HEALTH AND CARE FOR MIGRANTS AND DISPLACED PERSONS: STRENGTHENING HUMANITARIAN ACTION

ASIA PACIFIC REGIONAL MEETING

6-7 June Kuala Lumpur, Malaysia

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ACKNOWLEDGEMENTS

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Thank you to all Secretary Generals and representatives from National Societies who participated throughout the Meeting, for your time, for your vision and for your dedication to improving the health and care of migrants across the globe. A special thank you to all National Societies who shared their experience of working to address the health needs of migrants and displaced persons: Australian Red Cross; Bangladesh Red Crescent; Brunei Red Crescent; Fiji Red Cross; Indonesian Red Cross (PMI); Italian Red Cross; Korean Red Cross; Maldivian Red Crescent; Mongolia Red Cross; Myanmar Red Cross; New Zealand Red Cross; Pakistan Red Crescent; Qatar Red Crescent; Solomon Islands Red Cross and Swedish Red Cross.

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OVERVIEW

On 6 and 7 June 2017, the IFRC hosted an Asia Pacific Regional Meeting on *"Health and Care for Migrants and Displaced Persons: Strengthening Humanitarian Action"*, in Kuala Lumpur, Malaysia.

The Regional Meeting brought together 71 participants, from 26 National Societies, including 18 National Societies from the Asia Pacific region. The Meeting also brought together a number of migration and health experts from external partner organisations, including from the United Nations High Commissioner for Refugees (UNHCR), International Organisation for Migration (IOM), the International Planned Parenthood Federation (IPPF), the Secretariat of ASEAN, the European Union and the United Nations Population Fund (UNFPA). The Meeting was also supported by the technical expertise of IFRC and ICRC colleagues from across the Asia Pacific region, and from Geneva.

The Regional Meeting provided the first opportunity for Red Cross Red Crescent practitioners and experts from the fields of migration and health to come together, to share experiences, best practices, challenges and to chart a common way forward for addressing the critical health needs of migrants and displaced persons across the region.

The aims of the Regional Meeting included:

1. To share best practices from National Societies from across the Asia Pacific region in addressing the health needs of vulnerable migrants;
2. To understand the perspectives of Partner organisations, including perspectives on emerging trends and how best to work together;
3. To develop effective humanitarian diplomacy skills, particularly relevant to discussions around health and care for migrants and displaced persons;
4. To raise awareness of existing tools and initiatives to support National Societies to address the health needs of migrants; and
5. To discuss the challenges and opportunities around Red Cross Red Crescent action and programmes to address the health needs of migrants.

Overall, participants responded very favourably that the Regional Meeting met their expectations (97.5 %) and addressed the topics that they wanted to be covered (97.5 %). The most valued sessions during the Regional Meeting were the sharing of experiences by National Societies, and the workshop on Humanitarian Diplomacy in Action.

BACKGROUND

We are living in the age of migration. There are more migrants on the move today than ever before. The United Nations estimates that there are currently 1 billion migrants across the world. Approximately 250 million of these migrants have crossed an international border and 763 million have moved within their own country. This also includes 65.6 forced migrants – refugees, asylum seekers and Internally Displaced Persons (IDPs) - the highest number recorded since World War II. An additional 26 million persons are newly displaced each year by disaster, a number projected to rise as the impacts of climate change intensify.

In the Asia Pacific region, human mobility is dynamic and diverse. The region includes major countries of origin, transit, destination and return. The region hosts a quarter of all international migrants and almost a third of all international migrants globally originate from the Asia Pacific region. The Asia Pacific region hosts large numbers of irregular migrants, stateless migrants, refugees, Internally Displaced Persons (IDPs) and there are significant concerns related to people smuggling, bonded labour and human trafficking. Increasing human mobility trends in the region are linked to urbanisation and climate change.

Many migrants across the world thrive in their new communities and bring critical economic, societal and cultural benefits to their communities of origin and their new homes. In the words of the former United Nations Secretary-General, Ban Ki-Moon:

However, many other migrants face considerable humanitarian challenges – including abuse, violence, discrimination, exploitation, formal and informal barriers to accessing basic services, lost family, community and social connections, the fear and reality of arrest and detention and an inability to access protection and justice. These humanitarian concerns are often amplified for particularly vulnerable migrants, including women, unaccompanied and separated children, the elderly, marginalised ethnic and other groups and migrants with disabilities.

One of the key humanitarian concerns for many migrants, including in the Asia Pacific region, is the ability to live and work in safe and healthy conditions and to enjoy access to health services and expect health outcomes similar to that of the rest of the population.

In the Asia Pacific region, health concerns for migrants may arise at all points of the migratory journey. *Prior to departure*, migrants fleeing persecution may have faced or experienced trauma, war, human rights violations, torture or sexual violence. This can have a profound and lasting impact on the physical and mental health of many migrants. *During the migratory journey* – especially irregular journeys – health needs may arise due to the mode of travel, the duration of the journey and as a result of any traumatic events. For example, during the 2015 Andaman Sea crisis, many of the migrants experienced acute health needs, including beriberi, dehydration and severe malnourishment. *In countries of transit and destination*, health concerns may arise because of abuse, violence, exploitation, inadequate working conditions, inadequate living conditions, poor nutrition, sexual violence or as a result of the conditions of immigration detention.

Often, these health vulnerabilities are compounded by formal and informal barriers to accessing health services. *Formal barriers* include legal and policy restrictions on migrants accessing health services – especially for irregular migrants. *Informal barriers* may include cost, awareness, language or cultural barriers, including pre-existing health beliefs and practices or the fear of arrest and detention if migrants make themselves known at health facilities.

There are many diverse and strong examples of National Societies across the Asia Pacific region working to meet the health needs and vulnerabilities of migrants – in countries of origin, transit, destination and on return – and with Internally Displaced Persons (IDPs), persons who have been trafficked, refugees, asylum seekers, irregular migrants and labour migrants.

In this context of significant health need and vulnerability for migrants and in an environment of both informal and formal barriers to effective health and care, this IFRC Asia Pacific Regional Meeting highlights the existing strong practices of National Societies in addressing the health and care needs of migrant and displaced populations. The Meeting focuses on the challenges that have been faced by National Societies and migrant communities, the lessons learned and the strengths of the Red Cross Red Crescent Movement. The overall aim of the Meeting was to capture and maximise the individual and collective strength of the Red Cross Red Crescent Movement in addressing critical humanitarian needs linked to health and care for migrants and displaced persons.

