olivier Irion and Alfredo Morabia. 2005. "Health Care and Illegality: A Survey of Undocumented Pregnant Immigrants in Geneva." *Social Science & Medicine* 60(9): 2149-2154.
- Yan, Wudan. 2016. "Only One Country Offers Universal Health Care to All Migrants." NPR March 31. <http://www.npr.org/sections/goatsandsoda/2016/03/31/469608931/only-one-country-offers-universal-health-care-to-undocumented-migrants> (accessed September 22, 2017).

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<Abstract>

A Migrant Clinic at the Thailand - Myanmar
Border: Legitimacy, Partnerships, and
Cross-border Health Care Mobility

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This study examines how a Burmese migrant clinic in a Thai border town cares for migrant patients and activates cross-border health care mobility. Established in 1989, the clinic has developed its capacity and serves as a prominent healthcare institution across the border. Despite its illegality, Thai authorities recognize its importance and collaborate with the clinic. The study reveals that collaborations with various partners play important roles in the constitution of the clinic. Unlike existing literature on the health of migrants, which concerns structural constraints, the study emphasizes migrants' agency in creating their own health care institution through collective partnerships, shedding light on the cross-border health care mobility of underprivileged patients. The legitimate presence of the migrant clinic in the border town mediates and strengthens their transnational mobility across the border. Partnerships with various individuals and organizations have empowered the clinic to undertake a unique role

in the border society.

Key Words: Mae Tao Clinic, cross-border health care mobility, Thailand-Myanmar border, Dr. Cynthia, migrants

<국문초록>

태국-미얀마 국경지역 미얀마 이주민 클리닉에 관한 연구: 정당성, 파트너십, 초국적 의료 이동성을 중심으로

이 상 국

본고는 태국 국경 도시 매솟에 자리한 미얀마 이주민 클리닉(매따오 클리닉)이 어떻게 이주민들의 건강을 증진하고 초국적 의료 이동성을 촉진하는지 살펴본다. 1989년에 설립된 매따오 클리닉은 비합법적 지위이지만 국경지역에서 독보적인 의료기관으로 성장했다. 태국 당국조차도 지역 사회의 보건 개선에 이바지하는 그 클리닉의 역할과 중요성을 인정하고 있으며 태국 의료기관은 그 클리닉과 협력 관계를 맺고 있다. 본고는 매따오 클리닉이 보건을 보편적인 인권 문제로 내세우고 여러 다양한 파트너들과 긴밀한 협력 관계를 구축했기에 비합법적인 지위를 극복하고 국경지역의 중심 의료기관으로 성장했다고 밝힌다. 나아가 본고는 매따오 클리닉이 열악한 의료 환경 탓에 적절한 치료를 받지 못하는 미얀마 내의 환자들도 돌보는 역할을 하고 있다는 점을 밝히며 초국적 의료 이동성의 새로운 측면을 부각시킨다. 미얀마의 민주화 과정과 지역통합의 움직임 속에서도 매따오 클리닉은 국경지역의 정당한 의료기관으로서 여러 주체들과 파트너십을 강화하고 있으며 그 역할과 기여가 유지되고 있다는 점을 밝힌다.

주제어: 매따오 클리닉, 초국적 의료 이동성, 태국-미얀마 국경, 신시아 마웅, 이주민