PARTICIPANT LIST

Name	Job Title	Organisation
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Jessica Van Son	Secretariat, Asia Pacific Migration Network (APMN)	Australian Red Cross
Michael Kunz	National Program Coordinator, Immigration Detention Monitoring Program	Australian Red Cross
Vicki Mau	National Manager, Migration Support Programs	Australian Red Cross
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Justin Dell	Country Manager of Afghanistan and Pakistan, ASIA Region	British Red Cross
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Day 1: MIGRATION, HEALTH AND HUMANITARIAN ACTION IN ASIA PACIFIC

I. OPENING OF REGIONAL MEETING BY DATO' SAYED A. RAHMAN SAYED MOHD, SECRETARY GENERAL, MALAYSIAN RED CRESCENT SOCIETY AND XAVIER CASTELLANOS, DIRECTOR, IFRC ASIA PACIFIC REGIONAL OFFICE

Dato' Sayed A. Rahman Sayed Mohd, Secretary General, Malaysian Red Crescent Society

Dato' Sayed welcomed all participants to Malaysia and to the Regional Meeting on Migration and Health. Dato' Sayed reflected on the importance of migration in the 21st Century, where it continues to play a critically important and defining role, particularly across the Asia Pacific region.

Dato' Sayed provided a positive reminder of the strength of the Red Cross Red Crescent Movement and emphasised that throughout the meeting participants should not delve too deeply into the academic slant of migration, but to focus more on the instruments and mechanics of addressing the challenges faced by migrants, be they at the local, regional or global level. Dato' Sayed emphasised that the "how, what, where and when" of addressing the health and care of migrants was the appropriate and challenging focus of the meeting.

Xavier Castellanos, Asia Pacific Regional Director, IFRC Asia Pacific Regional Office

Xavier Castellanos gave a welcoming address to all participants on behalf of the International Federation of Red Cross and Red Crescent Societies (IFRC). Mr Castellanos, emphasised that National Societies, the IFRC and external partners should always place dignity at the centre of humanitarian action for migrants. Mr Castellanos noted that dignity was often a forgotten or underemphasised word – and asked participants to positively reflect on whether we can truly claim that the people we assist are living with dignity?

Mr Castellanos also emphasised that one of the greatest strengths of the Red Cross Red Crescent Movement is our presence in 190 countries and at all stages of the migratory route. Mr Castellanos noted that a critical component of this is cooperation amongst National Societies – at the national level, at the regional level, but also, importantly, at the branch level. Mr Castellanos called on all components of the Movement to help strengthen Red Cross Red Crescent cross-border cooperation, including strengthening humanitarian action at the branch level.

II. SETTING THE SCENE: MIGRATION, DISPLACEMENT, HEALTH AND CARE IN ASIA PACIFIC

Why Are We Concerned About Health and Care for Migrants and Displaced Persons?

Ezekiel Simperingham, Asia Pacific Migration Coordinator
IFRC Asia Pacific Regional Office

The Asia Pacific Migration Coordinator provided a broad overview of current and emerging trends, challenges and dynamics related to health and care for migrants and displaced persons. Zeke noted that there are more people on the move than at any other point in recorded human history, and that migration, including forced migration, would continue to be one of the defining features of the 21st century.

Zeke highlighted that the Asia Pacific region has major countries origin, transit, destination and return –and that migratory flows and "people on the move" in the region can be characterised as both dynamic and diverse. The region has large numbers of migrants (approximately 60 million who have crossed international borders) and a considerable impact on global migration trends (a third of all migrants globally come from the Asia Pacific region).

The Asia Pacific Regional Migration Coordinator highlighted that many migrants in and from the region bring important social, economic and cultural benefit to their families, their host communities and to themselves. However, Zeke also emphasised the humanitarian challenges that many other migrants face – including but not limited to - forced migrants (IDPs, refugees, asylum seekers and persons who have been trafficked), irregular migrants, stateless migrants and those who have been trafficked. These humanitarian needs include abuse, violence, discrimination, exploitation, formal and informal barriers to accessing basic services (including health, livelihoods and shelter), lost family and community connections, the fear and reality of arrest and detention and an inability to access protection and justice. One of the key concerns of many migrants is the ability to effectively access basic health and care services.

Health Needs and Access to Essential Services for Migrants

Dr. Oyungerel Amgaa, Asia Pacific Health Coordinator,
IFRC Asia Pacific Regional Office

Dr Gerel highlighted that migrants should be able to live and work in safe and healthy conditions, enjoy access to health services and expect health outcomes similar to that of the rest of the population. However, migrants by virtue of their mobility and status can be at risk of being invisible, deprioritised or even excluded from national health strategies, programmes and care. The physical and mental health vulnerabilities and needs of migrants in the Asia Pacific region can arise at all stages of the migratory journey – in countries of origin, transit, destination and return. The health, including mental health, of families left behind is also a concern.

Gerel emphasised the humanitarian health concerns related to exploitation, trauma and mental health needs and a lack of access to health services. In all our work to address the health and care of migrants, Gerel emphasised that we need to pay special care to particular vulnerable migrants, including women, children, persons with disabilities, older persons and those who have faced torture and exploitation. Gerel then addressed some common key barriers faced by migrants to effectively access public health systems, including discrimination, legal and policy barriers; financial and cultural barriers, including language. Gerel highlighted that those migrants who move within their own country also may face exclusion or barriers from effectively accessing public and emergency health services.

Gerel emphasised that migrant health is a major concern, not just for the individuals, but for our aspirations to achieve Universal Health Care (UHC) and to leave no one behind, in line with the aspirations of the Sustainable Development Goals.

Gerel concluded by emphasising that, in order to effectively tackle this challenge, we need collective leadership and vision; integration with national service delivery systems and health care financing; multi-sectoral coordination and coherence of policies; inter-country collaboration; engagement of migrants; migrant and refugee sensitive health services; engagement with other health providers and connection between short-term (humanitarian) and longer-term approaches.

The Approach of the Red Cross Red Crescent Movement: International Committee of the Red Cross

Cornelius Brueser, Asia Pacific Regional Migration Officer, ICRC

Leo emphasised that the approach of the Red Cross Red Crescent Movement is always centred on our Fundamental Principles. This means that we take a deliberately broad approach to "Migration", including all persons based on vulnerability, focused on their needs rather than on their legal status.

The ICRC focuses its response to the needs (Protection and Assistance) of migrants in areas where it has an added value, namely Restoring Family Links (RFL) and "missing" migrants, including in forensics and human remains; immigration detention; the protection of migrants (including *non-refoulement)* and primary healthcare.

The ICRC works with the Red Cross Red Crescent Movement in a coordinated and complementary way to support National Societies with Restoring Family Links (RFL) services; financial support; regional meetings and Global Implementation Group as forums for exchange of information and best practices; participation in Global Compacts together with IFRC and National Societies and in confidential dialogue with relevant authorities.

III. HEALTH AND CARE IN THE CONTEXT OF LARGE SCALE POPULATION MOVEMENT

ROOM 1 Facilitators:

Kym Blechynden, Regional Emergency Health Coordinator, IFRC Asia Pacific Regional Office; and Thomas Thorhauge, Migration Surge Delegate, IFRC Bangladesh Country Office

Bangladesh Red Crescent Society (BDRCS): Population Movement Operations in Cox's Bazar for Rakhine Muslim Community

A K M Mohsin, Assistant Director & Migration Focal Point, Restoring Family Links (RFL) Department

AKM Mohsin began by noting that during the last quarter of 2016, violence in the northern part of Rakhine State in Myanmar led to displacement which resulted in mass cross-border population movement to Cox's Bazar District in Bangladesh. To date, approximately 70,000 people, all Muslims from Rakhine, are reported to have crossed into Bangladesh. Mohsin noted that population movements are not a new event in this region. Hundreds of thousands of persons have been displaced from Myanmar into Bangladesh over the past three decades, particularly to the coastal upazilas (sub- districts) of Teknaf and Ukhiya in Cox's Bazar District where they have lived either as "registered refugees" or without formal legal status.

It was noted that the displaced population is divided into three categories: (1) "Muslims from Rakhine" New Influx (2) "Undocumented/ Unregistered Muslims from Rakhine" and (3) "Registered Refugees". The BDRCS response to new influxes of Rakhine Muslims has included food distribution; distribution of NFIs; health services and Restoring Family Links (RFL).

As part of health support, BDRCS has provided mobile clinics and trained 25 volunteers on Psychosocial Support. Under RFL, BDRCS has 5 teams mobilised to provide phone calls, notification/ 'safe and well' message collection; tracing requests and a separated child/UAM list collection.

People reached to date include: 9,116 patients through the mobile medical team; 2,000 families (10,000 persons) with 4,000 blankets and 2,000 jerry cans; 5,200 households (25,000 persons) received food distribution; 601 tracing requests and 185 SC/ UAMs list collected and successfully connected 200 families through phone calls and 'safe and well' messages; 15,313 families (more than 76,000 persons) with food and Non Food Items (NFIs). Current activities include: mosquito net distribution; setting up of BDRCS office; warehouse set up; hiring of new staff and participation in inter-agency coordination meetings.

Indonesian Red Cross (PMI) Human Services for Migrants in Indonsia (Andaman Sea Crisis)

Andreanne Tampubolon, Head of Restoring Family Links Sub Division

Andreanne began by noting that in May 2015, during the Andaman Sea Crisis, 561 migrants from Myanmar and Bangladesh arrived in Aceh, Indonesia, including 457 men, 81 women and 23 children. Government institutions, NGOs, INGOs and the Indonesian Red Cross provided basic assistance to the migrant arrivals.

Andreanne provided an overview of the field experience of Indonesian Red Cross, including noting their experience and coordination with Government, NGOs and other stakeholders. As part of the response to the Andaman Sea Crisis, the Indonesian Red Cross provided 20 baby kits; 80 family kits and deployed three doctors, seven paramedics and provided psychosocial support and Restoring Family Links (RFL) services for the new migrant arrivals.

Andreanne noted that lessons learned from the response included: the importance of building and maintaining a trusted relationship with the Government; the importance of maintaining access to vulnerable migrants; the challenge of language barriers in working with migrants; legal and regulatory barriers related to receiving support from internationally deployed interpreters and the need to manage technical disruptions, including to the phone network, as a crucial part of providing Restoring Family Links (RFL) services.

Italian Red Cross: The Migration Crisis and Italian Red Cross Response

Francesco Sofia, Regional Delegate, Asia Pacific

Francesco began by providing a historical overview and perspective on the number of migrants arriving in Italy by sea between 1997 and 2016. In 2016 and 2017 this number increased considerably. Francesco also highlighted that a number of unaccompanied minors were included in the sea arrivals to Italy. Francesco provided an overview of the reception system for migrant arrivals in Italy, including the process of migrants applying for asylum. Francesco noted the engagement and support provided by the Italian Red Cross throughout this process.

Francesco then highlighted some of the key aspects of the Italian Red Cross migration response including the MOAS (Migrant Offshore Aid Station), a Malta based foundation that has had an agreement with the Italian Red Cross (since June 2016) to provide search, rescue and health assistance to migrants at sea.

The Italian Red Cross provides two post rescue health teams on the Phoenix and Responder vessels, including provision of water, food, blankets and clothes to rescued migrants.

Francesco then discussed the “Praesidium” project which has operated on Lampedusa island since 2005 and is funded by the Italian Government. Francesco noted that the project has now been extended to all of Southern Italy and provides reception centres, first assistance after rescue and short term reception.

In the mixed migration flows that reach Italy, there has been a multi-agency approach, including IOM, UNHCR, Save the Children and the Italian Red Cross. In that multi-agency context, the Italian Red Cross focuses on first aid, food, water, NFI, and on the first phases of PSS, hygiene and prevention, RFL and health assistance.

The Italian Red Cross also has long term assistance programmes, which include 8 centres managed at the national level and more than 70 projects managed at the branch level. These include SPRAR (Protection System for Asylum Seekers and Refugees) and CAS (Non-Ordinary Reception Centres).

Services provided by the Italian Red Cross in the longer-term centres include cultural and linguistic mediation; first aid training; material assistance; information on access to NHS; vocational training; PSS, RFL, counselling and guidance for employment and Italian language classes.

Francesco concluded by noting that the main challenges the Italian Red Cross faces include creating and maintaining standards in a saturated system; strengthening anti-trafficking and protection services; division among EU members on relocation and a context of polarised national debate on the issue.

ROOM 2 Facilitators:

Phil Brewster, Migration Delegate, IFRC Myanmar Country Office; and Ritva Jantti, Health Programme Manager, IFRC Myanmar Country Office

Pakistan Red Crescent: Impact of Migration on Health (A Pakistan Red Crescent Perspective)

Dr. Babar Khan Jadoon, Provincial Health Manager

Dr Babar provided introductory remarks on the context of Pakistan, noting that there are large numbers of Internally Displaced Persons (IDPs) / Temporary Displaced Persons (TDPs) who are those individuals who are forced to flee their residences but remain within their nation's borders as a result of armed conflict, militancy or natural disaster. Dr Babar noted that between 2007 and 2014 there have been a series of large scale major displacements within Pakistan, affecting approximately 5 million persons. These displacements have occurred both as a consequence of military operations and disasters.

The humanitarian needs of the displaced populations are often considerable and are marked by low resilience; living below the poverty line; low literacy; unskilled/low earning capacity; exposure; safety and security; disasters and cultural constraints. Dr Babar also highlighted that host communities also face the humanitarian consequences of displacement, including a weak economy; poor infrastructure; limited resources; insufficient services; water and sanitation (WASH) and health needs; limited education; disasters and safety and security concerns.

In responding to large scale displacement, the Pakistan Red Crescent operates in a complex environment, including low resilience of the displaced population; low resilience of the host communities; an environment of often extreme weather conditions; cultural constraints to humanitarian action; limited resources and services; and ongoing risk of disaster and safety and security considerations.

Dr Babar provided an overview of the Pakistan Red Crescent response to displacement, including in IDP relief operations (from 2009 to 2012) in 11 camps run by the Pakistan Red Crescent. In this context Pakistan Red Crescent provided health, WASH, food and Non Food Items (NFIs) for 266,000 individuals. IDP relief operations (from 2010 to 2013) in Hangu Camp included Pakistan Red Crescent support for 45,000 persons.

Temporary Displaced Person (TDP) relief operations (from 2014 to 2017), included Pakistan Red Crescent emergency response and health services within TDP camps. Dr Babar then provided a detailed overview of the Pakistan Red Crescent health response to over 200,000 TDPs in 2014, including the support of Mobile Health Units and Static Health Units. At Bhaka Khel TDP camp, PRCS provided quality curative and preventive health care services, including 24-hour emergency services, health and hygiene promotion and ambulance referral services.

These health services for TDPs were extended upon the request of authorities. Between 2015 and 2017, at the Bhaka Khel Field Health Unit, the Pakistan Red Crescent has provided health support to over 164,000 persons, of whom 58.5% were children; 26.2% were female and 15.3% were male. Major achievements by the Pakistan Red Crescent include controlling an outbreak of measles; controlling an outbreak of diphtheria; and controlling an outbreak of dysentery.

Myanmar Red Cross: Promotion of Community Assistance of People with Specific Needs in Areas Affected by Displacement Southeastern Myanmar Project (MRCS/UNHCR) and Myanmar Red Cross Migration-related activities

Dr. Saw Ni Tun, Project Director, South East Community Support Project

Dr Saw Ni Tun began by providing an overview of Myanmar Red Cross engagement in migration/displacement contexts, including in Rakhine State (where services include First Aid, community mobilisation, shelter, health facilities, health promotion, mobile clinics, water and sanitation (WASH) and livelihood cash grants); Kachin State (where services include livelihood cash grants for Internally Displaced Persons (IDPs) in camps, disaster preparedness, health and livelihood cash grants for vulnerable people in host communities); Southeastern Myanmar (where services include IDP and refugees return monitoring, refugee reintegration through livelihoods, community governance support and training, access to healthcare, water and sanitation (WASH), disaster risk reduction and social cohesion); ICRC-supported programmes (Mine Risk Education (MRE), Restoring Family Links (RFL) and physical rehabilitation); and indirect programmes (Community Based Health and First Aid (CBHFA), Community Based Disaster Preparedness, Community Based Health and Resilience, Urban DRR, health systems strengthening, Maternal Child Health, and water and sanitation (WASH)).

Dr Saw provided an overview of the context in Southeastern Myanmar, noting that after 6 decades of conflict, in January 2012 the Karen National Union (KNU) entered into a ceasefire agreement with the Government; there are currently 102,000 refugees living in 9 camps along the Thailand border; there are up to 400,000 IDPs; an estimated 4 million undocumented Myanmar migrants, with concerns related to people smuggling and human trafficking. Dr Saw note that in this context, community structures have been fractured, and there is the pervasive presence of landmines.

Myanmar Red Cross has been UNHCR's implementing partner for Southeastern Myanmar since 2014. The aim of the Myanmar Red Cross/ UNHCR project has been to mitigate the effects of conflict and displacement on communities and prioritise the needs of potential returnees and other persons of concern – including those who are socially, economically marginalised and suffer low access to basic services, particularly health and education. Achievements of the project over the past 13 years have included, working in over 1,000 villages through a community based approach; the training of over 17,000 community volunteers in health, life skills, first aid, Mine Risk Education, WASH, psychosocial support (PSS) and violence prevention; 78,000 persons receiving peer education; 79 rural health sub-centres constructed and 93 primary schools, with 212 school latrines; Mine Risk Education and medical assistance to more than 7,000 mine survivors.

In the context of refugee return and IDP assistance, Dr Saw noted: return monitoring is one of the key activities of the Myanmar Red Cross in the Southeast; there have been over 10,000 spontaneous returns to date; the first group of refugee returns occurred in October 2016 and the second group is scheduled for 2017; reintegration support for facilitated returns has been provided, including small scale livelihoods projects, homestead gardening and livestock breeding.

Dr Saw concluded with "food for thought": including the need to integrate migration/displacement issues into health and resilience programmes; promote safe labour migration and raise awareness on dangers of irregular migration; further integrate protection issues into work with displaced populations – including gender based violence (GBV), child protection and human trafficking and to assess the capacity of Myanmar Red Cross to support durable solutions for IDPs and refugees.

Mongolia Red Cross: Cross-Border Project in Mongolia - STI/HIV Prevention Among Mobile Population and Most at Risk Population

Dr. Gantulga Batbyamba, Health Promotion Team Leader, Mongolian Red Cross

Dr Gantulga provided an overview of the "Sexually Transmitted Infections (STI)/HIV prevention among mobile and most at risk population" project, noting that the project aimed to decrease risks of STI/ HIV prevalence among youth, female sex workers, mobile populations and people living in cross border areas by conducting activities to change their behaviour. The first objective of the project was to improve provision of Sexual Reproductive Health (SRH) and STI/HIV prevention services among youth, female sex workers, mobile population and people living at cross border areas. The second objective was to improve the provision of Sexual and Reproductive Health among youth in cross border towns and major cities in the country. The Mongolia Red Cross focused on (1) mobile populations, including people living and working in remote areas, particularly in the mining industry, road construction, cargo transportation as well as small traders at cross border towns and (2) Female sex workers) (FSW) in Erlian city, China.

The project implementation strategy included five features: (1) information and education; Information, Education, Communication (IEC) material distribution; STI/HIV prevention awareness sessions; voluntary counselling; peer to peer education; advocacy to local authorities; (2) promotion of Voluntary Counselling and Testing (VCT); cooperation with the National Center of Communicable Disease, cooperation with local health centers, conducting of mobile VCT at Erlian city and other project sites; cooperation with private clinics in Erlian City; counselling and course treatment; provision of female and male condoms and (5) monitoring.

Dr Gantulga noted that the project reached over 100,000 persons during the 2012-2016 implementation period; including 31,000 youth; 67,000 mobile population; 3,300 female sex workers and 6,800 people involved in mobile Voluntary Counselling and Testing (VCT).

Challenges related to the project included: difficulties monitoring outcomes because of the mobility of the target population; problems relating to permission to conduct VCT activities (doctors, license etc); the transport of IEC materials and medical supplies across the border from Mongolia to China and a lack of funding to sustain the project.

IV. HEALTH AND CARE IN COMMUNITY AND DEVELOPMENT WORK

ROOM 1 Facilitators

Gopal Mukherjee, Health Programme Manager, IFRC Philippines Country Office; and Helen Brunt, Senior Migration Office, IFRC Bangkok Country Cluster Support Team

Brunei Red Crescent: Health an First Aid for Labour Migrants

Sheikh Kadir Abdullah, Secretary General

The Secretary General of Brunei Red Crescent noted that Brunei is a tiny kingdom in Asia. Brunei relies heavily on foreign labour in lower-skill and lower-paying positions, with approximately 120,000 Labour Migrants brought in to fulfil work in construction, followed by wholesale and retail trade and then professional, technical, administrative and support services. Most unskilled labourers in Brunei are from Bangladesh, India, Indonesia, Malaysia, and the Philippines.

The Secretary General noted that Brunei Red Crescent provides (1) First Aid training, knowledge and skills and (2) health and safety awareness. The target groups for these programmes are construction labourers, maids and elderly care assistants, and nannies and childcare assistants.

Brunei Red Crescent emphasises safety in the workplace, which is an important issue due to lack of proper training or experience; especially to new workers who are not familiar with the workplace hazards (experienced workers tend to have less injuries). Workers also do not often know their legal rights; although all workers have legal rights in Brunei including the right to protect their health and safety. Often migrant workers are afraid to ask questions, to appear incompetent or “rock the boat” at work. Migrant workers have the right to know about dangers in the workplace; induction training; on the job training; work supervision; hazard information.

The Secretary General emphasised the shared responsibility between employer and employee for health and safety. For the employer: establishing a health and safety policy and programme; providing adequate training (HSSE, Occupational First Aid and CPR); providing not only information, instructions and supervision; but also the necessary safety equipment; and information on hazards in the workplace; displaying important HSSE information; keeping employee health and medical records. For the employee: obeying the law; using machines and equipment safely; wearing personal protective equipment; reporting hazards; working safely at all times and “not to fool around on the job”.

Brunei Red Crescent has provided free First Aid and CPR training to labour migrants since 2015. Brunei Red Crescent also provides occupational First Aid and basic cardiac lifesaving training. This is important because First Aid and CPR are rarely taught in the workplace; having trained employees can make a substantial difference to a safe work environment; employees will be able to respond more effectively (and quickly) when medical emergencies occur; employees will become more prepared and responsive, as well as more aware of their surroundings and likely to spot potential hazards.

Brunei Red Crescent also provides health awareness on non-communicable diseases, including hypertension, diabetes, heart attacks, cardiac arrests and cancer; as well as outbreak diseases.

Qatar Red Crescent: Foreign Worker's Health Services

Dr Daoud Al Bast, CEO Medical Affairs Division

Dr Daoud Al Bast began by noting that Qatar is one of the most rapidly growing economies in the Middle East due to the huge projects received for hosting World Cup 2022. These projects require a huge number of male workers, mainly in the construction sector. These workers make up 60 percent of Qatar's population. Currently, Qatar Red Crescent Medical Affairs Division manages four (three plus one) health centres that provide medical services to single male workers in Qatar for free, and are distributed among areas that cover most of the worker's presence.

These centres provide: medication; internal medicine clinic; chronic diseases clinic; ophthalmology clinic; Ear Nose and Throat (ENT) clinic; dermatology clinic; cardiology clinic; respiratory disease clinic; dental clinic; Physical Therapy Department; public clinics; minor surgery; bandaging section; radiology and ultrasound section; medical laboratories; urgent and emergency case care; pharmacy; social reform section and a health education and awareness section.

During 2016, more than 625,000 patients were reached by Qatar Red Crescent services. Since 2012, a total of more than 2 million persons have received health support and services by Qatar Red Crescent. The primary countries of origin for patients are India, Bangladesh, Nepal, Sri Lanka and Pakistan.

The Doha Specialised Health Centre is currently under construction and will be used for chronic diseases that are currently distributed among the other Qatar Red Crescent centres. There will be an estimated 10,000 visits per month at the new centre.

Medical Commission Units provide their services to expatriate workers, both male and female, where in order to obtain a residence permit in Qatar, Medical tests are done. Qatar Red Crescent Medical Commission Units served 109,403 migrants in 2016. Medical specialties and services provided by Medical Commission Units include: chest scan to detect Tuberculosis; laboratory blood test to detect HIV; laboratory blood test to detect Hepatitis (B&C).

Ambulance and Emergency Medical Services are also provided by Qatar Red Crescent, including to workers through contracts with companies, institutions and Sports Federations in Qatar. Qatar Red Crescent provides health education, training and development, including: Continuing Medical Education courses; First Aid and CPR courses and Marine Rescue Course (Life Guard CPR).

Qatar Red Crescent maintains an ERU – Rapid Medical Intervention Unit. The ERU is an international unit that has the ability to be deployed to any place within 72 hours and works self-sufficiently for up to one month, with no external resources. It can continue to work for up to 4 months. The ERU can be deployed as a medical intervention unit as a primary health care centre and as a field hospital.

Maldivian Red Crescent: Health and Care for Migrants

Aishath Noora Mohamed, Secretary General

The Secretary General of the Maldivian Red Crescent provided an overview of migration in the Maldives, including that migrants make up 16% of the country's population; 60 percent of migrants are in unskilled labour, with many becoming irregular after they arrive. Housing and work conditions often make migrants vulnerable to communicable diseases and Non Communicable Diseases (NCDs). Migrants are often blamed for overall hygiene and disease spread. All employers in the Maldives are required to take a minimum health insurance coverage for their foreign employees, but this covers very minimal services (outpatient consultations only). Irregular migrants, without proper identification, do not get health services at the Government-run hospitals.

The Secretary General noted the experience of Maldivian Red Crescent, a young National Society, with a strong legal base (emphasising independence and the auxiliary role of the National Society) and a positive perception among the public and partners. The Maldivian Red Crescent is one of the few organisations that accepts foreign members and volunteers, and has strong principles of non-discrimination.

Examples of Maldivian Red Crescent health support for migrants include Dengue Awareness: disseminating information on how to prevent mosquito bites and providing information on preventing flu. The Maldivian Red Crescent also provided psychosocial support (PSS) for the Nepali community after the 2015 Nepal Earthquake. The Maldivian Red Crescent set up a tent in a public park in the capital Malé in the evenings. Members of the psychosocial support (PSS) team and Nepali translators were available to talk, and PSS materials in Nepali were handed out. A telephone hotline was also set up for those who were not able to come or did not want to seek support at the tent. Through a partnership with IOM, the Maldivian Red Crescent trained volunteers, including those from migrant communities, in health, hygiene and various communicable diseases. In 2016, the Maldivian Red Crescent held a "Celebrate Diversity" event, to commemorate International Migrants Day.

The Secretary General highlighted some achievements, including that Government agencies have recognized migrant health as a priority, alongside the current and potential contributions of the Maldivian Red Crescent; that the Maldivian Red Crescent has developed a small, reliable pool of volunteers from various nationalities; that volunteers and leadership of Maldivian Red Crescent have recognized the need for special programmes focused on migrant health; and that governance sub-committees have been formed for migrant health programmes and services oversight.

The Secretary General concluded by noting that the way forward for Maldivian Red Crescent includes increasing migrants among the volunteer base and increasing skills among volunteers; launching a Health and Wellbeing programme to improve the lives of vulnerable persons, including migrants; strengthening partnerships with likeminded agencies, including the Health Protection Agency and National Drug Agency.

Indonesian Red Cross (PMI): Psychosocial support for Returning Labour Migrants

Leo Pattiasina, Head of Psychological Support Programme Sub-Division

Leo began by providing background, including that in 2014, the Indonesian Red Cross and the Indonesian Government Department for Overseas Workers (BNPT2KI) signed a on support for Overseas Indonesian Workers, which included preparation for migration (capacity building) and support on return, including rehabilitation, psychosocial support (PSS) and health services.

Leo noted that some migrant workers return with success stories, and some return with sad stories and for whom PSS is critical. Some of the concerns reported by returning labour migrants included: torture; sexual harassment; work accidents; unilateral termination and unpaid salary.

Leo highlighted that in general, very little PSS is provided to returning labour migrant, despite the high needs. This leads to a number of returning labour migrants experiencing trauma; shame and guilt; social withdrawal and a lack of trust.

Indonesian Red Cross support to returning labour migrants includes psychosocial support (PSS) through support group sessions. Indonesian Red Cross also provides psychoeducation to family members to increase knowledge about stress and reactions.

Future plans of Indonesian Red Cross for PSS support to returnee labour migrants include long term community based psychosocial support; intervention at the village level, involving all components of the community; partnerships, with local communities, Government, NGOs, community leaders; training local volunteers; providing direct psychosocial support to migrant workers; raising awareness at family and community level and direct health services, including clinics, ambulances, and the skills of a professional psychologist and finally, to establish effective referral pathways.

ROOM 2: Facilitators:

Lasha Goguadze, Senior Health Officer, IFRC Geneva; and David Stephens, Health Practice Lead, Australian Red Cross

New Zealand Red Cross: Trauma Support and Recovery

Rachel O'Conner, Head of National Refugee Programme

Rachel provided an overview of the main New Zealand Red Cross programmes supporting migrants (including refugees), including: Pathways to Settlement; Family Reunification; Pathways to Employment and Refugee Trauma Recovery.

The Refugee Trauma Recovery programme aims to "improve resettlement outcomes including wellbeing" and "to work to ensure equitable mental health services nationally for former refugees". The programme addresses the need of some former refugees who have experienced torture and trauma issues, often prior to arriving in New Zealand and including as a result of the persecution experienced or feared by refugees, the refugee journey, or related to resettlement issues.

Rachel emphasised that torture, trauma and multiple loss can be considered a normal reaction to an abnormal situation for survivors of torture, trauma and abuse; due to resettlement stress; the impact on children in particular and the loss of status, identity, health, property, land and possessions.

Rachel noted that New Zealand Red Cross does not work with acute mental health issues including psychotic illness. People in acute, critical conditions and at high risk of self-harm and harm to others will be referred to crisis intervention teams; alcohol and drug problems; and domestic violence and other marital issues unless they are clearly the consequence of torture and trauma.

A bio-psychosocial approach is taken, including community development projects; counselling and body work. The programme also includes clinical and non-clinical interventions, including: screening; assessment; treatment; community care coordination; onward referral; consultation and liaising; advocacy and public education and community development. The staff supporting the Refugee Trauma Recovery programme include: counsellors, social workers, psychologists, a psychotherapist, a body therapist and a psychiatrist.

The programme focuses on a pathway to wellbeing, centred on restoring control, safety, connections, identity, dignity and wellbeing and reducing fear, guilt, grief; loss, shame, distrust and hopelessness.

Rachel highlighted that the challenges for the programme include stereotypes of the 'traumatised refugee'; lack of specialist refugee mental health workers; cultural training required for referrals; general awareness of refugee; access to an interpreter and experience of working with torture and trauma victims. Opportunities of the programme include vicarious resiliency and advocacy on stereotypes.

Solomon Islands Red Cross and Fiji Red Cross (Pacific Working Group): Advancing Health for Migrants and Displaced Persons across the Pacific

Clement Manuri, Deputy Secretary General, Solomon Islands Red Cross and Sneh Kumar, RFL Focal Point, Fiji REd Cross

The Asia Pacific Migration Network (APMN) Pacific Working Group (represented by the Solomon Islands Red Cross and Fiji Red Cross) began by providing an overview of migration in the context of the Pacific, including seasonal migration, usually relating to labour and both internal and external and both permanent or short term; disaster related migration, people moving to live with relatives after homes destroyed due to cyclones/floods/conflict; study, migration can be internal or external, usually to Australia, New Zealand and Fiji; and permanent resettlement, usually forced migration due to climate change; asylum seekers and refugees – usually received by Australia and New Zealand. Issues and vulnerabilities related to migration in the Pacific include: exploitation; increased crime rates; overcrowding leading to poor living standards; health and sanitation concerns and an increase in poverty.

Fiji Red Cross has created an action plan, the main features of which include: continuing to create awareness in the communities in terms of Early Warning Systems; Integrated Vulnerability Capacity Assessments (IVCA) that are conducted in communities holistically in an integrated approach between health and disaster teams; identification of risks and hazards; the drawing up of an action plan and risk mapping.

The impacts of Tropical Cyclone (TC) Winston were emphasised, including that the Tropical Cyclone was one of the most severe ever to hit the South Pacific; over 350,000 people (about 40 percent of the nation's population) were affected, across all four divisions of Fiji; 44 people died and 32,200 houses were damaged or destroyed; water, power, health and educational services and infrastructure were significantly damaged; Government reported 229 schools and other public buildings such as health centres were damaged or destroyed; livelihoods, particularly those of farmers and fisher people were significantly impacted; at its peak over 50,000 people were in over 1,000 evacuation centre; health and hygiene was and remains a concern; the Fijian Government estimated the total damage bill to be more than 500 million USD; Shelter, health, food, water, sanitation and hygiene, education and protection were identified as the most urgent needs for affected people.

Internal migration on Koro island was also highlighted, including due to the devastation of TC Winston. It was noted that data was a challenge due to the constant movement of people. Overall, data showed that most people left Koro island immediately after the Cyclone, and then returned 2-3 months later; although some have not returned at all. Those returning cited economic difficulties and overcrowding as the main reasons for returning to Koro Island.

The Asia Pacific Migration Network (APMN) Pacific Working Group was created at the 'Mobilising the Movement' migration meeting in Kuala Lumpur, 2016. The working group has held regular meetings either via webinar or skype. With the assistance and support of the Asia Pacific Migration Network Secretariat, a "Pacific Statement" was drafted at the 2016 APMN General Meeting, developed over the following months and then presented to the Pacific Leaders meeting in November which was held in Fiji. The Statement was discussed and deliberated at the meeting, and feedback was given to ensure it reflected the views of all National Societies in the Pacific. It was fully endorsed by Pacific leaders in May 2017.

Korean Red Cross: Health Services for Migrants

Yoonkyung Kim, Deputy Head International Relation and
Sang Gyu Park, Senior Officer, Programme Develpment & Operation Team

There are more than 2 million foreigners living in the Republic of Korea, accounting for nearly 4 percent of the total population. There has recently been an increase in the number of foreign residents. Many of the migrants to Korea come from Asian countries, including China, Vietnam, Thailand, Mongolia, the Philippines and Bangladesh. Among these migrants, around 600,000 are temporary labour workers, 160,000 are marriage migrants and there are approximately 211,000 irregular migrants. It was highlighted that many migrant workers, especially irregular migrants and refugees, face barriers to basic services, including health, education, housing and livelihoods. Since 1994, there have been more than 25,000 asylum seekers in the Republic of Korea, with a low acceptance rate as refugees (slightly more than 7 percent) and a restriction on work for the first 6 months. Often it is complicated for migrants to receive health insurance, there is limited support for livelihoods and it can take more than one year to be confirmed as a refugee.

Korean Red Cross has the "Windmill of Hope" programme, which targets four main groups: children and youth; seniors; families in crisis and migrants. The Windmill of Hope programme has four main services: livelihoods; housing; education and health and care. The total budget for this project in 2017 is 6 million USD. The project also has partnerships with the Ministry of Justice; UNHCR; the Foreign Workers Support Centre; the Multi-Cultural Family Support Centre and from refugee support organisations and others.

In 2012, the Korean Red Cross established a Healthy Neighbour Centre, to provide medical services to migrant workers, multicultural families, refugees, asylum seekers, and other vulnerable groups. The Centre was established with a tripartite agreement between Hyundai Motor Chung Mong-Koo Foundation and Seoul National University Hospital. The Health Neighbour Centres provide basic knowledge, organises workshops and seminars for local community centers and INGO/NGOs to develop networking and promote services and provide free vaccination to migrant workers at their workplaces. The Happy Mom Project is a partnership between the Korean Red Cross and Lotte, Samsung and Hanjin. The project provides maternity bags, 6 hours maternal training and care to vulnerable women, including migrant women, who are expectant.

Korean Red Cross concluded by noting positives of engagement in migrant health, including the positioning of Korean Red Cross as a leading organization to provide quality health services to migrants; strengthened partnerships with relevant authorities and strengthened networks with migrant-related organizations and "covering a blind health spot" where the Government cannot reach. The Korean Red Cross also noted challenges, including difficulties in promoting services to irregular migrants; sustainable funding; negative public perception of migrants, especially migrant workers and language and communication barriers.

V. PERSPECTIVES FROM PARTNERS

Facilitator:

Zeke Simperingham, IFRC, Regional Migration Coordinator, Asia Pacific Regional Office

International Organisation for Migration (IOM): Migration Health - Why, What, How?

Patrick Duigan, Regional Thematic Specialist Migration Health,
IOM Asia Pacific Regional Office, Thailand

Patrick noted that internal and international migration is unprecedented throughout Asia and is likely to grow in the future. Some of the factors stimulating population movement include: increasing levels of political and economic cooperation; opening up of borders; rapid development of transport sector, new socioeconomic opportunities; high demand for low-skilled workers in developed countries, especially those with aging populations and low fertility rates which need migrants to maintain economic competitiveness and the growing impact of disasters and climate change.

Migration Mega-trends by IOM

Patrick then emphasised the importance of migrant health, including: migrants are human beings, and have a right to health; migrant-inclusive health systems improve public health and global health outcomes; healthy migrants contribute to positive sustainable development outcomes.

One of the common migrant health myths is that “migrants are carriers of disease” and that “migrants are a burden on the health system”. However, the reality is that migrants are often more vulnerable than nationals to health risks; migrants often underutilize services; migrants contribute hugely to development and that migrants are very diverse.

Some of the key migrant health concerns include infectious diseases, linked to inadequate sanitation and hygiene; cramped and crowded living conditions; access to prevention and treatment, immunization, Non-Communicable Diseases (NCDs), linked to availability (promotion) of unhealthy lifestyles, decreased physical activity; environmental and occupational health impacts. Trauma, linked to workplace injuries; traffic accidents; violence (including Sexual and Gender Based Violence). Mental health, linked to isolation, stigmatisation and discrimination, forced migration, exploitation, legal status and, for example, the threat of eviction.

Patrick noted that some of the challenges in addressing migrant health include language and communication, health education and prevention among migrants; health care financing; cross-border collaborations and effective collaboration with the private sector.

Patrick concluded by noting that migration is not a problem to be solved, but a reality to be managed. It is inevitable, given demographic among other driving forces; necessary, if skills are to be available, jobs to be filled and economies to flourish and

United Nations Refugee Agency (UNHCR)

Dr. Herve Isambert, Senior Public Health Officer, UNHCR, Regional Office, Thailand

Dr Herve noted that "persons of concern" to UNHCR include refugees, asylum seekers, stateless persons, internally displaced persons (IDPs) and returnees. Dr Herve highlighted that the majority of refugees now live in urban settings or rural areas. The health challenges of urban settings include safety (related to legal status); cost of health care and treatment; Non-Communicable Diseases (NCDs) and mental health.

UNHCR's focus on health is on Primary Health Care, as well as on providing essential life-saving referral care; ensuring quality services and minimum standards are met and using data for evidence-based planning and programming.

Dr Herve highlighted the recent New York Declaration on Refugees and Migrants, and the forthcoming Global Compact for Refugees. Considering the scale of displacement and the duration often lasting for decades, it is now well recognised that purely humanitarian responses to health will often be inadequate and are not cost effective. Working through and supporting national systems is a "win win strategy" and that in all health interventions, partnerships are vital.

Dr Herve concluded by suggesting that IFRC National Societies and the UNHCR could work together on collaborating at the community level; resetting the partnership agenda – viewing UNHCR not just as a donor, but as a collaborator and engaging with UN-

International Planned Parenthood Federation (IPPF): Sexual and Reproductive Health Issues in Humanitarian Settings

Keya Saha-Chauhury, Senior Capacity Development and Partnerships Advisor, Humanitarian Programme, IPPF, Regional Office, Thailand

Keya began by providing a snapshot of humanitarian trends and concerns including that 99% of maternal deaths occur in developing countries; 60 percent of these occur in countries affected by natural disasters, displacement or conflict. And that Asia Pacific is the world's most disaster-prone region.

Keya then noted that vulnerability to poor sexual and reproductive health can increase in times of disaster and displacement due to persisting gender inequality, breakdown in social structures, family separation, reduced access to health/legal services, overcrowding and inadequate shelter, exploitation and changes in legal status. Such factors can heighten the risk of Gender Based Violence (GBV) and HIV transmission in times of humanitarian emergency.

IPPF works to decrease mortality and morbidity in humanitarian emergencies through integration of the MISP (Minimal Initial Service Package) on Sexual and Reproductive Health in Humanitarian Settings (recognised within the SPHERE standards) into preparedness and response activities.

This includes through advocacy and integration into national and sub-national Disaster Risk Reduction policies and health curriculums; coordination with global, regional and national partners during preparedness and response; service delivery and referral; training and capacity building support on MISP for national member associations and partners. Moving forward IPPF plans to strengthen its focus on inclusion of vulnerable populations in preparedness and response.

Keya concluded with noting current and potential areas of collaboration between the IFRC National Societies and IPPF Member Associations including: RCRC representatives included in MISP Trainings in Pakistan; Sri Lanka MoU between FPA SL and the Red Cross – focused on prepositioning and joint assessments, shared service sites for psychosocial support (PSS) and health services; joint advocacy in the Philippines; and logistics support in Indonesia.

Association of South East Asian Nations (ASEAN): ASEAN Health Cooperation on Migration and Health

Jennifer dela Rosa, Senior Officer Health Division, Human Development Directorate, ASEAN Socio-Cultural Community Department, Indonesia

Jennifer began by providing an overview of the structure of the ASEAN Socio-Cultural Community Department (ASCC); the ASCC objectives on migrant health and the challenges and opportunities facing the ASCC.

Jennifer noted that under the Roadmap for an ASEAN Community (2009-2015), migrant health cooperation is focused on "ensuring access to adequate and affordable healthcare, medical services and medicine, and promotion of healthy lifestyles for the peoples of ASEAN". Under the ASEAN Strategic Framework on Health Development (2010-2015), regional migrant health strategies include (a) increased access to primary health care for migrants (b) evidenced-based advocacy on migrant health and (c) sharing of information and best practices on migrant health.

Under "ASEAN 2025: Forging Ahead Together", migrant health is focused on "a community that is healthy, caring, sustainable and productive and one that practices healthy lifestyle, resilient to health threats and has universal access to healthcare" and on "promoting increased accessibility for persons with disabilities and other vulnerable groups". The ASEAN Post 2015 Health Development Agenda (APDHA) (2016-2020) identifies 20 health priorities, including monitoring progress of Universal Health Covergae (UHC) with regard to special populations; development of guidelines on health coverage of special populations (including documented migrants); conducting a workshop to develop guidelines on health coverage for documented migrants and on sharing and recommendations for policy consideration and a research and development of health research agenda for 2017-2020 for special population.

Jennifer concluded by noting that possible areas for collaboration between IFRC National Societies and ASEAN include around communicable diseases; non-communicable diseases (NCDs); mental health; occupational health; disaster health management; Universal Health coverage (UHC); food safety; nutrition and water and sanitation (WASH). At the sectoral body level, possible collaborations include through the work programmes on labour, health, migrant workers; the operationalisation of ASEAN Declarations (including on HIV/AIDS, non-communicable diseases (NCDs), social protection, and the promotion and protection of the rights of migrant workers.

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